NHS Education for Scotland

NES/20/01

AGENDA FOR THE ONE HUNDRED AND FIFTY-THIRD BOARD MEETING

Date: Thursday 30th January 2020
Time: 10.15 a.m.
Venue: Meeting Rooms 3 and 4, Westport 102, Edinburgh

1.	**Chair's introductory remarks**	
2.	**Apologies for absence**	
3.	**Declarations of interest**	
4.	**Minutes of the One Hundred and Fifty-Second Board Meeting** To approve the minutes of the meeting held on 31st October 2019.	NES/19/121 (Enclosed)
5.	**Matters arising from the Minutes**	
6.	**Actions from previous Board Meetings** For review.	NES/20/02i (Enclosed)
7.	**Chair and Chief Executive Updates**	
	7a. Chair's Report	NES/20/02ii (Enclosed)
	7b. Chief Executive's Report	NES/20/03 (Enclosed)
8.	**Update on Cabinet Secretary Priorities: Integration** *(K. Wilson)*	NES/20/04 (Enclosed)
9.	**Governance and Performance Items**	
	9a. Finance Report *(A. McColl)* To receive and endorse.	NES/20/05 (Enclosed)
	9b. Performance Report *(D. Cameron)* For consideration.	NES/20/06 (Enclosed)
	9c. Staff Governance Committee: 7th November 2019 *(A. Currie)* To receive a report and the minutes.	NES/20/07 (Enclosed)
	9d. Educational & Research Governance Committee: 12th December 2019 *(D. Hutchens)* To receive a report and the minutes.	NES/20/08 (Enclosed)

9e.	Digital Sub-Committee: 13th December 2019 *(G. Huggins)* To receive a report and the minutes.	NES/20/09 (Enclosed)
9f.	Audit Committee: 16th January 2020 *(D. Steele)* To receive a report and the minutes.	NES/20/10 (*To follow*)
9g.	Finance & Performance Management Committee: 21st November 2019 *(D. Garbutt)* To receive a report and the minutes	NES/20/11 (Enclosed)

10. Strategic Items

10a.	Medical Trainee Progression Outturn *(R. Parks)* For consideration	NES/20/12 (Enclosed)
10b.	Medical Revalidation *(R. Parks)* For consideration.	NES/20/13 (Enclosed)
10c.	Annual Operational Plan 2020-21 *(D. Cameron)* To consider a draft.	NES/20/14 (Enclosed)
10d.	Financial Plan *(A. McColl)* To consider a draft	NES/20/15 (Enclosed)

11. Risk Register *(S. Irvine)* NES/20/16 (Enclosed)

12. Items for Noting

12a	NES and SFC Joint Action Plan *(D. Felix)* For noting.	NES/20/17 (Enclosed)
12b.	Partnership Forum: 30th October 2019 *(L. Ford* To receive a report and the minutes.	NES/20/18 (Enclosed)
12c.	Training and Development Opportunities for Board Members For information.	NES/20/19 (Enclosed)
12d.	Growing the next generation of GPs: Gillies Report *(R. Parks)* For information.	NES/20/20 (Enclosed)

13. Any Other Business

14. Date and Time of Next Meeting

Thursday 26th March 2020 at 10.15 a.m.

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January 2020

IN CONFIDENCE **NES/19/121**

NHS Education for Scotland

MINUTES OF THE ONE HUNDRED AND FIFTY-SECOND BOARD MEETING HELD ON THURSDAY 31st OCTOBER 2019 AT SCOTTISH HEALTH SERVICE CENTRE, EDINBURGH

Present:
Mr David Garbutt, Chair
Ms Anne Currie, Non-executive member
Mrs Linda Dunion, Non-executive member
Mrs Jean Ford, Non-executive member
Ms Liz Ford, Employee Director
Mr Douglas Hutchens, Non-executive member
Professor Stewart Irvine, Medical Director and Deputy Chief Executive
Ms Audrey McColl, Director of Finance
Ms Caroline Lamb, Chief Executive (agenda items 7b to 15)
Ms Vicki Nairn, Non-executive member
Dr Doreen Steele, Non-executive member
Ms Sandra Walker, Non-executive member
Mrs Karen Wilson, Director of NMAHP

In attendance:
Mr David Feruson, Board Services Manager (Board Secretary)
Dr David Felix, Postgraduate Dental Dean
Mr Donald Cameron, Director of Planning and Corporate Resources
Ms Dorothy Wright, Director of Workforce
Ms Laura Allison, Head of Programme, Quality Improvement (particularly for agenda item 8)
Mr Colin Brown, Head of Governance, Digital (particularly for agenda Item 9d)
Mr John MacEachen, Head of Corporate Communications

1. CHAIR'S INTRODUCTORY REMARKS

The Chair welcomed everyone to the meeting and advised that Laura Allison would be joining the meeting for agenda item 8 – Cabinet Secretary's Priorities: Access.

The Chair advised that this would be David Ferguson's last formal Board meeting before retiring from NES at the end of December and, on behalf of the Board, thanked David for his contribution to the work of the Board and wished him well for the future.

The Chair confirmed that Caroline Lamb would soon be joining Scottish Government for a period of six months secondment in the role of Director of Digital Reform and Service Engagement. Professor Stewart Irvine will take up the role of Acting Chief Executive for this period and there will be backfill for his substantive role of Medical Director. The secondment arrangement will be reviewed after one month and again after three months.

2. APOLOGIES FOR ABSENCE

Apologies were received from Geoff Huggins, NDS Director and Christopher Wroath, Digital Director.

3. DECLARATIONS OF INTEREST

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

4. MINUTES OF THE ONE HUNDRED AND FIFY-FIRST BOARD MEETING (NES/19/107)

The minutes of the Board meeting held on 26th September 2019 were approved.

Action: DJF

5. MATTERS ARISING FROM THE MINUTES

None.

6. ACTIONS FROM PREVIOUS BOARD MEETINGS (NES/19/109)

The Board noted that most of these actions had been completed or were in hand.

The following points were noted or discussed:

1) It was noted that John MacEachen will be meeting with non-executive members after today's Board meeting to discuss the NES Communications Plan which will be submitted to the Board in January 2020.
2) It was agreed, moving forward, to assign 'target dates' to the actions, where appropriate**.** **Action: DJF**

7. CHAIR AND CHIEF EXECUTIVE REPORTS

a. Chair's Report

The Chair provided a verbal report on recent meetings and activities, including the following:

1) Discussions on a new governance structure in relation to NES's digital activities.
2) Welcome speaker at the Scottish Quality and Safety Fellowship Programme, Cohort 12, Residential 1. The lack of participants from NES in this programme will be raised with the Chief Executive. **Action: DG**
3) Discussion on an agenda for a joint meeting of NHS Board Chairs and Chief Executives.
4) Attendance at a NHS Board Chairs Away-Day, including useful discussions on culture, leadership, health and social care integration and primary care.

5) Discussions on the work of the GMC and NES Wellbeing Advisory Group, the forthcoming GMC report on the health and wellbeing of doctors (anticipated in mid-November) and the forthcoming submission to the CMO of a proposal in relation to a new mental health service for doctors.
6) A meeting of the National Performance Management Committee, at which it was noted that only one executive in the whole of NHSScotland had been successful in gaining an 'outstanding' appraisal rating. This may be a result of setting unrealistic targets for executives. In discussion, it was agreed that talent management is a priority area and it was agreed to circulate, for the Board's information, a Scottish Government paper from 2017 on Executive Level Leadership and Talent Management in NHSScotland. **Action: CB**
7) Involvement in the recruitment of a Board member for NHS Lanarkshire.
8) A meeting of the Corporate Governance Steering Group. It has been confirmed that the Blueprint for Good Governance will include a model for educational governance.
9) Discussions on the appointment of Alan Cooper as the new head of support staff for the NHS Board Chairs and Chief Executives Groups.
10) A meeting of the NHS Global Citizenship Programme Board.
11) Discussion with Scottish Government on mental health priorities.
12) Discussions regarding NHS Tayside's intention to recruit new joint non-executive Board member and IJB appointments, with additional remuneration for the IJB component (which is not the norm).
13) Discussions on the implications for NHS Boards of the new Public Health agenda. A paper on the actions for NES will be circulated. **Action: DG**
14) A meeting with Scottish Government on the development of a performance dashboard for NHS Boards and Chief Executives.
15) Discussions on a new structure for research and innovation across NHSScotland, involving the Scottish universities.
16) A meeting with Keith Redpath, the new Chair of NHS NSS. Topics discussed included the Digital Health and Care Strategy.
17) A meeting of the Talent Management Board.
18) Discussion regarding a new Value Management QI initiative.
19) Discussions with the Cabinet Secretary, at which the need to progress the digital agenda was underlined.

In a brief discussion on talent management and succession planning, it was agreed that the aims of Project Lift are laudable, although the scheme may be constrained somewhat by its self-referral nature.

b. Chief Executive's Report **(NES/19/110)**

The Chief Executive introduced a report on recent meetings and activities, highlighting the following items in particular:

1) Liz Ford's intention to stand down from her role as Employee Director and non-executive Board member at the end of March 2020, when her current term ends. On behalf of the Board, the Chief Executive thanked Liz for her contribution and staff side expertise.
2) David Ferguson's retiral from NES at the end of 2019. The Chief Executive thanked David for his contribution to NES in the role of Board Services Manager and advised that his departure from NES will be marked more formally at the Board Development Session on 28th November.

3) Jan Clarkson, Associate Postgraduate Dental Dean, was congratulated on her receipt of the Fletcher of Saltoun Award for 2019 from the Saltire Society, for her contribution to Science. The Board agreed to send Jan a letter of congratulations. **Action: DG**
4) Shirley Rogers' intention to step down from her role as NHSScotland Chief People Officer and Director for Health Workforce, Leadership and Reform, with effect from the end of March 2020.
5) Attendance, with the Chair, at a Joint NHSS Chairs and Chief Executives Development Session.
6) NES's continuing preparations for the UK's planned withdrawal from the EU (Brexit).
7) An update on the transfer of responsibility for Workforce Statistics from NHS NSS to NES with effect from 1st April 2020. Members will be provided with information on NES's forthcoming role as the official provider of NHS workforce statistics. **Action: CL**
8) Corporate Communications, Quarterly Report, Quarter 2, 2019-20: attached to the Chief Executive's Report as an Appendix.
9) The successful launch of Turas FNP on 9th October.
10) Dr Amjad Khan representing NES at the Health and Sport Committee meeting on 1st October, in relation to its Inquiry into Primary Care.
11) An update in relation to the first cohort of the re-modelled AHP Careers Fellowships.
12) An update on the Psychology of Parenting Project.
13) NES's excellent achievement of a 94% iMatter Action Plan completion rate for 2019 (up from 81% in 2018).

The Chief Executive added that Christine McLaughlin has decided to take a career break from her Director of Health and Care Finance role at Scottish Government.

Some discussion took place on certain items within the report and the following points arose:

14) It was acknowledged that communication and public engagement are key to the success of the integration agenda. The Scottish Health Council and the local authorities have key roles in this engagement agenda.
15) The key roles of line managers in valuing and engaging with staff were highlighted and it was noted that the expectations of the line manager role will be explored at the Staff Governance Committee meeting on 7th November.
16) It will be useful to let members know the future dates of AHP Careers Fellowships celebration and learning events.
17) Discussions are ongoing regarding the creation of a new medical school in Scotland. This may provide opportunities for partnership arrangements between existing medical schools and other HEIs.
18) Regular submissions are made to Scottish Government in relation to the implications of Brexit and NES's preparedness, centring mainly around workforce supply issues. It may be useful for the Board to discuss this At some point.

8. UPDATE ON CABINET SECRETARY'S PRIORITIES: ACCESS (NES/19/111)

This was the second in a regular series of updates on NES's contributions to progressing the Cabinet Secretary's published priorities.

Laura Allison was welcomed to the meeting for this item.

Karen Wilson introduced a paper providing an update in relation to work currently being progressed in NES as a result of the Cabinet Secretary's priority to improve access. The following points were highlighted:

1) Attention was drawn to the publication, in October 2018, of the Scottish Government's Waiting Times Improvement Plan.
2) There are key roles for role development, innovation and quality improvement.
3) Elective centres and trauma centres are key drivers of the Access agenda.

Laura Allison provided an overview of the Access QI Programme. NES has worked in partnership with HIS to develop and design this programme, which was launched on 30th October in the accelerator NHS Boards, that is NHS Lothian, NHS Tayside and NHS Grampian.

The following points arose in discussion:

4) It was recognised that Access is a complex area, with a cluttered landscape, and that it is important to co-ordinate activity and avoid duplication of effort.
5) NES is working with NHS Boards to improve the quality of the workforce data which is currently available. A detailed action plan is being produced for submission to Scottish Government, including developments in the AHP workforce.
6) The relevance of previous work on the 18 weeks referral-to-treatment target was acknowledged.
7) A whole system approach is being taken in the accelerator NHS Boards, with a strong focus on demand management.
8) There is a need for a concentrated effort to improve workforce planning, led by Scottish Government. The considerable supply side deficit was once again highlighted.
9) It will be important to grasp this opportunity to consolidate current QI initiatives, utilising the skills of the staff in NHS Boards who have undertaken QI training.

Following discussion, the Board supported NES's work in relation to improving access, subject to adequate resource being available.

9. GOVERNANCE AND PERFORMANCE ITEMS

a. Finance Report (NES/19/112)

Audrey McColl introduced a paper presenting the financial results for the first six months of the financial year to 30th September 2019 and indicating the current forecast outturn as at 31st March 2020.

The following points were highlighted:

1) The position as at 30th September reflects an underspend of £4.1 million, of which £1.4 million relates to training grades, £1.5 million is timing variances and £0.6 million is an underspend in staff costs (which will be re-allocated to other business priorities before the year-end.
2) The current projected year-end outturn is an underspend of £2.7 million. Of this projected underspend, £2.1 million relates to medical training grades, which, if it continues, will reduce the £4.9 million required from Scottish Government in 2019/20 to address the recurrent medical training grades gap, leaving an underspend of £0,6 million across the rest of NES.
3) Particular attention was drawn to the sections of the paper relating to: Training Grades; Savings – Vacancy Clawback; Transformation Fund Projects; Risks to forecast position; and Medical Training Grades Baseline Funding Gap (referred to in the bullet point above).

The following points arose in discussion:

4) The Board will be kept updated in relation to the NDS financial position.
5) The reduction in Scottish Government funding for NMAHP was discussed. This has led to a need to prioritise activities.
6) It was emphasised that NES only has financial flexibility in relation to recurrent baseline funding.
7) The challenges of recruiting specialist finance staff, despite trying a number of different approaches, was noted.

The Board noted the information contained in the Finance Report.

b. Educational & Research Governance Committee: 9th October 2019 **(NES/19/113)**

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

The usefulness of the Educational Governance Lead Officer's Report was highlighted.

c. Audit Committee: 3rd October 2019 **(NES/19/114)**

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

The updated Audit Committee remit was approved. **Action: DJF**

d. Proposed Remit and Membership of Digital Committee **(NES/19/115)**

David Garbutt introduced a paper containing proposals in relation to the remit and membership of the Digital Committee.

Subject to the amendment of clause (a) to include a responsibility for the oversight of resource utilisation, the proposed remit was approved. The proposals in relation to membership were approved. **Action: CB**

10. STRATEGIC ITEMS

a. Blueprint for Good Governance Action Plan: Progress Report **(NES/19/116)**

Caroline Lamb introduced a paper providing the Board with a progress update on the Blueprint for Good Governance Action Plan agreed at the Board Away-Day on 24th – 25th April 2019 and submitted to the Cabinet Secretary on 30th April.

It was noted that there has been no feedback on the action plan from Scottish Government as yet.

In relation to one of the action points in relation to Holding to Account, it was clarified that the NES Assurance Framework had been shared with a colleague at the Scottish Ambulance Service, for the attention of all NHS Boards.

The progress report was noted by the Board.

b. Operational Planning 2020/21 to 2022/23 **(NES/19/117)**

A paper had been circulated to provide an update on the process for operational planning for the three-year period 2020/21 to 2022/23 and to outline the process which will be undertaken over the next five months under NES's integrated operational and financial planning cycle. The following points were highlighted:

1) It was pointed out that the timescale for the publication of the Scottish Budget is not yet known.
2) As in previous years, the operational planning process for 2021/22 – 2022/23 has begun in the absence of Scottish Government planning guidelines and a confirmed budget for NES.
3) The annual operational plan will take account of the new NES Strategy and the Cabinet Secretary's priorities.

Discussion produced the following points:

1) Attention was drawn to the recent publication of the Gillies Report on growing the next generation of GPs. Although the recommendations are for Scottish Government to take forward, the report will be included on the January 2020 Board agenda for information. **Action: DJF**
2) It was accepted that, due to the unusually short timescales, it may be necessary for draft operational and financial plans to be circulated for comment between formal Board meetings.

The paper was noted.

c. Board Development Session on 28th November 2019: The Digital Landscape **(NES/19/118)**

Caroline Lamb introduced a paper providing an early sight of a draft programme for the next Board Development Session on 28th November 2019.

It was noted that the time available for this development session would be slightly curtailed due to an important meeting to review the ATOS contract taking place in Livingston later at 2.00 p.m.

The following points arose in discussion:

1) Alistair Hann's presentation could usefully include a section on Cloud Technology.
2) It may be useful to include perspectives from more than one NHS Board.
3) It would be useful to be clear on the aims/purpose of the development session and members were invited to provide any comments on this to Caroline Lamb as soon as possible. **Action: All Board members**
4) On an associated point, it was suggested that there is a need to review the current arrangements for the approval of information governance proposals at a national level.

The foregoing points will be taken into account in revising the draft programme.
Action: CL

11. RISK REGISTER (NES/19/119)

Caroline Lamb introduced a paper presenting the NES Risk Register as at October 2019.

It was suggested that it may be useful to review the mitigating measures in relation to Corporate Risk R7, due to the forthcoming loss of a number of key individuals.
Action: CL

The role of the Change Management Programme Board was explained, for the benefit of one of the members.

12. ITEMS FOR NOTING

a. Training and development opportunities for Board members **(NES/19/120)**

The Board noted a paper providing details of any upcoming training and development events for Board members, together with details of opportunities for members to gain a deeper understanding of NES's business**.**

The Chair encouraged members to attend Quality Improvement events, where possible.

b. NHS in Scotland: Audit Scotland Report, 24th October 2019

The Board noted this recent Audit Scotland report.

13. ANY OTHER BUSINESS

There was no other business.

14. DATE AND TIME OF NEXT MEETING

The next Board meeting will take place on Thursday 30th January 2020 at 10.15 a.m.

CLOSED SESSION

15. MINUTES OF CLOSED SESSION BOARD MEETING HELD ON 28TH SEPTEMBER 2019 (NES/19/107(a))

A number of officers withdrew from the meeting for this session.

Subject to the addition of a comment suggested by one of the members, the minutes were approved by the Board. **Action: DJF**

NES
November 2019
DJF

NES **NES/20/02**
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January 2020

Actions arising from Board meetings: Rolling list

Minute	Title	Action	Responsibility	Date required	Status and date of completion
Actions agreed at Board meeting on 31st October 2019					
4	Minutes of previous Board meeting	Add the approved minutes to the Corporate Hub.	David Ferguson	1st November 2019	Added on 1st November 2019
6	Actions for previous Board meetings	Assign target dates to actions, where appropriate, from now on.	David Ferguson	1st November 2019	Actioned on 1st November 2019.
7a	Chair's Report	(i) Raise with Caroline Lamb the issue of the lack of NES participants in the Scottish Quality and Safety Fellowship Programme.	David Garbutt	8th November 2019	In progress – to discuss with Acting CE during January 2020.
		(ii) Circulate a 2017 SG paper on Leadership and Talent Management.	Colin Brown	1st November 2019	Circulated on 31st October 2019
		(iii) Circulate a paper on the actions for NES in relation to the new Public Health agenda.	David Garbutt	8th November 2019	In Progress.
7b	Chief Executive's Report	(i) Provide information on NES's forthcoming role as official provider of workforce statistics for NHSS.	Caroline Lamb	8th November 2019	Complete - Included in January 2020 CE Report
		(ii) Send a letter of congratulations to Jan Clarkson on her receipt of the Fletcher of Saltoun Award for 2019.	David Garbutt	8th November 2019	Completed – letter issued
9c	Audit Committee minutes	Actions, as required, following approval of the updated Audit Committee remit.	David Ferguson	12th November2019	Completed
9d	Digital Committee	Amend clause (a) in the remit, as agreed,	Colin Brown	8th November 2019	Completed – remit updated

Minute	Title	Action	Responsibility	Date required	Status and date of completion
10b	Operational Planning for 2020/21 to 2022/23	Include the Gillies Report in the January 2020 Board agenda, for information.	David Ferguson	12th November 2019	Completed – agenda item 12d refers
10c	Board development session: 28th November 2019	(i) Any comments on the aims/purpose of the session to be passed to Caroline Lamb.	All Board members	8th November 2019	Completed
		(ii) Revise the programme, as discussed.	Caroline Lamb	8th November 2019	Completed – session held on 28 November
15	Closed Session Board minutes: 28th September 2019	Amend the minutes, as agreed.	David Ferguson	8th November 2019	Completed
Actions agreed at Board meeting on 26th September 2019					
9e	Board and committee meeting dates for 2020/21	Provide information on Board and committee meeting venues, once booked.	David Ferguson	December 2019	In hand.
10b	Corporate Parenting	Give consideration to co-opting a care-experienced young person onto a Board committee(s) and/or appointing one to a training position on the Board.	David Garbutt and Caroline Lamb	N/A	Currently under consideration
10e i	NDS Status Update	Consider the nature and timing of a Board development session on Cloud Technology.	Geoff Higgins and Christopher Wroath	November 2019	Completed - included in the Board development session on 28th November 2019.
Actions agreed at Board meeting on 31st January 2019					
9b	Medical Revalidation	Discuss with the RDBS Chair how best to present the recommendations from the annual quality assurance reports in future.	Stewart Irvine	N/A	Completed – discussed with the RDBS Chair – the MARQA report is on the Board Agenda for January 2020.

NES **NES/20/02ii**
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NHS Education for Scotland

Chair's Report for 30th January 2020 Board Meeting

28th Nov	Attended NDS Team Meeting and discussed progress on developments.
29th Nov	Meeting with John Crichton (President of the Royal College of Psychiatrists) re Document on Mental Health Support Services for Doctors in Scotland.
2nd Dec	Mentored Meghan McEwan on applying for Chair's role
3rd Dec	Met with Neena Mahal (Chair, NHS Lanarkshire) & Peter Murray (Chair, IJB Chairs Group) re integration
4th Dec	Attended shortlisting meeting for NHS Lanarkshire Board member appointments
5th Dec	Meeting with Elinor Mitchell (Director of Primary Care, Scottish Government) re information governance
9th Dec	Attended NHS Chairs Private Meeting
	Attended Private Meeting with Cabinet Secretary
11th Dec	Attended shortlisting meeting for NES Board Secretary & Principal Lead – Corporate Governance role
12th Dec	Attended NES Educational & Research Governance Committee
13th Dec	Attended NDS Digital Sub-Committee
	Chair & Vice Chair Teleconference with Chair/Vice Chair of Board Chief Executives Group
16th Dec	Attended Talent Management Board
	Conference call with Chris Martin (Silvermaple) re Non-Executive and Chairs appraisal
13th Jan	Meeting with Shirley Rogers, Colin Brown and John Brown (Chair, NHS Greater Glasgow & Clyde) regarding Clinical Leadership and Health and Wellbeing Review
15th Jan	Meeting with Colin Brown and John Brown re Corporate Governance
17th Jan	Attended NHS Lanarkshire Board Member Interviews
21st Jan	Conference call for Chairs and Cabinet Secretary Agenda Setting
	Conference call re NES Human Factors Update with Paul Bowie (NES)
22nd Jan	Attended Ministerial Working Group on Health and Social Care re integration

23rd Jan	Chaired NES/SSSC Partnership Group
24th Jan	Attended Scottish Access Collaborative Programme Board Meeting
	Conference call with Stewart Irvine and Charlie Massey (Chief Executive, GMC) re: GMC Wellbeing Report and Supporting a Profession under Pressure
27th Jan	Attended Meeting of NHS Board Chairs & Cabinet Secretary
	Attended Private Meeting with Cabinet Secretary
29th Jan	Meeting with the Scottish Clinical Leadership Fellows (SCLFs)

CHIEF EXECUTIVE'S REPORT

Professor Stewart Irvine, Acting Chief Executive

January 2020

1 INTRODUCTION

1.1 I would like to welcome everyone to the first NES Board meeting of 2020 and my first as Acting Chief Executive. The agenda includes a mix of governance and strategic items, with a particular focus on operational and budgetary planning for the 2020-21 year.

1.2 In line with our agreement on reporting on the Cabinet Secretary's priorities, this agenda includes the third report which provides an update on NES's contribution to the delivery of Integrated Care.

1.3 Strategic items for discussion include papers on **Medical Trainee Progression Outturn** and **Medical Revalidation**. These papers aim to support the Board's understanding of the current status of progression and performance management in postgraduate medical education and training.

1.4 Our **Annual Operational Plan** (AOP) for 2020/21 sets out our plans for the second year of our corporate strategy for 2019-24 and positions NES to develop both a national workforce and digital leadership role. We are keen to receive feedback from Board members on the content of this draft plan. The paper also includes a subsequent letter received from Scottish Government requesting a more detailed **Digital Health & Care** plan. The output of this further work will be shared at the March Board meeting.

1.5 The draft **Financial Plan** sets out the way in which we will deploy our resources to support the AOP and articulates the challenges of achieving a balanced budget. The Board will meet on 27 February, before the planned Board Development Session, to discuss the final version of this plan.

1.6 There are several governance and performance items for noting which include the 2019-20 Quarter 2 Performance Report, a Finance Report and the minutes from various NES Committees. As requested at the last Board meeting, Members have also been provided with Professor John Gillies' report commissioned by Scottish Government on undergraduate medical education in primary care. Colleagues from the Medical directorate have prepared a cover paper summarising the content of the report and its implications for NES.

2 ANNOUNCEMENTS

NES Employee Director

2.1 **Liz Ford** has previously announced that she will be standing down from her role as Staff Side Chair/Employee Director and Non-Executive Member of the NES Board on 31 March 2020, which is the end of her current term. I would like to thank Liz again for all her hard work and dedication to the role.

2.2 I am pleased to confirm that **Lynnette Grieve**, a Unison Steward has been appointed as to the NES Staff-Side/Employee Director position. Lynnette has been an employee of NES since 2005 and has been a Unison Steward for a number of years.

NES Acting Medical Director

2.3 I am pleased to confirm that **Professor Rowan Parks** has been formally appointed to serve on the NES Board in his role of Acting Medical Director. Rowan's appointment is with immediate effect and will run until a new Chief Executive is appointed in due course.

NES Caldicott Guardian

2.4 The Board will wish to note that **David Felix** has assumed the role of NES **Caldicott Guardian**. There are currently a number of activities in NES that will require consideration in relation to the security and handling of patient data including the evolving NES Digital Platform and the Family Nurse Partnership.

Christopher Wroath, Non-Executive Director, Disclosure Scotland

2.5 Christopher Wroath has been appointed as a Non-Executive Board Member to the Board of Disclosure Scotland. His appointment commenced in November 2019 and will be a three-year tenure. This appointment was a targeted non-Executive role, with the main area of focus to support the delivery of Disclosure Scotland's Change Programme.

New Year's Honours

2.6 The full New Year Honours list for 2020 was published on the 27 December 2019. A link can be found here. The New Year's honours recognise the achievements and service of extraordinary people across the United Kingdom, and several colleagues from Scotland were awarded honours for their services to Health, Healthcare or Education.

2.7 The Chair and I have asked that a process be developed in NES to allow nominations to be fed through on a regular basis. My office are liaising with colleagues at the Scottish Government to develop an agreed process.

3 STRATEGIC UPDATES

NES Data Group

3.1 The transition of responsibility for **NHSS workforce data**, statistical and intelligence functions came from a review of existing arrangements, including the vision outlined in the Health and Social Care Workforce Plan (link). The workforce plan sets out an enhanced role for NES in workforce intelligence and also includes the planned move of ISD into the newly established Public Health organisation.

3.2 The transfer offers an opportunity to achieve greater alignment of workforce analytics with development of a supply-side workforce data platform by NES Digital. The ten-strong Data Group comprises of workforce statistical analysts located in Edinburgh, Glasgow and Dundee and is headed up by Colin Tilley.

3.3 In December, the NES Data Group achieved another key milestone towards its transition of workforce analytics functions from ISD to NES, with the release of the first quarterly workforce publications produced exclusively by NES.

3.4 During 2020, the transition will complete with the transfer of workforce data to NES and the replacement of existing reporting dashboards on the ISD website to a suite of NES-built dashboards within Turas Data Intelligence.

NES 2019/20 Mid-Year Review with Scottish Government

3.5 Audrey McColl, Karen Wilson and I participated in the NES Mid-Year Review, led by colleagues from the Workforce Directorate at Scottish Government. The focus of the review included an overview of performance management outlined in our 2019-20 Annual Operating Plan and our Performance Target Plan. We also discussed issues relating to the current financial landscape. Formal feedback is awaited, but the discussion was very positive.

Integrated Health and Social Care Workforce Plan for Scotland

3.6 I would like to highlight to the Board that the Integrated Health and Social Care Plan for Scotland was published in December 2019[1].

3.7 The Plan highlights the intention to put effective workforce planning at the forefront of achieving safe, integrated, high quality and affordable health and social care services for the people of Scotland. It underlines the need for better evidence which can support the many national actions that are being taking to address the challenges our services currently face. There is a focus on national challenges, including further embedding integration, improving waiting times and improving mental health support. The report sets out a number of recommendations to address these challenges.

3.8 The report also contains a range of activities which are likely to have an impact on NES. The Executive Team will consider a paper on this report at a meeting at the end of the month.

Publications from General Medical Council (GMC)

3.8 I would like to draw the attention of the Board to three recent reports published by the General Medical Council. The Chair and I recently had a teleconference with Charlie Massey, Chief Executive of the GMC, to discuss these reports in a Scottish context.

3.9 These reports are:

- Independent review of gross negligence manslaughter and culpable homicide[2] (June 2019)
- Fair to Refer? Reducing disproportionality in fitness to practice concerns reported to the GMC[3] (June 2019)
- Caring for Doctors, Caring for Patients - How to transform UK healthcare environments to support doctors and medical students to care for patients[4] (November 2019),

[1] An Integrated Health & Social Care Plan for Scotland (Scottish Government)
[2] Independent review of gross negligence, manslaughter and culpable homicide (GMC)
[3] Fair to Refer? Reducing disproportionality in fitness to practice concerns reported to the GMC (GMC)
[4] Caring for Doctors, Caring for Patients (GMC)

3.10 The *Caring for Doctors, Caring for Patients* report, written by Professor Michael West and Dame Denise Coia is closely linked to work being developed in Scotland by our Board Chair. The report reinforces existing evidence around the link between staff experience and patient culture. It is based on a suite of case studies undertaken with medical professionals across the UK. The report further emphasises the link between staff wellbeing and the retention of doctors. The report concludes that six urgent steps are needed to be taken to improve Autonomy, Belonging and Competence across the medical workforce.

NES Director of Workforce - Recruitment

3.11 Recruitment to the Director of Workforce post is now underway. As required by the Scottish Government circular on valued based recruitment for executive level posts, applicants will be required to complete psychometric testing, role play, a presentation and a competency values-based interview. Eden Scott, a recruitment agency, are conducting the search and will run the assessment centre process. In addition to two NES Executive Directors and two Non-Executive Directors, a representative from Scottish Government will join the interview panel on 9 March. Candidates will also have the opportunity on the to meet members of the Executive Team as part of the interview process.

4 Media interest and Communications activity

4.1 Work progresses on preparing our stakeholder engagement survey, which will be used to inform our refresh of our Corporate Communications Strategy. The Communications team have been assisted by Board Non-Executives to draw up both an online survey (which will be used to obtain baselines of awareness attitude towards NES) and a more detailed telephone interview script (which will be used to obtain more in-depth opinions and recommendations for how we engage with our stakeholders). We are currently refining our mailing lists, with a view to commissioning a survey to take place as soon as possible this Quarter.

4.2 Other notable Communications activity this quarter includes Scottish Government commissioning our Design team to do both a refresh of the NHSScotland branding and to create assets to be used for the NHS winter campaign. This is useful ‘Once for Scotland’ work – the commission will carry through to mid-2020, and potentially beyond.

4.3 This quarter we saw a good return on our social media in terms of reach and impressions. Consistent with previous quarters, the posts which perform best are those with an obvious human element, for which we can encourage comment and re-posting.

4.4 A copy of our latest Comms Quarterly report is attached as Appendix 1.

5. Dental (including Healthcare Science)

Caring for Smiles - 10th Anniversary

5.1 'Caring for Smiles' (CfS) is the Scotland-wide oral health improvement and support programme, which aims to provide the basic human right of good oral health for dependent older adults, enhancing quality of life through preventing pain and boosting confidence in social settings with friends and family. The programme is led by the National Older People's Oral Health Improvement Group (NOPOHIG) and developed through collaboration between NHS Education for Scotland (NES), NHS Health Scotland, University of Glasgow Dental School, and partners such as the Care Inspectorate (CI) and Scottish Social Services Council (SSSC). The programme provides training including local Health Board non-accredited training and SCQF accredited foundation and intermediate training provided by Health Boards and awarded through NES. The aim is to equip the workforce with the knowledge and skills to support them in the delivery of daily oral care to this priority group which can be complicated by factors associated with ageing and disability.

5.2 Since the programme began in 2010, 911 (97%) Care Homes have at least one member of staff trained and 50,739 care home staff have been trained (both non-accredited and accredited) in the CfS programme, although the percentage of care homes involved at any one time obviously fluctuates. Since accredited training began in 2013, 2450 care staff have completed foundation accredited training and 111 care staff have completed intermediate training. The Care Home sector is a dynamic environment with care homes closing, new homes opening, changes of ownership and management and a very high turnover of care home workers. These can all make access to staff for training difficult. To counteract these barriers and facilitate training examples of flexible approaches include arranging to visit night shift staff in the evenings and overnight, lunch time training and the introduction of a pilot whereby a number of care home workers are trained to SCQF intermediate level, which then allows them to delivering training at foundation level to fellow staff.

5.3 A 10th anniversary educational event hosted by NES is planned for 30th September 2020 and will look to build on the success of the programme over the last 10 years and look forward to exciting new developments for the future. The programme will continue to evolve as partnerships with other specialities are developed. For example, links are being made with NMAHP in NES to widen coverage to the Care at Home sector and acute hospitals whilst identifying ways to make training more accessible to staff in social care and third sector.

Healthcare Science

5.4 NES Healthcare Science recently published an annual report 2018-19[5], which was distributed to Boards' Scientific Leads and Executive Leads (usually Medical Directors). The report summarises our activities around commissioning

[5] NES Healthcare Science Annual Report 2018-19

training grades, CPD/workforce development offers and quality monitoring of training. The report is available via the NES website.

5.5 **Annual monitoring** of Healthcare Science training to year-end 2019 comprises trainee and supervisor standard surveys, training plan audit, annual review of progression checks. Training surveys, which are voluntary, have had a mixed response rate of around 50% and are useful in helping shape our offers. However, direct monitoring mainly of postgraduate trainees saw 136 requests for progression reports and we received nearly 91% positive response. Also, of 154 training plan audits we received nearly 94% response. Progression and training plan audits are key tools in our assurance strategy. The 8% of trainees who have not made a submission are very likely to be the ones with sub-standard training and/ or supervision problems. We are considering what next steps in terms of how we address this minority. In 2020 we will recommence a cycle of training centre recognition. We are running a trainees' and supervisors' national event at COSLA on 7th Feb 2020; Board members are welcome to attend to see our next generation of NHS scientists in the making: https://events.nes.scot.nhs.uk/hcs-february-2020/

5.6 Following discussion with NES Executive Team earlier this year on Healthcare Science resources, Dr Rob Farley, NES HCS Lead, submitted a request to Scottish Government to consider a case for raising scientist training grade numbers. In nearly two decades there has been no change to centrally commissioned clinical scientist training places despite significant rises in allied professional areas in diagnostics, particularly medical consultant staffing. At present NES can afford 17-19 clinical scientist trainees annually on a 3-year scheme; perennial demand is for an intake closer to 30 per year. Our case was presented in September to the Waiting Times Improvement Board; NES was advised to include the ask in its 2020-21 annual operation plan submission. The additional places have been included as ‘unconfirmed’ in terms of funding; a Government response may be forthcoming in March 2020.

5.7 In parallel with our bid, the NSS Diagnostic Steering Group has submitted a detailed workforce survey of the state of the laboratory workforce (both medical and non-medical). NES was a key participant in shaping this study. The work reinforces our own bid to Scottish Government and highlights the transformation possibilities of consultant clinical scientists and biomedical scientists to solve medical specialty shortages in diagnostics. Stewart Irvine (NES CEO), Peter Johnston (NES Medical) and Rob Farley (NES Healthcare Science) met with Chief Medical Officer and others at Scottish Government to explore the case. The issue is with Scottish Government workforce for next steps.

5.8 The Scottish Government's Workforce Plan (Dec 2019**)** includes support for additional clinical physiology trainees in cardiac physiology. This has followed significant lobbying by the professional groups. Whilst additional investment is welcome, we did signal prior to publication that the move is potentially challenging as those specialties effectively unsupported are woven in to the primary training scheme. NES's role in this additional investment is

unspecified, but the assumption is that we will be asked to lead the commission / management of these new places.

6 Digital

Family Nurse Partnership

6.1 Digital are pleased to confirm that towards the end of 2019 Family Nurse Partnership (FNP) England and NES signed a contract spanning five years. The Turas FNP system now has CHI access and has been live since 9 October.

NES Data Group

6.2 In December the NES Data Group achieved another key milestone towards its transition of workforce analytics functions from ISD to NES, with the release of the first quarterly workforce publications produced exclusively by NES. For further details around the work of the Data Group please follow this link.

Internal NES Digital activity

6.3 The NES Data Protection Procedures have been endorsed by the NES Senior Operational Leadership Group, with communication of these updated procedures to be distributed to all NES staff in early 2020.

6.4 A series of Microsoft Office 365 hints and tips guides have been circulated to staff via the NES Yammer channel with very positive feedback. At the end of 2019 the Knowledge Management and Discovery business unit ran a successful campaign as part of the 'Health Literacy Month'. There was excellent engagement from of over 50 people submitting challenges and many retweets of videos.

6.5 Webinars in October 2019 included highlighting the launch of a new series of digital tools available to staff such as webinars with PowerPoint features, Kahoot (a formative assessment tool in medical education), Slido (a voting system) and Padlet (a collaborative tool for boards, documents, and webpages)

6.6 A NES Digital Summit was held at the end of 2019 which all Digital staff were invited to attend. Please visit the mural (also copied on the following page) which is situated floor 1 of our Westport (Edinburgh) office depicting outputs from the day and which was designed by talented colleagues in the Communications team.

7 NES Digital Service (NDS)

7.1 ReSPECT - we are planning to go live in early 2020 with a small-scale trial in 1 ward with 5 clinicians and 5 GPs. The roll out will be in four phases, culminating in citizen access.

7.2 Progress continues on a number of new work streams for NDS, including opthamology, endocrinology and cancer treatment summaries. Work on genomics continues positively with the recent appointment of a new member of staff, Honghan Wu, to take the work forward.

7.3 NDS colleagues have met with a number of third sector organisations to discuss future collaboration, including Voluntary Health Scotland, SCVO and Support in Mind. Actions include a future VHS/NDS roundtable event and an NDS themed meeting of the Cross Party Group on Health Inequalities at the Scottish Parliament.

7.4 Work is underway to consider the impact of inequalities and equalities on NDS related products and services. We are engaging with a wide range of stakeholders, including the NHS Equality and Diversity Lead Network and have convened a special meeting of the Lead Network in February.

7.5 We had a planned visit from Brian Whittle MSP, on 22 January to the Bayes Centre. Future engagements/speaking opportunities at the Holyrood Digital Health event on 26th February (Alistair Hann) and the FutureScot Digital Health and Care Scotland Conference on 30th April (Rohan Gunatillake). We will also have a Thought Leader Column in the Digital Health edition of Holyrood (end of February). The redeveloped NDS website is now live. (Link)

8 Medicine

PGMET Recruitment 2019/20

8.1 The fourth and final round of recruitment for 2019 recruitment concluded in November 2019. Of the vacancies advertised and filled, the fill rates at the end

of this round were considerably higher with a 92% fill, compared to an 85% fill in 2018.

8.2 Information on fill rates against the total training establishment, to include the 2019 expansion posts, is being finalised and is again favourable compared to 2018, with a 98% fill of all available training posts. Further detail by specialty and region will be available to inform discussion at the February Board Development day.

8.3 For recruitment to vacancies with a start date commencing August 2020, applications for Round 1, which recruits to Core and Specialty training at ST1 level, closed on 28 November 2019. The first of several assessment centres took place on 9 January and these will be continuing throughout January/February, prior to initial offers being issued from 9 March. There are 680 Indicative vacancies for round 1 to date.

8.4 Round 2, which recruits to Specialty training at ST3/ST4 level, opens on 29 January. Indicative vacancies are being finalized. Following further assessment centre activity, initial offers will be issued from 23 April.

Credential in Rural and Remote Health

8.5 NES has been asked by the Scottish Government to develop a credential in Rural and Remote Health, as one of four early GMC credentials. This is being led by Professor Alan Denison, Postgraduate Dean (North Region), and a credential development group including representatives from NES, Scottish Government and Rural Practitioners have developed the required Purpose Statement, which is at a very advanced stage. A competency framework is also at an advanced stage.

8.6 This will be discussed at the Scottish Rural Medicine Collaborative Board and will be shared for comment with the other UK Nations regulatory bodies in Q1 2020. The purpose statement will thereafter be submitted to GMC for consideration by the Curriculum Oversight Group in Spring 2020.

State of Medical Education and Practice in the UK 2019 (SoMEP) Report

8.7 The information provided in this report will support work to develop better working environments through collaborative quality management and improvement activity. The report was published in December 2019 and can be found here.

8.8 This report was the ninth ‘state of medical education and practice in the UK’ report to be published by the GMC. We expect that work flowing from this report will be a key focus for the GMC in 2020. It will be important for us to draw upon the evidence base in this report (and others) as we play our part in listening to the concerns of employers, patients and clinicians and take action to grow and retain a sustainable workforce.

9 NMAHP

NMAHP's contribution to the World Health Organization's Year of the Nurse and the Midwife 2020

9.1 The World Health Organization (WHO) has designated 2020 as the Year of the Nurse and the Midwife, in honour of the 200th anniversary of the birth of Florence Nightingale. The aim is to raise the status and profile of nurses and midwives and to encourage global government investment in the two professions. 2020 gives the opportunity to reflect on the skills, commitment and expert clinical care these professions bring, and the impact they make on the lives of so many.

9.2 NMAHP is contributing to a Five Nations Task-and-Finish Group which has been established to oversee the Year of the Nurse and Midwife 2020 in the UK, to represent Midwifery Education Services for Scotland, and also to a country-specific group led by the Chief Nursing Officer for Scotland. There will be a series of national and local events to celebrate nurses' and midwives' contributions to healthcare taking place throughout the year, supported by a targeted social media campaign.

Second Cohort of Allied Health Professionals (AHP) Fellows recruited

9.3 The Allied Health Professions Careers Fellowship Scheme has recruited a second cohort of Fellows who are due to commence their Fellowship journey in April 2020. There are 18 Fellows from across eight Health Boards and five professions (i.e. dietetics, occupational therapy, physiotherapy, radiography, and speech & language therapy).

9.4 The AHP Fellows will attend structured learning days as well as deliver work-based projects over ten-to-twelve months. More information on the AHP Fellows' projects is available here (Link).

Allied Health Professions' Professional Portfolio launch

9.5 NMAHP are pleased to report that Allied Health Professionals now have access to the Turas Professional Portfolio. A positive first few months demonstrated through 1,172 users registering. Nursing and Midwifery Professional Portfolio has been in place since 2015 and there are currently 28,442 Nursing and Midwifery Professional Portfolio users.

Palliative and End of Life Care

9.6 NES/Scottish Social Services Council (SSSC) published *Enriching and improving experience: 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 April 2017. This was mentioned in a recent Scottish Government Parliamentary Debate and Parliamentary Question Members' Business debate. Implementation has been supported through:

- a learning resource (informed about Palliative and End of Life Care) to help those who support people who need palliative and end-of-life care and their carers. This resource can be used in any health or care setting.

- inclusion of the framework by the Scottish Collaboration for the Enhancement of Pre-Registration Nursing (SCEPRN) Group in their national resource document to facilitate consistency of approach across Scotland.

NHS Western Isles new Nursing & Midwifery Practice Educator

9.7 NES's NMAHP Practice Education Team is delighted to welcome Anna Nicolson to the Team. Anna took up post as the Nursing and Midwifery Practice Educator, hosted within NHS Western Isles, on 6 January 2020. The Team also wished a fond farewell and long and happy retirement to Bernie McCormack who left the post.

Person Centred Care Programme

9.8 Iain MacRitchie, Head of Programme Person Centred Care (Chaplaincy), is working with Addenbrookes NHS Foundation Trust who have now established a Values Based Reflective Practice (VBRP) Community of Practice will now be the first to pilot VBRP under licence from NES out with Scotland. Jane Davies will travel to Cyprus to delivery Person Centred Complaints training for the Medical Defence Services, helping them to be able to deliver improved complaints handling and investigation, focusing on the needs of the complainants.

NMAHP Digital Health and Care Leadership Programme opening for applications

9.9 Cohort 14 of the NMAHP Digital Health and Care Leadership Programme will be open to applicants on 21 January 2020 (closing on 4 March 2020). This successful programme has supported over 200 people to develop their leadership skills in supporting the use of technology to improve health and care. More information can be found here. (Link)

10 Pharmacy

Educational Governance review of the Pharmacy Directorate

10.1 NES Pharmacy were involved in their triennial Educational Governance review on 12th December 2019, which was chaired by Judy Thomson, Director of Psychology at NES and involved external representatives from the profession from Scotland (Chair of Directors of Pharmacy, Board member of Community Pharmacy Scotland and the Royal Pharmaceutical Society, Lead Pharmacy Technician for Education and Training) as well as from other UK bodies (HEE Pharmacy Dean and the GPhC`s Head of Education).

10.2 The team were congratulated on an excellent report and their preparations for the review. Several commendations on good practice and some minor recommendations for consideration were provided by the panel. An action plan with estimated timescales is being developed by the team to respond to these recommendations. The review panel were also very complimentary about

many aspects of the work and were clear that NES Pharmacy is recognised within the profession as being top in the UK!

10.3 The Board will receive a full update via the Education and Research Governance Committee in due course.

11 Psychology

11.1 In December, we were very honoured to be invited to present on Transforming Psychological Trauma to the Victims Taskforce Scotland chaired by Humza Yousaf.

11.2 We also delivered STILT (Scottish Trauma Informed Leaders Training) to key leaders in Argyll and Bute in January as part of their local delivery trial for trauma informed services for children & young people.

11.3 We were pleased to participate in the Mental Health Strategy Annual Forum and discuss the proposed Adult Mental Health Collaborative.

11.4 In early December we held a celebration event bringing together practitioners we have trained from across Scotland who are delivering early intervention approaches to support children and young people's mental health and wellbeing in schools and other settings.

12 Workforce

Careers Attraction and Promotion

12.1 The NHS Careers website provides a focal point for information about careers in NHS Scotland, and specific promotion campaigns (including internationally). In the calendar year 2018, there were just short of 100,000 visits to the website. In 2019 we have had 298,000 visitors to the website. We have also seen a steady increase on social media platforms with a net growth of seven followers per day across platforms.

12.2 At the beginning of 2019, we carried out a website audit and research to look at ways we could increase audience engagement. The key outcomes were to improve the visual design, improve information architecture, make content more efficient and easier to read, add new features like podcasts, job profile search and a chatbot and make sure the website complies with new accessibility legislation.

12.3 We are currently working with Scottish Government, Boards and other national groups to develop promotional resources these include posters for nursing career pathways, pharmacy technician careers, international recruitment banners, Nursing, midwifery, AHP and healthcare science flyers.

12.4 Scottish Government's careersinhealthcare.scot campaign covers Nursing, Allied Health Professionals and Healthcare Science roles. The purpose of the campaign is to raise awareness of these roles. There is also a planned a cinema advert and outdoor publicity of this site through the campaign. Each of the roles that are featured in the campaign have links to the https://careers.nhs.scot/ run by NES. NES have also designed character set that that is being used by the campaign.

12.5 Over the next few weeks we will be with stakeholders on campaigns for Scottish Apprenticeship Week and Healthcare Science Week.

12.6 The following link describes the work we have been doing on Careers in more detail: **presentation**

NES Recruitment

12.7 In June 2018 the NHS Scotland Chief Executives agreed as part of the Shared Services Strategic Proposal to implement a National Recruitment Service model, delivered regionally, and underpinned by a new single national recruitment system together with a national standardised process and practice.

12.8 The procured cloud based national recruitment system is called Jobtrain and it has been rolled out across all 22 Boards during 2019 - NES is part of the final implementation phase and went live on 2 December. To support the roll out across NES, training is being delivered to hiring managers and a communications plan is in place.

12.9 The transition to Jobtrain will deliver certain key benefits to NES, most notably to our hiring managers. Jobtrain will allow our hiring managers to view, track and access applications immediately and they will have greater flexibility and control during all stages of the recruitment process. Jobtrain will help streamline NES' existing recruitment activities and will eventually reduce our time to hire.

12.10 NES is actively involved in the ongoing development of Jobtrain with representation on the Recruitment Systems Project Group and the Recruitment Standardisation Group. Full transformation to the National Recruitment Service model will continue regionally throughout 2020, NES HR and staff side continue to contribute to the East Region Recruitment Transformation programme, alongside NHS Lothian; NHS Fife; NHS Borders; Health Improvement Scotland; and the Scottish Ambulance Service.

CALENDAR -

2 December - HIS Medical Director interviews
I participated in the interview panel to recruit a new Medical Director for Health Improvement Scotland.

4 December - Management Steering Group (MSG)
I attended this meeting where members received a number of Agenda for Change (AfC) and Medical Workforce updates. In relation to AfC updates specifically, the MSG received a paper on the CAJE system (Computer Aided Job Evaluation) replacement which NES Digital has developed. As part of the Medical Workforce updates, members noted and discussed the recent GMC wellbeing report.

9 December - David Garbutt and Rowan Parks
I met with David and Rowan to discuss the GMC wellbeing report and any potential implications for NES.

10 December

NES Executive Team
Substantive items on the agenda included updates and papers on the 2020/21 Budget development timetable, the draft Annual Operational Plan, the GMC wellbeing report, the NHSS Whistleblowing process and Talent Management/Project Lift processes in NES.

NHSS Chief Executives - Private Meeting
The main items for consideration at this meeting included an update on the rollout of Microsoft O365 across NHS Boards, a presentation on the NHS in Scotland 2019 Audit Scotland report and a paper on revised National Guidance on the Clinical and Care Governance of Integrated Health and Social Care services.

NHSS Chief Executives - Private Meeting with Malcolm Wright
I, and other NHSS Chief Executives, met with Malcolm Wright after the CEs Private Meeting.

11 December - NHSS Chief Executives - Development Session
This session comprised of two individual items: a discussion on Health Finance and Infrastructure led by Christine McLaughlin (Scottish Government) and a discussion on the development of the Health and Care Strategy linked to NHSS Chief Executives development as an overall group.

16 December - Change Management Programme Board
I chaired this meeting at which members received a paper on the review of Band 8c and 8d roles in NES and updates on the Workforce directorate organisational change update and the Dental Care Professionals restructure.

17 December – Audrey McColl
I met with Audrey to discuss the 2019/20 Mid-Year Review with Scottish Government on 19 December.

18 December

Eden Scott
Morag McElhinney (Head of HR) and I met with colleagues from Eden Scott to discuss the Director of Workforce recruitment process.

Nicola Cotter, Head of GMC Scotland Office
I had a telephone call with Nicola Cotter to discuss the GMC's State of Medical Education and Practice in the UK report, which was published in December 2019.

Scottish Government National Workforce Planning Group
Myself and Christopher Wroath attended this meeting. The Group discussed the National Health & Social Care Integrated Workforce Plan and associated guidance/scenario-planning documents. Christopher also gave an update on the Turas Data Intelligence: Workforce (TDI-Workforce) project.

19 December - NES 2019/20 Mid-Year Review with Scottish Government.
Karen Wilson, Audrey McColl and I attended this meeting. A more detailed update is included in the Strategic Updates section of this report.

13 January - NES Executive Team
Substantive items on this agenda included a review of the January 2020 Board papers, a Finance update on 2020/21 budget planning, and items on the stakeholder survey and a letter from Scottish Government regarding a framework for Community Health and Social Care and what this framework will mean for the delivery of secondary and tertiary care.

14 January – National Boards Collaborative Programme Board Workshop
The National Boards Chief Executives met to review the work that has been completed by the Programme Board and agree a set of priorities for the year ahead.

NHSS Chief Executives - Private Meeting
The main items for consideration at this meeting included reviewing a draft Terms of Reference for the Chief Executives group and the 2020/21 workplan. Members also discussed a briefing for the Cabinet Secretary. NES was mentioned in reference to developments regarding Primary Care, Mental Health and digital work.

15 January – NHSS Chief Executives – Netherlands and Scotland Executive Exchange
NHSS Chief Executives met with colleagues from the Dutch healthcare system to share knowledge and establish connections to improve health and care.

NHSS Chief Executives - Business Meeting
The substantive items on this agenda included papers on Infrastructure, Performance (including Winter) and Targets, and Primary Care.

NHSS Chief Executives - Private Meeting with Malcolm Wright
I, and other NHSS Chief Executives, met with Malcolm Wright after the CEs Private Meeting.

16 December - Karen Wilson and Rowan Parks
I met with Karen and Rowan to discuss the NHS Scotland Academy which is a joint development between NES and the Golden Jubilee.

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

NES update on the Cabinet Secretary's priorities – Integration

2. Author(s) of Paper

Karen Wilson – Director of NMAHP
Moraig Rollo – Interim Associate Director NMAHP (AHPs)

3. Purpose of Paper

To update the Board on NES' contribution to delivery of the Cabinet Secretary's Key Health Priority of Integration

4. Key Issues

Integration as laid out in the Public Bodies (Joint Working) (Scotland) Act 2014 was a significant change to health and social care services in Scotland. The Act placed a greater emphasis on joining up of services and a focus on anticipatory and preventative care. Integration and the Act aimed to improve care and support for people who use health and care services, their carers and their families. The Audit Scotland Report (2018) highlighted significant barriers to be overcome to enable integration to progress at pace and scale.

The workforce delivering integrated health and social care services are facing significant challenges within an increasingly complex environment. This reality reinforces the importance of partnership and collaborative working to ensure a workforce that is able to deliver the services and support people need, so their care feels seamless to them, and they experience good outcomes and high standards of support. The work of the NES/SSSC Partnership Group is focused on equipping and developing the health and social care workforce with the skills and support to deliver care.

SSSC is the regulator for the social service workforce in Scotland. SSSC is responsible for registering people who work in social services and regulating their education and training. The SSSC is also the national hub for workforce development and planning for social services in Scotland and acts as the sector skills council.

NES is the national health board responsible for supporting NHS services in Scotland by developing and delivering education, training and workforce support for those who work in Health and Care in Scotland.

In partnership both NES and SSSC can support the national health and care workforce in development, promoting a culture of learning and encouraging evidence-informed practice, whilst delivering the Scottish Government's drive for continuous improvement and efficiency in public services. The Partnership is not limited to NES and SSSC and includes working with a wider range of other partners for example Health Scotland, Healthcare Improvement Scotland, Alzheimer Scotland and the Thistle Foundation as examples.

5. Educational Implications

Integration has many implications and opportunities for education to be developed and delivered in partnership. Provision of a variety of educational resources from bespoke programmes to multi sector cultural education and learning resources such as the Scottish Improvement Leaders Programmes. Increasingly NES are developing resources and supports workforce development opportunities that are designed for staff across health and social care, specifically, learning and development opportunities that reflect and support the current and emerging environments health and care staff work in.

6. Financial Implications

There are no specific financial implications for the NES Board to consider in relation to the Cabinet Secretary's priority of Integration. However, different programmes, projects and developments are funded within Directorates through various routes for example Promoting Excellence is funded from the Mental Health Directorate at Scottish Government. As a result, much of this funding is awarded on an annual basis which makes managing these areas more complex than longer-term funding would allow.

7. Which of the 5 Key Areas of Focus in the NES Strategy for 2019-24 does this align to?

1) A high quality learning and employment environment
    a. Improved promotion of career opportunities in health and care and easy access to information
    b. Improved opportunities to access learning for health and care staff
2) National infrastructure to improve attraction, recruitment, training and retention
    a. Greater awareness of career opportunities in health and care for young people and school leavers
    b. Sufficient education and training capacity to meet future workforce needs
    c. Initiatives to support succession planning

3) Education and training for a skilled, adaptable and compassionate workforce
    a. Learner-centred professional development ensures practitioners keep up to date
    b. Coherent approach to developing and sharing learning resources
    c. Clear career progression routes for all roles
    d. People developed with the right values and behaviours to operate across boundaries
    e. A culture of continuous improvement embedded in everyday practice
    f. Well-developed multi-disciplinary teams
    g. Enhanced roles to support an improved skill mix and service redesign
    h. A caring and compassionate workforce
    i. Excellence in clinical practice based on evidence and safe models of care
5) A higher performing organisation (NES)
    a. A culture of innovation, improvement and shared responsibility
    b. Improved training, organisational development and quality improvement capacity and capability

8. Impact on the Quality Ambitions

This work is aligned to all the quality ambitions:
Caring, Compassionate, Communication, Collaboration, Clean Environment, Continuity of Care and Clinical Excellence

9. Key Risks and Proposals to Mitigate the Risks

There is an engagement risk given that this work covers the whole health and care workforce, in order to ensure efficient use of Health and Social Care resources it is essential to be able to engage more effectively. In particular, NES does not yet have strong networks with the Integrated Joint Boards or Health and Social Care Partnerships and depends on SSSC having these communication pathways.

There is a risk of duplication of work within the Directorates which we mitigate through the quarterly partnership reports and working closely with SOLG. There is a risk that NES works in a way that does not consider a whole systems approach. The mitigation could be NES' role working with integration authorities to support the implementation of the Framework for Community Health and Social Care Integrated Services

There is a financial risk to the sustainability of projects in that funding models are mostly agreed annually and vulnerable to changes in policy direction and

financial prioritisation. This can be mitigated by building resilient sustainable models of learning and development.

10. Equality and Diversity

Key equality and diversity findings related to the duty or equality and diversity risks relevant to integration work are identified in EQIAs that are completed within directorate work programmes

11. Health Inequalities

Health and Social Care Integration is designed to improve care and support for people requiring health and care services and focussing on the needs of local communities. The health and wellbeing of the population, and therefore the demands on the Integration Joint Boards are hugely influenced by the health inequalities experienced within and across communities. Therefore indirectly, all the work carried out by NES and in partnership with SSSC, should have an impact on reducing the effects of health inequalities.

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]

13. Recommendation(s) for Decision

The Board is asked to note the variety of activities which NES and its partner SSSC is undertaking in relation to Integrated Care.

NES
Jan 2020
KW/MR

Update on the Cabinet Secretary's key priorities – Integration

1 This paper is the last of three updates for the NES Board highlighting the NES contribution towards the Cabinet Secretary's Key priority of Integration as identified in a presentation to the Board in June 2019.

2 NES has a longstanding partnership with SSSC working together to deliver learning and development opportunities to people working across the health and social care sectors. The NES/SSSC Partnership Group steers this partnership work whilst also looking for opportunities for further collaboration. The NES/SSSC Partnership Group produces an Annual Report informed by update reporting through the NES Senior Operational Leadership group (SOLG) and the Development and Innovation Managers' group in SSSC.

3 The work of the partnership is not limited to NES and SSSC and has included collaborations with Health Scotland, Healthcare Improvement Scotland (HIS), the Care Inspectorate and third sector organisations such as Alzheimer Scotland and the Thistle Foundation.

4 The Partnership provides the focus for the totality of work within NES which affects or develops integration and is summarised in the group's annual report.

5 The Framework for Community Health and Social Care Integrated Services, published by the Ministerial Strategic Group for Health and Community Care in Feb 2019 offers a succinct description of what good looks like in terms of the provision of effective, integrated community-based assessment, treatment, care and support. The Framework is a tool to support the operational planning and delivery of services and models of care on a whole system basis by:

   a. Offering an underpinning ethos of how care and support should be configured to understand and respond to the needs of local people
   b. Clarifying the characteristics that are present with integrated care and support is at its most effective
   c. Describing the components of an effective, integrated health and social care system and
   d. Defining the 'enablers' that need to be in place if the benefits associated with effective integrated care are to be fully realised

6 This update paper summarises recent integration work, identifies current areas of integration work being delivered and future activity.

   a. Summary of the NES/SSSC Partnership Group Annual Report 2018/19 and updates since publication
   b. Wider Activity – Workforce development across the integrated environment
   c. Summary

Summary of the Partnership Group Annual Report 2018/19 and Updates since publication

7 Below is a brief summary of some of the work undertaken by the Partnership Group and notes updates since publication of the 2018/19 report. Full report is available on the NES website.

8 **Promoting Excellence (PE):** PE framework supports the implementation of the 3rd Dementia Strategy and by March 2020 over 1,000 Dementia Champions will have been trained. 108 care staff have already completed the NES training in Palliative and End of Life Care (PEOLC) in Dementia for Front Line staff. 212 people from across health and social service have attended various Enhanced Level of Promoting Excellence Master Classes. NES delivers capacity building 'Train the Trainers' Programmes across health and social care in areas such as Essentials of Psychological Care; Palliative and end of life care and dementia; meeting the complex physical health needs of people with dementia and pharmacological care and dementia. The focus now is on legacy building by creating sustainable national and local infrastructures and continuing the reach of PE education across the health and social care workforce.

9 **Personal Outcomes Network (PON)**: The Personal Outcomes Network (PON) aims to influence, inform, promote and embed personal outcomes approaches. A personal outcomes approach acknowledges the individual's strengths and works towards establishing a shared sense of purpose to which everyone can contribute, including the person, their family, carers and other community resources as well as services. PON meetings are planned and managed by a co-ordinating group across a wide range of organisations, NES, SSSC, Care Inspectorate, Scot Govt, the Alliance, the Thistle Foundation and University of Strathclyde. 4 national events have taken place for health and care staff. The personal outcomes resource has been refreshed and there are now 302 members of the PON across health and social care.

10 **Leadership for Integration (LfI):** The LfI programme aims to build the leadership capacity and capability of primary care and other health and social care professionals to work effectively at a local level. It is offered in partnership by NES, SSSC and the Royal College of General Practitioners (Scotland). LfI offers 2 main development opportunities, firstly, You as a Collaborative Leader (YACL) which in 2018/19 delivered 2 cohorts of 60 participants and A YACL Train the Trainer programme was also delivered. Secondly, Collaborative Leadership in Practice (CLiP) was delivered in 5 locality groups. The work stream also delivered 6 Readiness (for integration) Workshops also 3 practitioner briefings. YACL trained trainers are now delivering leadership learning locally as well as further work to support Readiness for Collaboration events.

11 There has been an integrated approach to Project Lift. Materials are accessible to the health and social care workforce and SSSC has started working with NES and the Project Lift team to engage social service workforce with Project Lift development and engagement activity, focusing on Chief Social Work Officers and those aspiring to that role.

12 NES and SSSC continue to work to support middle managers for social services to engage with Leading for the Future (LftF). Cohort 10 included recruitment from

NHS Boards and Community Leadership (110 participants across 31 organisations).

13 1NES, in partnership, is currently leading on the redesign of the Manager Leadership 360 Tool, recently running focus groups with Social Services, Local Authority, Third/Voluntary sector and SSSC.

14 **Carers:** This work stream supports health and social care partnerships, health boards and third sector organisations in the delivery of workforce requirements associated with the Carers (Scotland) Act 2016 and its implementation plan. This work has included the dissemination and evaluation of an outcomes-focused support planning resource, with an emphasis on the requirements of adult carers support plans and young carers statements. An evaluation of the Section 28 Hospital Discharge projects. The Equal Partners in Care (EPiC) learning resource has also been refreshed. EPiC is a resource that helps support staff or students to have a better conversation and interaction with carers. The aim is to make a positive difference and improve outcomes for carers and the people they care for. NES appointed a Senior Educator (NMAHP) with a remit to support the implementation of EPiC. Progress to date has included 4 national awareness raising events run by NES and SSSC where the refreshed EPiC resource was launched (Nov & Dec 2019) with approx 70 people attending. There has been comms activity for EPiC across all NHS Boards and SSSC networks and EPiC has been publicised at 3rd Sector carer organisation events nationally.

15 NES Dental directorate developed the Caring for Smiles programme in partnership with Health and Social Care Partners and delivered to Care Home Staff, enabling them to undertake a SQA NES qualification in oral health, equipping staff with the knowledge and skills to deliver appropriate daily oral care to care home residents. The train the trainer model is now also being piloted.

16 **Palliative and End of Life Care:** NES/SSSC published enriching and improving experience: 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 April 2019. Implementation has been supported through:

a. A learning resource (Informed about Palliative and End of Life Care) to help those who support people who need palliative and end of life care and their carers. This resource can be used in any health or care setting.
b. Inclusion of the framework by the Scottish Collaboration for the Enhancement of Pre-Registration Nursing (SCEPRN) Group in their national resource document to facilitate consistency of approach across Scotland
c. delivery of PEOLC skills set incorporated within the PEOLC guidance toolkit for SVQ candidates, assessors and learning providers.
d. delivery of PEOLC elearning resource for Care Inspectors linked to the Health and Care Standards and the completion of Action Learning set for PEOLC test sites.

17 In addition, the work of the NES Digital Services (NDS) contributes to the commitment to ensure that future requirements of digital systems support the effective sharing of anticipatory care planning conversations. This will be done by

the ReSPECT application, developed in partnership between NSD and NHS Forth Valley, then through extension of this service to other sites across Scotland.

18 **Integrated working workforce research:** Commissioned research to gain a deeper understanding of the workforce experience of working in integrated teams, at a time of major organisational change in 3 test sites. An initial report was produced in March 2019 and discussed at the NES/SSSC Partnership Group.

Wider Activity which has relevance to workforce development across the integrated environment

19 The NES/SSC Partnership Group identified five themes around which to share intelligence about wider activity. Work under these themes progresses as follows:

20 National Workforce Plan

a. To support workforce planning the delivery of a new careers website for social services and updating the NHS careers website to include Allied Health Professionals (AHPs) working across health and social care settings.
b. Developing a professional practice framework for social work and social care. This year SSSC have signed the NES AHP Stakeholder Statement in Support of Practice Placements for AHPs. NES AHP Practice Education Leads (PELs) have hosted local events to promote Practice Based Learning (PrBL) experiences across sectors. There has now been agreement with the Higher Education Institutions (HEIs) for NES to start collating information about AHP student PrBL provision across all sectors in Scotland.
c. NMAHP is an active member of the Neighbourhood Care Learning Network, hosted by SSSC and HIS that aims to build on the work of the Neighbourhood Care sites and new models of care across Scotland (Burtzorg Model).
d. NES are also members of the SSSC Careers Reference Group that works to promote recommendation 6 of the National Health and Social Care Workforce Plan.
e. NES and SSSC are working to provide data and analysis to support a system of integrated data to increase our understanding of current career journeys in the sector and look at ways to develop career opportunities to support retention and succession planning.
f. Promoting funding opportunities for training is a key action.
g. Pharmacy National Training Programmes for Advanced Practice Pharmacists, Foundation Pharmacists, Pharmacy Technicians to support the Primary Care Implementation Plans and the new General Medical Service contract.
h. Transforming Psychological Trauma – NES with SSSC as a key partner have delivered a National Knowledge and Skills Framework, a National Training Plan and a range of educational resources to support local training across all levels of practice for a Trauma informed workforce.

21 Digital Transformation

a. Both organisations (NES and SSSC) moving to Office 365 as part of a digital transformation. Increasing use of Microsoft Teams as a reliable video conferencing and virtual collaboration.
b. NES Digital is also supporting the move to Office 365 across all health boards. This will support a key NES NDS objective to improve sign-on and authentication arrangements for the NHS by creating a more seamless route to accessing key systems.
c. NDS has responsibility for addressing this issue for the integrated workforce across health, local government social care and third sector. This will also extend to supporting direct citizen access to relevant health and care information.
d. A key component of the Digital Health & Care strategy is the delivery of a national digital platform. Developed by NDS, this will make information across a range of integrated health and care services available to those who need it, when they need, wherever they are, in a secure and safe way.
e. Technology enabled care playing an increasingly important role in supporting people to stay at home or homely setting with education and learning to support staff introducing and working with technology including hi-tech systems to support communication requirements.
f. Since April 2019 NES have awarded over 200 Open Badges. These are accreditations for learning related to digital information literacy skills. NES Knowledge Services host 10 open badges on the SSSC Open Badges platform.

22 Service Improvement

a. NES, SSSC and other partners including Care Inspectorate and the Alliance are collaborating to develop and strengthen the capacity of people working across health and social care to use different improvement approaches, tools and techniques. NES continues to deliver a program of quality improvement learning including Scottish Improvement Leaders (ScIL) programme across all sectors. NES is working with SSSC (as the workforce development lead for social services) to develop quality improvement capability and capacity of social service workers, widening access to ScIL and ScLIP.
b. Focus on Dementia - a national improvement portfolio based within the Improvement hub of HIS and in collaboration with SSSC and NES, is taking a whole systems approach to improvements in diagnosis and post-diagnostic support, care co-ordination in the community and hospital settings for people with dementia.
c. NMAHP Practice Education Programme have conducted a survey in relation to AHP supervision across Health and Social Care, making links with colleagues in SSSC who had been conducting similar supervision work.
d. In collaboration with the Care Inspectorate, The My Plan project aims to create a resource which provided guidance for inspectors and care service providers to create effective personal plans. As part of this project NES, the Care Inspectorate and SSSC will pilot a new peer review.

23 Public Health

a. The Mental Health Improvement and Suicide and Self Harm Prevention work programme is a key area of NES partnership work the NHS Health Scotland and SSSC with a wide-reaching scope targeting staff across health, social care and wider public services. This has included the development of a Knowledge and Skills Framework, 3 Informed Level Animations targeting staff supporting adults who may be a risk of suicide or self-harm and workers supporting children and young people, Facilitators' guides, a Skilled Level resource and working with 3 Health and Social Care Partnerships to support cross sector learning needs analysis to inform future workforce development plans.

b. NES and SSSC will consider the public health learning implications for integrated health and social care staff including AHPs working across health and social care settings. A focus on the benefits of physical activity across the life span and in all settings including promoting physical activity within care home settings and with young people in Scotland.

24 Clinical & Care Governance

a. NES and SSSC make a key contribution to the safe delivery of services and the educational needs regarding governance of service provision. Good quality supervision including managerial, operational, clinical/practice and professional forms of supervision is a key factor in enhancing the practice of staff especially staff working in isolated roles. SSSC and NES are committed to supporting the education of supervisors and supervisees. A focus for joint working with an "openness and learning" agenda incorporating the education resources supporting the Duty of Candour legislation. SSSC and NES also work collaboratively with a range of other organisations to support clinical and care governance in the integrated service setting and will consider education opportunities to support volunteers, carers, personal assistants and community link workers.

b. NMAHP Practice Education programme have delivered Train the Trainers education for Postural Care, enabling carers to develop their educational skills and confidence in running postural care session and help implement the postural care strategy.

c. NES Digital is currently making the Care Standards eLearning module available via Turas Learn.

In Summary

25 The NES/SSSC Partnership Group provides the focus for the totality of integration work within NES and is summarised in the group's joint annual report for 2018/19, this paper references the work done to date, notes updates since publication of the report and in this summary mentions future activity.

26 Over 2019/20 the partnership work will focus on equipping and developing the workforce with the skills and support to deliver on Integration of health and social care: Realistic Medicine: and Reform of Adult Social Care.

27 The Partnership will also further explore and develop partnership activity related to the 5 themes relevant to workforce as discussed in the previous section. The plans for 2019/20 include Phase 2 of the Integrated working workforce research, identifying and building on the learning gained by staff through being involved in the research, summarising and sharing key findings of phase 1, agreeing and implementing next steps for test site and national partners. Strengthen the links between this work and projects being undertaken as part of the national Health and Social Care Workforce Plan.

28 Beyond 2019/20, in response to the significant demand for the YACL Programme, CLiP and to provide more Readiness Workshops the LfI project team has submitted a bid for funding to Scot Govt Primary Care Division for a continued programme of activity for 2020-21. As well as additionality there is a shift in focus towards more scalable and sustainable model by building capability in the system for the future delivery of LfI activity. NES also is in discussion with SSSC about accessing further SclL places for social service workers in 2020/21.

29 NES and the Partnership Group will consider the implications of The Framework for Community Health and Social Care Integrated Services in future developments of learning requirements and resources. NES has a role to play in supporting integration authorities to implement the Framework.

30 NES has the expertise as well as the learning and development resources to support Organisational Development and Leadership across all the partners. In partnership both NES and SSSC supports the national health and care workforce to deliver integrated care.

Further information:

NES, SSSC Partnership Group Annual Report 2018/19 (link)

A Framework for Community Health and Social Care Integrated Services (link)

Integrated Working Workforce Report March 2019 (attached as Appendix 1)

Health and social care integration Update on Progress, Audit Scotland, Nov 2018 (link)

NES/SSSC Partnership Group – September 2019

Briefing Paper: Integrated Working Workforce Research Project

1. Introduction

In April 2019, Integration division of Scottish Government invited the SSSC to commission research into the skills, qualifications and competencies required in the integrated work environment. It was identified that the findings of research would help inform wider work to meet recommendation 6 of the National Workforce Plan (part 2) promoting career opportunities in adult social care. The SSSC undertook this work in partnership with NES and other national partners. Two health and social care partnerships; Clackmannanshire and Stirling, and Perth and Kinross, and between them three integrated teams (Perth south locality team, the Bellfield Centre and the rural Stirlingshire Neighbourhood Care team) volunteered to be part of the study.

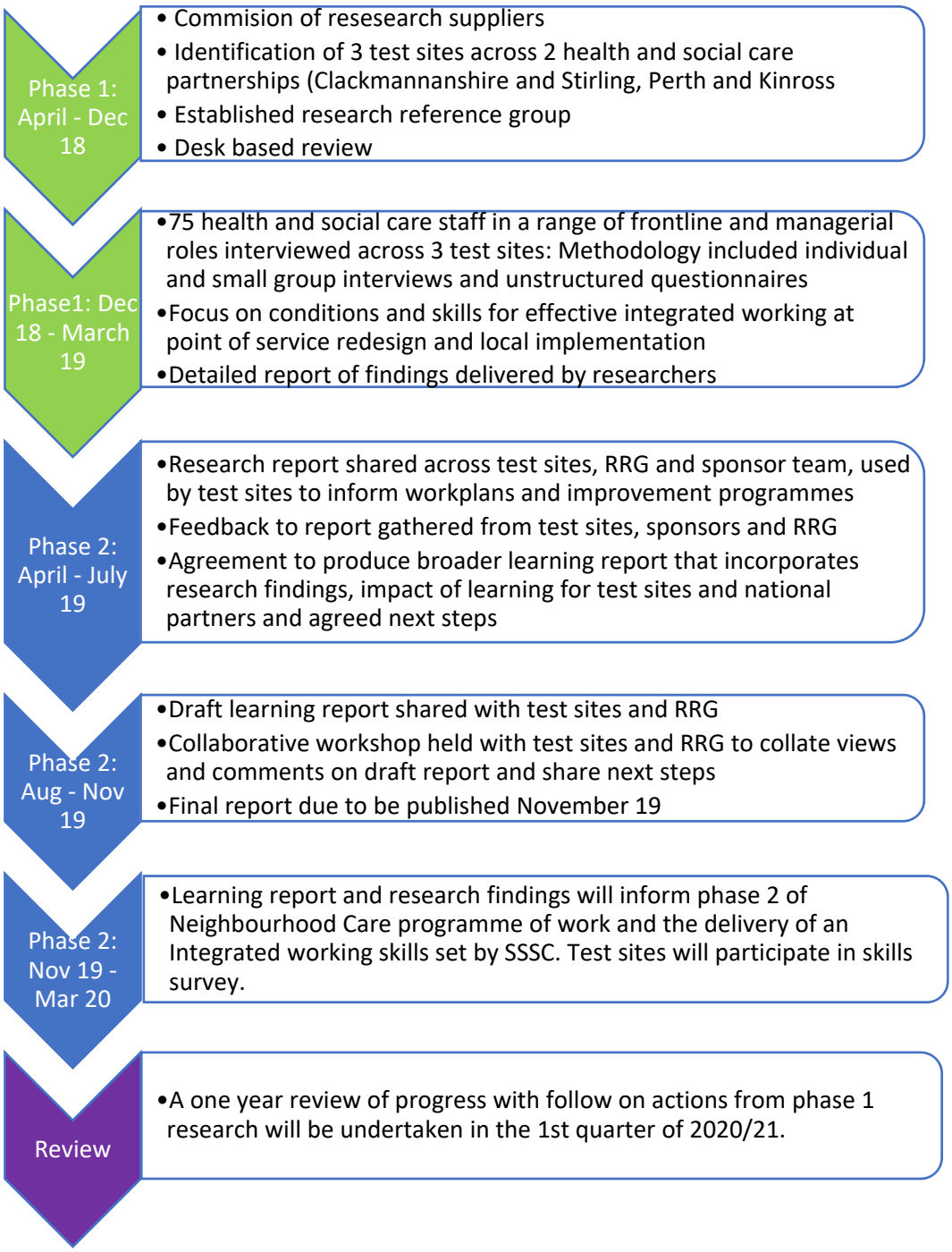
A research reference group[1] was established to co-design and develop the research scope and methodology. It agreed the purpose of research as:

- To gain a deeper understanding of the workforce's experience of integrating health and social care
- To consider the conditions required for effective integrated working
- To identify what skills, competencies, qualities, values, behaviours and qualifications the workforce have or need in an integrated working environment

This briefing paper provides a timeline of the activity within this research project together with an overview of the findings from phase 1 of the project and the corresponding messages for effective integrated working which are informing the work being taken forward across test sites and other members of the RRG in phase 2.

[1] Research Reference Group membership: Test sites, NES, SSSC, SG(OCSWA), Care Inspectorate, Skills Development Scotland

2. Project Timeline and Deliverables



3. Key Learning Points from Action Research: Phase 1

3.1 Creating positive and supportive conditions for change at the outset is key to longer term success: This research, undertaken at a time of major organisational change in test sites, showed that creating supportive and positive conditions for change were critical. In particular; setting aside time for staff development, open conversations and relationship building were essential preparation for change.

3.2 Giving staff a voice and listening to their ideas and concerns through change helps develop solution focused integrated working: Feedback from staff involved in this action research was that they both valued and felt valued through being asked their views and having them recorded. Seeing their responses to questions recorded developed a foundation of trust and willingness to work with others in their team to collaboratively identify ways in which integrated working could be enhanced.

3.3 When developing integrated working; acknowledge and build on existing good practice and agree the language of integration which fits best for the team. There were contrasting opinions about the language of integration and the word itself was found to sometimes motivate staff and at other times act as a constraint. Some staff support the use of the language of integration as they strongly believe this describes the way they should and want to work with people. Where teams felt they had been successfully working in this way for many years, the 'integration' agenda was felt not to acknowledge this and in fact sometimes ironically lead to less effective integrated working by introducing new systems.

3.4 When high level visions of integrated working are matched with plans of how to deliver these locally, a better shared understanding amongst staff and culture change are promoted: There was consensus from the research participants around a high-level vision of integrated working, but a wide variety of definitions were given to describe the practical implications of integrated working. A vision for integrated working which identifies and defines the different roles of staff within this vision was pinpointed by some staff as invaluable for an efficient, sustainable and positive shift towards integrated working

3.5 Integrated working requires co-ordinated planning with other policies and priorities, time and leadership: A vision for integrated working that is agreed by leaders of all the relevant services, with transparent organisational and resource implications, was identified as a way to demonstrate the importance of integrated working and how this agenda sits among the other priorities of the Partnership. A few managers recognised that in some cases this may involve delaying the involvement of frontline staff until management can form a clear vision of what was needed

3.6 Clarity of roles, responsibilities and accountability enhance staff buy in and cohesive working: Feedback highlighted the importance of clarifying roles, responsibility and accountability. When this happened, staff felt

more confident to buy in to the vision of integrated working and develop a combined identity for new integrated teams. Where staff were unsure where they fitted in and who was responsible and accountable for specific areas or tasks, teams worked alongside each other but lacked cohesion.

3.7 Developing a combined identity for integrated working teams whilst respecting individual professional identities is important: Just as a clear vision for integration is needed, so too is a combined identity for an integrated service. This was particularly important to avoid perceived power imbalances between clinical and care roles, This combined identity should recognise and respect the professional identities within the team and allow the contribution of distinctive roles each member of staff can bring to the common vision and delivery of services to people.

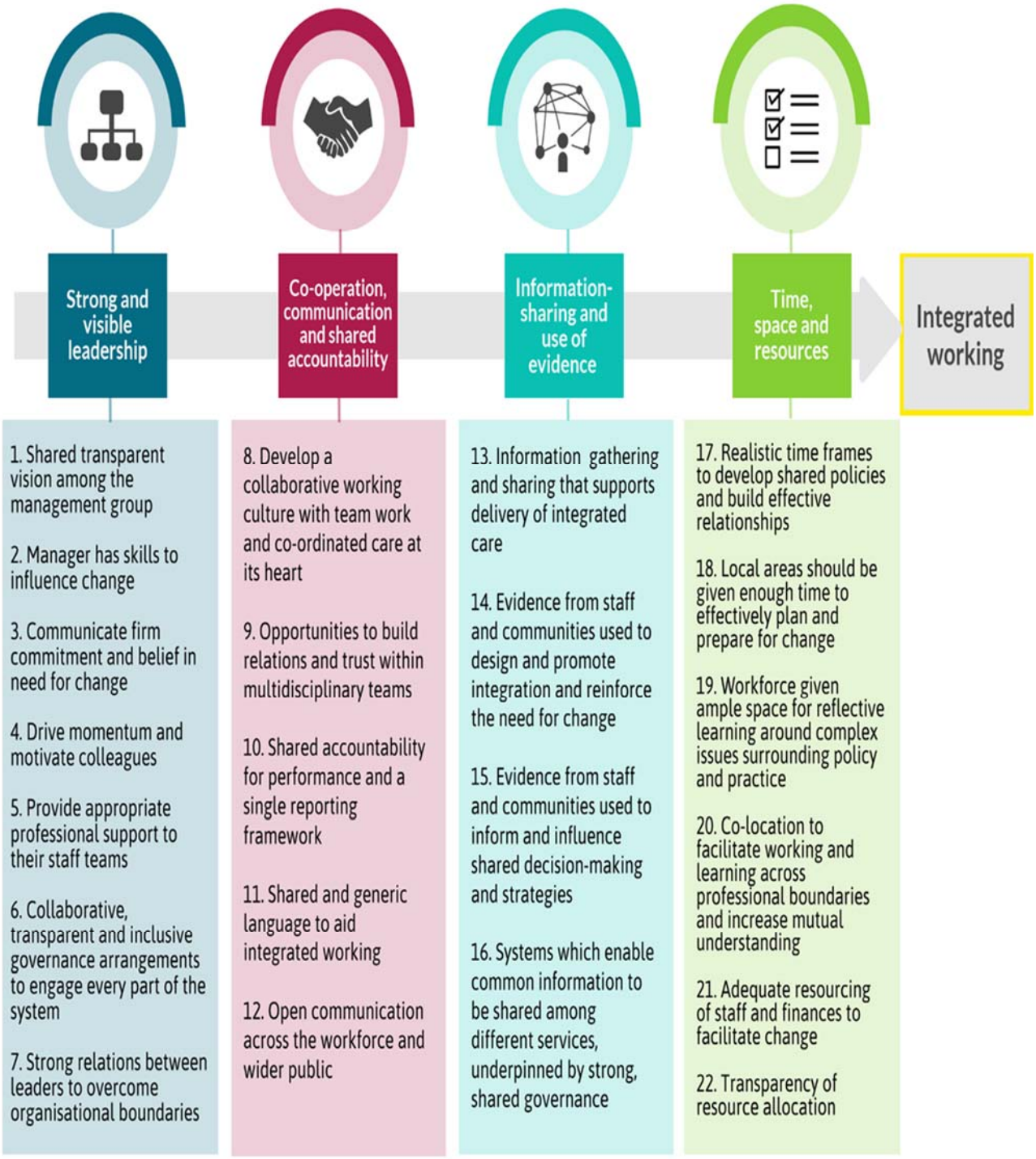
3.8 Time and skills are required to design and embed new approaches and systems which underpin transformational change: Research participants reported that time and specific skills are needed to to conceive, lead and implement this scale of change. A sound knowledge and understanding of the aims of integration are required alongside leadership, project and service design skills.

3.9 Systems which enable the sharing of common information among different services and organisations are key to support integrated working: Research participants reported that the ability of health and social care IT systems to share information, particularly personal and support planning information, greatly enhances integrated working for individuals using services and staff. Good practice examples were cited by multi-disciplinary teams and those who held integrated team meetings.

3.10 Co-location often enhances integrated working but is not enough on its own: Co-location was frequently highlighted by research participants as important in facilitating working and learning across professional boundaries and increasing mutual understanding in places where there was clear support and direction and appropriate shared working practices. Co-location together with time spent to gain an understanding of each other's roles and backgrounds enhanced develop positive relationships between team members.

3.11 All integrated working should be aligned to local needs, resources and communities: Research participants highlighted that the approach to integration must be aligned to the needs, communities and resources of each area. Involving public, private and third sector organisations in the local planning and delivery of integrated services can enhance outcomes for individuals and communities

4. Key Conditions for effective integrated working as identified by Action Research: Phase 1



NES **NES/20/05**
Item 9a
January 2020

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Finance Report as at 31st December 2019.

2. Author(s) of Paper

Lizzie Turner, Head of Finance Business Partnering.
Audrey McColl, Director of Finance

3. Purpose of Paper

The purpose of this paper is to present the financial results for the first nine months of the year to 31st December 2019 and to indicate the current forecast outturn as at 31st March 2020.

4. Key Issues

a We are currently reflecting an anticipated final budget for 2019/20 of £506.0m for NES.

b The current year-end forecast position is a deficit on Medical training grades of £2.6m being reduced by an underspend in the balance of the NES budget of £0.9m, to give an overall deficit position of £1.8m.

c Members will be aware that there is a historic recurrent funding deficit in Medical Training Grades which has been acknowledged by Scottish Government. An agreement is in place for the deficit to be addressed on a non-recurrent basis in the current financial year with a view to securing additional recurrent funding in future years. In this paper we have split out Medical Training Grades from the rest of NES, similarly to how the budget was presented, to simplify presentation of the financial position. When the 2019/20 budget was set it was expected that the amount required in 2019/20 to fund this deficit would be £4.9m and we previously built this into the budget as an anticipated allocation. We have now removed this allocation from the budget so that the underlying deficit of £2.6m in Medical Training Grades is reflected, further detail is provided in section 2.2 of the main report.

d At the NES mid-year review meeting with SG in December we provided an update noting that the anticipated amount of additional net funding we expected to draw down would be in the region of £2m. This assumed an estimated amount of underspend in the balance of the NES budget which would contribute to reducing the training grade deficit.

e Although NES contributed £2.5m on a recurring basis in 2018/19 to the National Boards savings target of £15m, the national target had not been achieved in full on a recurring basis. As a consequence, the Scottish Government initially removed a further £1.5m from the NES baseline in

2019/20 which we asked to be returned given the underlying recurrent deficit on the Medical training grade budget. This reduction was not built into our budget for 2019/20.

f Scottish Government have now provided the National Boards with a suggested allocation of how the outstanding element of the original £15m savings target could be met. The NES share of this is £1.3m. A meeting has been set up with Scottish Government at the end of January to discuss the position. If NES is required to make an additional contribution of £1.3m then this would impact on the level of funding available to reduce the deficit on the Medical training grade budget.

5. Educational Implications

N/A

6. Financial Implications

NES has three financial targets which need to be met on an annual basis. This report focuses on the requirement to meet the Revenue Resource Limit (RRL). The current financial forecast is break-even dependent on the receipt of additional funding from Scottish Government to cover the historic funding gap in the Medical Training Grade Salaries.

7. Which of the 5 Key Areas of Focus in the NES Strategy for 2019-24 does this align to?

A High Performing Organisation

8. Impact on Quality Ambitions

Delivering a break-even outturn will ensure that NES meets its Quality Ambitions.

9. Key Risks and Proposals to Mitigate the Risks

The key Risks to the final finance position are reported in Section 6. The most significant relate to unconfirmed allocation adjustments for both the Medical Training Grade salary funding deficit, and the level of any further contribution from NES towards the National Boards Savings Target. We will meet with SG colleagues this month to discuss how these will be managed.

10. Equality and Diversity

We currently anticipate a balanced financial position by the year end. The recommendations within the report will not create any equality and diversity risks.

11. Communications Plan

We are in regular communication with the Policy and Finance teams at SG. No further external communication plan is required.

12. Recommendations

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

NES
January 2020
AMc / LT

Finance Report to 31st December 2019

1. Funding Overview

We are currently reflecting an anticipated final budget for 2019/20 of £506m for NES.

Full details of the overall anticipated allocations and their classifications are shown in Table 1 below.

Table 1: Total Anticipated Revenue Funding

Area	Recurring		Earmarked		Non Recurring		Total		Total Funding Anticipated
	Received	Outstanding	Received	Outstanding	Received	Outstanding	Received	Outstanding	
2018/19 Baseline	423,353						423,353	0	423,353
2018/19 Pay award	8,558						8,558	0	8,558
National Boards Savings	(4,000)	1,500					(4,000)	1,500	(2,500)
2019/120 Pay Award	8,384						8,384	0	8,384
Board Development posts (HIS)	70						70	0	70
Excellence in care	165						165	0	165
Original budget	**436,530**	**1,500**	**0**	**0**	**0**	**0**	**436,530**	**1,500**	**438,030**
Superannuation	16,370						16,370	0	16,370
NDS		0	2,774				2,774	0	2,774
Transformation					2049		2,049	0	2,049
Aberdeen Dental School			3,140				3,140	0	3,140
Dental Outreach/VT/START			350		241		591	0	591
Speciality Training Expansion posts			5,510				5,510	0	5,510
MEP funding gap			5,049				5,049	0	5,049
IST & IMT Funding					625		625	0	625
Mental Health Programme					7,000		7,000	0	7,000
Psychology Trauma Funding					480	0	480	0	480
Psychology CAMHS					3,465	0	3,465	0	3,465
Pharmacy AEIPC & ACT					3,072		3,072	0	3,072
Pharmacy PRPS			5,455		840		6,295	0	6,295
Other Pharmacy			651	150	546		1,197	150	1,347
GPN Funding - Primary Care					1,350		1,350	0	1,350
GP Bursary - Primary Care					2,280		2,280	0	2,280
Other Primary Care Fund					1,172		1,172	0	1,172
Project LIFT					327		327	0	327
Digital Pharmpress			372	0			372	0	372
Outcome Framework-CNOD Bundle					2,495		2,495	0	2,495
Dental Overseas Levy (return of income)					(806)		(806)	0	(806)
Other allocations	0	38	224	134	2,527	59	2,750	230	2,981
Total Revenue Allocation	**452,900**	**1,538**	**23,524**	**284**	**27,664**	**59**	**504,088**	**1,880**	**505,968**
Total		**454,438**		**23,808**		**27,722**		**505,968**	**505,968**

All figures are in £000's

1.1 Movement in Revenue Funding

NES's original baseline budget for 2019/20, as approved by the Board on 28th March 2019, was £439.2m. As reported at the end of Month 6, September 2019, we revised that figure to £459.8m. The increase of £20.6m was the combined result of the following allocation adjustments:

Table 2: Budget movements previously reported

April to September 2019	**Funding Adjustments**		
Reason for Adjustment:	Increase £million	Reduction £million	Net Movement £million
Employer Pension Contributions	16.37		
NDS	5.01		
Other Allocations	0.62		
Pay Award Adjustment (3% assumption; 2.5% actual)		(1.37)	
Total Adjustments at M06	**22.00**	**(1.37)**	**20.63**

In addition to the baseline funding we were also expecting to receive £55.1m from Earmarked and non-recurring allocations. The total anticipated budget at M06 was therefore £514.9m.

Since September, the Earmarked and non-recurring budgets have reduced by £8.9m. The main reasons for the movement are:

Table 3: Budget Adjustments in reporting period

October to December 2019	**Funding Adjustments**		
Reason for Adjustment:	Increase £million	Reduction £million	Net Movement £million
Remove Anticipated funding for Medical Training Grade Gap- Final figure to be advised		(4.811)	
NDS reduction due to recruitment delays		(2.238)	
Psychology- CAMHS reduction in costs due to re-phasing of implementation programme		(1.424)	
CNOD Bundle		(0.275)	
Other Allocations	0.626	(0.772)	
Total Adjustments in Q3	**0.626**	**(9.520)**	**(8.894)**

The above adjustment to remove the £4.8m anticipated allocation at M6 to fund the historic gap in Medical Training Grade (MTG) salaries, reflects a new approach in reporting to enable the MTG pressures to be separately identifiable from the rest of the NES budget.

1.1 Outstanding Allocations

All but £1.8m of the anticipated allocations have been received, with the majority related to the allocation adjustment for the National Boards' Savings Target. See 1.3.3 below.

1.2 Non-Medical Training Grade movements in Anticipated Funding

1.2.1 NDS

The funding received for NDS reflects the outcome of discussions with Scottish Government to identify all anticipated in-year costs. The reduction from the previous anticipated allocation of £5m, is predominantly driven by delays in both developer recruitment and Cloud Storage procurement. The funding received also covers £200k costs of development work within Optometry to support the Programme for Government.

1.2.2 Psychology – CAMHS

NES was awarded funding from SG through the CAMHS Taskforce in late 2018-19, as part of an agreed workforce development plan integrating work-based learning with increased capacity for CAMHS. Agreements were drawn up with Health Boards, but due to operational delays in Boards resources were re-calibrated to match actual implementation requirements. As a result, we drew down £1.4m less from Scottish Government. We are currently delivering a programme of education and training in support of workforce expansion of 80wte multidisciplinary staff.

1.2.3 National Boards' Savings Target

Although NES contributed £2.5m on a recurring basis in 2018/19 to the National Boards savings target of £15m, the national target had not been achieved in full on a recurring basis. As a consequence, the Scottish Government initially removed a further £1.5m from NES in 2019/20 but have now informed us that a slightly reduced contribution of £1.33m is required. The proposed reduction in allocation has not been built into the figures contained within this report as we are meeting with Scottish Government at the end of January to discuss a way forward as this would affect the level of contribution that NES can make towards the underlying Medical Training grade deficit.

It should be noted the £1.3m saving is a recurrent saving and the forecast underspend we have identified in section 2, is on a non-recurrent basis.

1.3 Medical Training Grade Funding

The table below shows how the MTG salaries funding gap was originally reported and highlights some of the areas identified to reduce the gap on a non-recurring basis. Following a range of measures to recycle funding within MTG a £6m Medical Training Grade deficit remained, this was then reduced by £1.1m identified on a non-recurring basis from the all other areas of the NES.

Table 4: Medical Training Grade Funding Gap - Extract from March Board Report

	Training Grades		Rest of NES		
	Recurring £m	Non recurring £m	Recurring £m	Non recurring £m	Total
Anticipated budget available	245,719	0	193,496	0	439,215
Directorate budget submissions 19/20	(258,397)	0	(193,269)	(513)	(452,179)
Initial Gap	(12,678)		227	(513)	(12,964)
Requests for additional funding	0	0	(422)	(216)	(638)
Budget Gap	(12,678)	0	(195)	(729)	(13,602)
Proposed actions to reduce gap					
Recruitment Lag				1,500	1,500
Recycle Training Grade funding		6,676		0	6,676
Other Income				247	247
Procurement savings				300	300
Total Potential Funding Available	0	6,676	0	2,047	8,723
Remaining Gap	**(12,678)**	**6,676**	**(195)**	**1,318**	**(4,879)**
		(6,002)		**1,123**	**(4,879)**

The training grade budget is impacted by a complex combination of factors which are subject to change on a regular basis. These factors include how and where posts are filled, the hours trainees work, how many trainees take maternity/sickness leave, how many trainees will require remedial training and when the trainees find permanent posts at the end of their training. The assumptions made for each of these during Operational Planning can change throughout the year and particularly around August and February when trainees join and rotate through their training programmes.

In recognition of this volatility, we have agreed with the Scottish Government that the final amount they would need to provide would reflect the movements against these assumptions. As a result, the final figure will not be known until the end of the financial year, and we have regular discussions with Scottish Government to keep them aware of the forecast movements. As noted in the Board Paper Summary, we have now removed the anticipated allocation from the budget figures and will report on the financial outturn of the MTG salary costs separately in order to provide clarity around the level of funding required for MTG's.

2. Summary Financial Position

As discussed above, in a change to how our funding has been previously presented we are now reporting on Medical Training Grade Salaries separately from the rest of NES. Table 5 shows the combined, corporate position of NES; the 2 elements of which are then detailed in sections 2.1 and 2.2.

Table 5: Corporate Summary Financial Position

MONTHLY REPORTING FOR DECEMBER 19				Period 09				
Directorate	Year to Date			Full Year				
	Current Budget	Outturn	Variance	Current Budget	Outturn	Variance	Variance last month	Movement in variance from prior month
Training Programme Management - MTG Salaries	196,342	197,936	(1,595)	262,250	264,897	(2,648)	(2,874)	227
NES -excluding Medical Training grade Salaries	174,687	171,254	3,433	243,718	242,847	871	1,842	(970)
TOTAL NES	**371,028**	**369,190**	**1,839**	**505,968**	**507,744**	**(1,776)**	**(1,033)**	**(744)**

2.1 NES – Excluding Medical Training Grade salaries

2.1.1 Movement in Forecast from M6 – NES (Excluding Medical Training Grade Salaries)

At Month 6, we reported to the Board that the Directorates were forecasting an underspend of £2.7m, £2.1m of which related to MTG salaries and would be used to reduce the funding required for the training grade deficit from SG. The balance of £0.6m was to be re-allocated across NES to meet business priorities. In Month 7 we reported to the F&PMC that the underspend for non MTG salaries had moved to £0.8m and that directorates were being asked to identify potential opportunities to utilise this underspend to deliver against the NES agreed strategic objectives.

This review included looking at areas of spend which were identified as part of the 2019/20 budget setting process but were held back due to lack of funds; and identifying any areas of work originally planned for 2020/21 which could be brought forward and delivered in 2019/20.

The underspend rose again at Month 8 from £0.8 to £1.8m with the largest movements being in Medical £217k; Dental £102k, Digital £176k and Provisions £489k.

- Within Medical and Digital over half of the movement (£116k and £92k respectively) is due to higher vacancy savings.
- In Dental the movement arises from lower pay costs (£30k), reduced trainee costs (£34k) and a reduced Dental ACT payment due to lower than anticipated staffing in the Board (£46k).
- Within Provisions a variance of £0.5m arose. Additional funding of £1.2m was released corporately from budget adjustments and released accruals (where spend we previously assumed within our figures is confirmed as no longer required). This was offset by funding being provided for corporate priorities such as Digital Hardware and the development of the AfC Gateway required within TURAS Learn by Scottish government and the 360 Tool.

As a result of the review Directorates submitted bids for additional spend of £1.25m across the organisation largely relating to purchasing equipment to enhance Trainee Education in Medical, Dental and Optometry; and to improve the Digital infrastructure within the organisation. We have also approved expenditure to support the development of work on Remote and Rural credentials as requested by GMC and to support the learning experience of Healthcare Support Workers, specifically bands 2-4, by developing a high-quality learning resource to support work based learning and reflective practice and hosting 2 events for staff based in general practice. These bids were reviewed and approved by the Executive Team and are reflected in the forecast outturn figures reported in Table 6 below. After these measures were taken, we are currently forecasting a year-end underspend of £0.9m.

2.1.2 NES – Non MTG Salaries – Directorate Position

Table 6:

MONTHLY REPORTING FOR DECEMBER 19				**Period 09**				
Directorate	**Year to Date**			**Full Year**				
	Current Budget	**Outturn**	**Variance**	**Current Budget**	**Outturn**	**Variance**	**Variance last month**	**Movement in variance from last month**
Quality Management	61,411	61,362	48	82,256	82,229	27	24	3
Strategic Planning and Directorate Support	4,678	4,590	88	6,074	6,028	47	19	27
Training Programme Management Excl Training Grades	12,925	12,498	427	18,247	18,191	55	147	(91)
Professional Development	4,780	4,307	472	7,388	7,261	127	403	(276)
Pharmacy	7,817	7,418	399	12,426	12,249	178	171	7
Medical Total	**91,610**	**90,176**	**1,435**	**126,392**	**125,957**	**434**	**765**	**(331)**
Dental	33,499	33,463	36	45,107	45,292	(186)	56	(242)
NMAHP	8,201	8,428	(227)	13,682	13,722	(40)	(53)	12
Psychology	17,053	16,773	280	23,564	23,428	136	67	69
Healthcare Sciences	2,120	2,104	15	2,767	2,733	34	15	18
Optometry	810	776	35	1,094	1,201	(107)	8	(115)
NDS	1,440	1,426	15	2,514	2,446	68	0	68
Digital	8,944	8,302	642	12,647	12,970	(323)	263	(586)
Workforce	3,935	3,654	281	5,367	5,338	29	(0)	30
Finance	1,765	1,504	262	2,392	2,170	222	151	71
Properties	3,008	2,927	81	4,058	4,026	32	9	23
Facilities Management	534	498	35	712	690	22	13	9
Planning (incl OPIP)	975	948	27	1,312	1,286	26	11	15
Net Provisions	792	275	517	2,111	1,588	523	536	(13)
NES Total (revenue)	**174,687**	**171,254**	**3,433**	**243,718**	**242,847**	**871**	**1,842**	**(970)**

All figures are in £000's

The forecast revenue position still includes expenditure which will be reclassified as Capital and transferred to the balance sheet. This is estimated at around £2m. The overall forecast position will not be impacted as the associated funding will also be removed.

2.1.3 Year to Date

Currently NES, excluding Medical Training Grades, is showing a Year to Date underspend of £3.4m. Of this underspend;

- £0.9m is expected to flow through to the year end
- £2m has been redirected either as part of the reallocation exercise undertaken in December or through the ongoing reallocations via provisions and
- £0.5m is due to budgets being phased incorrectly – which we will take into account when phasing next year's budget

Significant variances within the **Full Year Forecast** are reported below:

2.1.4 Medical

The Medical Professional Development (PD) full year forecast underspend is £0.127m which arises primarily from under-recruitment of Rural Fellows starting in August 2019. Of the 12 posts available, only 4 filled (£266k underspend). This is a similar position to previous years. Additional spend of £245k was approved in PD which has reduced this underspend. Funds will be redirected across several areas including; a new Human Patient Simulator (HPS) manikin for use in clinical skills training costing £180k, Remote & Rural Credentials work (£25k), Psychometric testing (£20k) and realistic medicine £10k.

An underspend in Training Programme Management (exc Training Grade salaries) of £147k has been reduced by £91k due to increased costs in GP Trainer grants (due to higher remedial costs) and additional spend of £25k being approved to create a pilot to look at maximizing capacity in GP practices as part of the work of the Educational Capacity group.

The Pharmacy forecast underspend is currently £178k which is made up of a range of variances of less than £40k such as £36k due to 5 less Trainees April to July and £30k within Fellows as appointments have been on lower scale points than anticipated.

2.1.4 NMAHP

The Chief Nursing Officer Directorate at Scottish Government notified NMAHP that of the £3.4 m "bundle" of funding requested to deliver education and training for Nurses, Midwives and Allied Health Professionals only £2.7m was available to be allocated. Previously we reported that after discussion with CNO on priority deliverables, NMAHP were able to reduce the funding required to £2.9m, leaving a pressure of £0.2m.

Following a review of the Directorate's financial position the funding requirement reduced to £2.4m. The largest element of the movement relates to District Nursing where a review of the training needs in Boards identified significantly less training than anticipated was required. However, within the Post Registration training there is a high degree of uncertainty around uptake of training places and although this has been factored into the forecast, there remains a risk that uptake exceeds this.

The year to date underspend in NMAHP is largely due to payments for Advanced Nurse Practitioner courses being paid earlier than originally forecast (£231k)

The year-end overspend currently anticipated is due to additional staffing in place to support a long-term absence, which is not funded through the "bundle". Within the directorate redirected funding of £20k was requested and approved to support the learning of Healthcare support workers through the creation of online learning resources and 2 events run in partnership with General Nurse Practitioners.

2.1.5 Psychology

The year to date underspend of £280k is mainly due to underspends in salaries of £99k and £128k in Trainee Salaries where six resignations and seven maternity leaves are being offset by ten trainee extensions. £176k of this is forecast to remain at year end mainly due to the underspend in salaries which account for £120k of the total underspend.

2.1.6 Optometry

Optometry is currently projecting an overspend of £107k mainly though the approval of additional spend to the purchase of a Slit lamp which allows Anterior eye simulation training. This will enable excellence in educating around cataract referral refinement, maximising the service under the First Port of Call Optometry strategy, and facilitating safe training in gonioscopy – an essential skill in managing glaucoma and ocular hypertension in the community.

2.1.7 NDS

NDS funding of £2.5m has now been received from Scottish Government for 2019/20 reflecting all anticipated costs in this area.

The reduced funding requirement is predominantly driven by delays in recruitment and difficulty in attracting appropriate candidates. As posts were recruited from the top down initial delays in recruiting into senior posts had a knock-on effect across the teams.

In addition, Cloud Space was initially forecast to cost in the region of £500k. The Cloud procurement process is still ongoing. The technical and financial elements of the tenders have been evaluated, however, there have been several clarification points which have extended the time required to finalise evaluation. Due to the delay in the process, NDS have used Digital's Azure Cloud (paid via the Digital directorate), therefore other than some legal fees incurred as a result of the procurement process, the Cloud Expenditure will be minimal in 2019/20.

Scottish Government has requested additional development work within Ophthalmology which is anticipated to cost £200k and is included in the figures above.

2.1.8 Digital

The year to date position for Digital is a £641k underspend. The main drivers of this are £422k in pay as the directorate is undergoing reorganisation and is experiencing delays in recruiting to full establishment and non-pay timing issues.

Digital are showing a significant movement to a underspend of £323k at the yearend due to £525k of additional spend approved for the following; the purchase of IT hardware (£240k), 10 new Surface Hubs (£123k), room upgrades (£40k), replacement of the current room booking system so we have 1 system for all of NES which can be accessed off site (£64k) and additional purchase of a back catalogue of journals from the Royal College of Nursing (that were removed as an efficiency saving as part of the 2019/20 budget process)

2.1.9 Finance

The year-end is an underspend of £222k mainly due to 9 posts being vacant for the first part of the year following a review of the structure within the Directorate. This is also the cause of the year to date underspend of £262k. A schedule of recruitment is now underway with 3 new starts during December, 2 preferred candidates identified and 2 more posts currently out to advert.

2.1.10 Provisions

The full year budget for net provisions is £2.1m. This includes charges for depreciation (£1.2m), savings identified by directorates, budget adjustments and savings to be identified through procurement (£0.6m), the Apprenticeship Levy (£0.3m) and corporate budget identified as part of the budget setting process to cover work being undertaken at risk in Digital and NDS (£0.2m) less top-slicing of external income to cover overheads (£0.2m).

We anticipate a year end underspend of £523k due to movements which were not expected at the beginning of the year. For example from the write-back of accruals from 18/19 where estimated expenditure was charged to a previous year but it has since been confirmed it is no longer required (£331k) and a decrease to the year-end fixed term contract liability (releasing £271k). Provisions are also used to receive unused budgets from other directorates which will create an underspend in Provisions to be offset against overspends caused by the approved additional expenditure, across the Board to utilise these savings. These projects include the development of a 360 degree assessment tool on a Once for Scotland basis; capital investment to replace aged digital infrastructure which will provide resilience for our networks and the further development of TURAS Appraisal to reflect the Scottish Government's Agenda for Change reform requirements around implementing the Gateways for incremental pay progression

2.2 Medical Training Grades Salary Costs

Table 7

MONTHLY REPORTING FOR DECEMBER 19				Period 09				
Directorate	Year to Date			Full Year				
	Current Budget	Outturn	Variance	Current Budget	Outturn	Variance	Variance last month	Movement in variance from last month
Training Programme Management – Medical Training Grade Salaries	196,342	197,936	(1,595)	262,250	264,897	(2,648)	(2,874)	227

All figures are in £000's

The forecast position in Training Grades has not moved significantly since last reported.

- A £0.9m underspend in Hospital Trainees due to:

  Core and ST (£1.3m underspend):
  - 25.8 WTE fewer paid posts than budgeted creating an underspend of £1,305k. This arises because a filled expansion post is not paid for if the Board already has a vacant established training grade post which they would have received payment for. The policy is to only pay Expansion posts when all core established posts in the same programme are filled, we do not pay for unfilled expansion posts in line with the funding received from SG.
  - more (9.8 WTE) Less Than Full Time gaps in Core/ST than budgeted creating an underspend of £631k.

- Price variances create a further underspend of £181k due to a change to the payment rate for out of programme (OOP) vacancies to make them consistent with the rate paid for other vacant baseline funded posts.
- Partially offset by 4.5WTE more Certificate of Completion of Training (CCT) trainees opting to take up the six-month period of grace while applying for their preferred Consultant post, costing an additional £267k,
- 4.9 WTE higher double running than projected costing £318k due to trainees returning earlier to programme where the post has been replaced by another trainee and fewer vacancy savings than forecast £159k.

FY1 and FY2 (£192k overspend):
- 5.2 WTE fewer Less than Full time gaps than anticipated cause an overspend of £159k
- 1.8 WTE more remedials than anticipated causing an overspend of £60k
- Partly offset by £34k underspend in price variances arising from the fact that established vacant posts are paid at the bottom of the 2018/19 pay scale.

- £1.29m underspend in GP Trainee placements in Primary Care
  - 36.9WTE unfilled places across ST1 and ST3 (£2.5m) offset by a price variance caused by a higher average cost than budgeted £669k
  - and higher than anticipated Maternity and sick pay costs of £482k (6.2wte) and remedials £55k.

Medical Training Grade salaries show a Year to date underspend of £1.6m reflecting the part year impact of the full year forecast deficit.

2.2.1 Impact on Current Funding Gap

Since the last position reported to Board, to month 6, we have experienced movement of £531k, mainly from less Post CCT trainees staying on than anticipated. Whilst the financial position in Training grades is currently reasonably stable we know from previous years there may still be fluctuations as there is ongoing movement in trainee placements. Further movement is also likely as a result of the February 2020 GP intake in which we filled almost all the advertised posts.

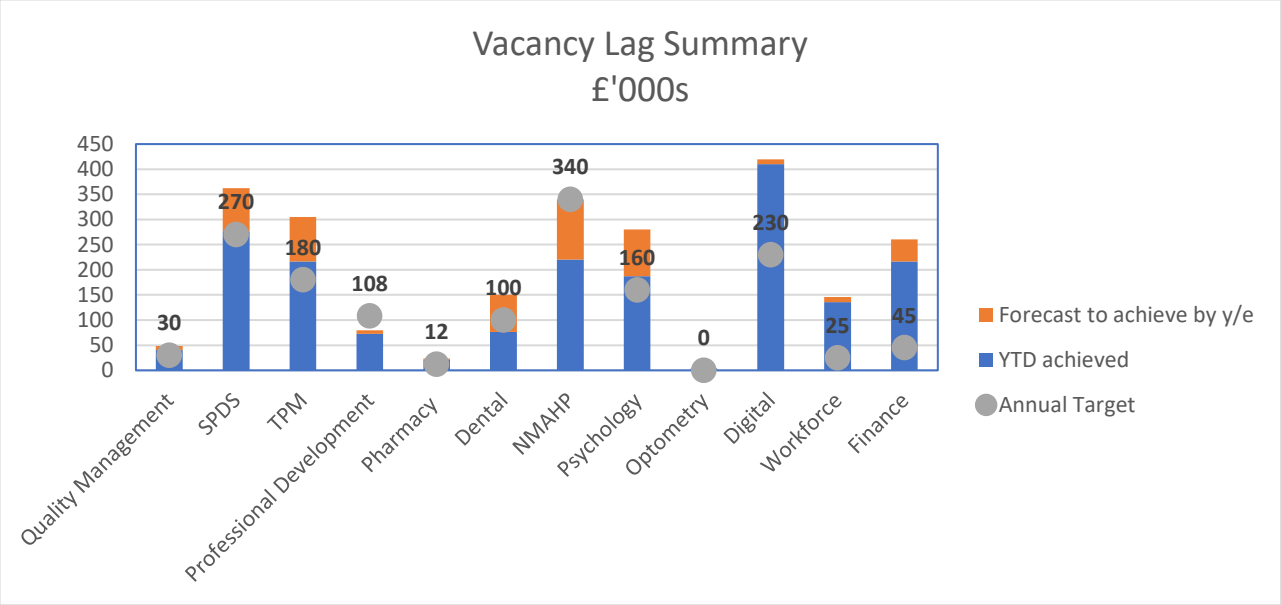
These changes impact on the amount of funding required to be drawn down from Scottish government to meet the recurrent Training Grade Deficit. If nothing else was to change, the amount of funding required to be drawn down at year end to address the funding deficit would be £2.2m as detailed below in table 8:

Table 8: Training Grade recurrent funding deficit	**Ref**	**£000's**
Current Deficit	Table 7	2,648
Additional Training Grade funding identified*		(400)
Total Funding required		2,248
Original Funding Deficit	Table 4	(4,879)
Reduction in required funding		2,631

Note:
** The original budget workings double counted a gap in funding for Foundation Training grade*

3. Savings – Vacancy Lag

A recruitment lag saving of £1.5m was included in the budget paper which, this year, has been allocated to directorates to allow greater control and ownership. To date £1.8m has been realised and we anticipate a further £0.6m to be released before year end. This is included in the directorate figures in table 6 above and explain a significant amount of the underspend which has been created in year. The graph below shows the amount achieved year to date and the anticipated saving that will be achieved by year end, per directorate, along with the original savings target.



The release of more vacancy lag in December, reflects the level of certainty within Directorates that posts will not be filled before the year-end given the recruitment timelines required. Over £0.5m of the additional vacancy lag expected in year comes from Digital, Workforce and Finance where restructures have been underway and there has been much higher levels of vacancy experienced than expected.

4. Transformation Fund Projects

NES has received a total of £2.5m in relation to Transformation priorities. £2.049m was received directly from the Transformation fund and additional £0.436m came from other areas within Scottish Government. NES has allocated a further £235k from within our own resources on a non-recurring basis (increased by £50k in P9), bringing the total available to £2.7m. Please see the table below for the details.

Table 9 – Transformation Funding

Source	**£000's**
Transformation Fund	2,049
NES non-recurrent allocation	238
Elective centre funding	128
SG Workforce Directorate	157
Psychology funding for CAMHS posts (£50k NES baseline/ Balance SG)	151
Total Funding	**2,723**

This funding has been split across several projects detailed below along with spend to date and a year-end forecast. Monthly reports are submitted to Scottish Government which cover the progress related to the £2.049m. All these figures are contained within table 6 of this report.

The funding is split between the 2 workstreams as follows:

Workstream	**Current Budget**	**Year to Date spend**	**Year-end Forecast**
Workforce Priorities	1,997	1354	1954
Business Systems	726	388	726
Total	**2,723**	**1,741**	**2,680**

£120k has moved from Workforce priorities to Business systems since M6 to offset the anticipated costs of the procurement support of the eRostering system and the completion of the full business case for the implementation of the eRostering system with the underspend in Training in Workforce Priorities.

The Workforce Priorities group consists of several projects including the ongoing support required for Lead Employer; the further development of the Turas Platform for People, Appraisal and Learn; the development of the Workforce Platform; the CAJE replacement; the Employee Engagement Portal and the hosting of the National Workforce Policies.

Business Systems is currently the e-Rostering project where this funding will enable an interface to be developed between SSTS and existing systems used for rostering. This interface will reduce the double keying of information until a long-term solution is agreed. The funding also supports the procurement of a new e-Rostering system to the point where a preferred supplier has been identified but no additional work will be carried out until a funding stream has been identified.

5. Risks to forecast Position

The risks to the year-end financial position result from the following:

5.1 Medical Training Grades Baseline Funding Gap

The initial review meeting has taken place with Scottish Government where it was acknowledged that the funding required to fill the historic gap in Medical Training Grades will move throughout the year as the cost drivers are out with NES' control. In order to manage this in-year movement it was agreed that whilst we will update Scottish Government on a regular basis as to the expected amount of funding required, a single drawdown figure will be agreed at year-end.

5.2 National Board Saving

There is a risk that the Scottish Government expects £1.3m National Boards savings contribution in addition to the £1m already agreed towards the Training Grade deficit. The financial implications of this will be discussed with Scottish Government at the January meeting.

5.3 General

Whilst we are now in Month 9 and levels of certainty around forecasting have increased, there are still some unknown factors influencing forecasts in directorates and the figures are based on assumptions for activity within the last quarter of the year. Those assumptions cover areas such as course take up rates, availability of goods, staff costs, maternity and long-term sickness rates. Whilst all figures provided are best estimates at this time, we also expect some movement.

5.4 Approval of Bids for Additional spend

There is a risk that bids approved of £1.25m cannot be fully utilised in 2019/20. Directorates are working with colleagues in procurement to identify where there is any possibility that goods or services cannot be delivered by 31st March 2020.

6.0 Recommendation for Decision

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

NES
January 2020
AMc/ LT

NES **NES/20/06**
Item 9b
January 2020

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Performance Management Report following 30th September 2019 progress updates.

2. Author(s) of Paper

Karen Howe, Planning and Corporate Governance Manager
Donald Cameron, Director of Planning and Corporate Resources

3. Purpose of Paper

This paper provides a summary of performance for the second quarter of 2019/20.

4. Key Issues

Overall, there are 562 targets, of which 8 are red, 51 are amber, and 503 are green. Of the 111 priority targets, 4 are red, 12 are amber and 95 are green.

5. Educational Implications

The performance targets cover all NES planned educational activity.

6. Financial Implications

The performance targets are delivered within the NES budget.

7. Which of the 5 Key Areas of Focus in the NES Strategy for 2019-24 does this align to?

A high performing organisation

8. Impact on the Quality Ambitions

The performance targets cover the quality ambitions.

9. Key Risks and Proposals to Mitigate the Risks

The performance targets have attached risks to delivery contained within the corporate risk register.

10. Equality and Diversity

Equality and diversity performance targets are included and reported each quarter.

11. Health Inequalities

There are a range of health inequality focused targets included.

12. Communications Plan

The Annual Operational Plan includes these performance targets and is published each year.

13. Recommendation(s) for Decision

To note and approve the current performance of NES.

NES
December 2019
KH

NHS Education for Scotland – 2019/20 Quarter 2 Performance Report

1. Corporate Dashboard

Full performance data can be found in the Corporate Insights area of TURAS | Data Intelligence which presents corporate metrics in one place. *Note: this will require a TURAS user sign in.*

2. Summary of Performance

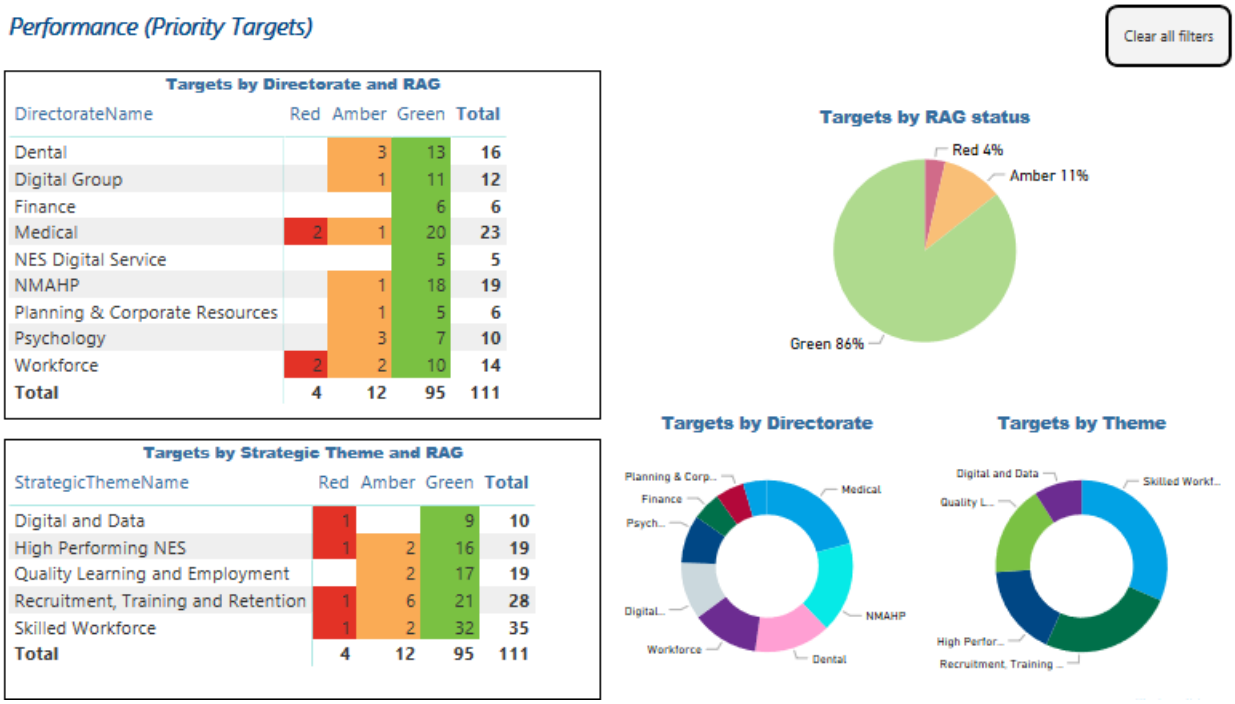
There are 562 performance targets for 2019/20, of which 111 have been identified as priorities and represent key performance indicators. Diagram 1 shows the performance across the 111 priority targets and diagram 2 outlines performance across all 562 targets. Performance is measured using RAG (Red, Amber, Green) ratings, the definitions are set out below:

Red – progress has not been satisfactory. The target is more than 10% below target and/or delayed by more than 3 months.

Amber – progress against this target/outcome has not been fully satisfactory. The target is below target by up to (and including) 10% AND/OR is delayed by up to (and including) 3 months.

Green – progress against this target/outcome has been satisfactory, with 100% of the target achieved or exceeded AND meeting all time deadlines.

Diagram 1 – Summary of performance for priority targets (Q2, 2019/20, n=111)



Of the 111 priority targets, 4 are red, 12 are amber and 95 are green. All priority target updates are reviewed to ensure the updates accurately reflect the content of the target and that the RAG rating is correct. Overall, 16 priority targets were followed up for further clarification. Of those 16: 13 remained unchanged; 2 were changed from green to amber; and 1 was changed from green to red.

A recent audit of performance management also recommended that we independently verify the supporting documentation behind a sample of the updates to provide additional reassurance that the inputs are accurate, complete and representative of the current status. Therefore, 5% (n=11) of the priority targets were independently verified, which included reviewing meeting agendas/papers, intranet/internet content and screenshots of appropriate documentation. All the information collected verified the updates that had been provided and no changes were made.

A spreadsheet with all 111 priority targets along with their quarter 2 updates and RAG status can be found here - further details of the red and amber priority targets are outlined in Tables 1 and 2 below.

Table 1 – Red priority targets Q2 2019/20

Target	Comment
Medicine - To increase the number of doctors completing Enhanced Induction and GP Returner programmes by 20%. (TAR0002541)	Uptake to the GP Returner and Enhanced Induction programmes is dependent on individuals coming forward and we are in a supply and demand situation. A social media campaign targeting GP returners was run in January 2019 and this has increased the number of expressions of interest. The new CEGPR Streamlined Australia Process has resulted in 3 enquiries since its inception with one confirmed later this year. This process is now extended to South Africa with New Zealand due to come online soon. USA and Canada may be included in future. The number of applications from the EU has decreased with imminent EU-exit. We normally have about 8 participants across both programmes each year. We had 2 GP Returners in post and no Enhanced Induction doctors at Q1 however there are 6 confirmed GP Returner starters and 2 possible starters for 2019 so we anticipate being on target to increase the total number of participants by 20% this year. This target was closed in Q1, but the latest position is that this is now on track. The target will be re-opened, and the final update will be made in Q3.
Medical - Appoint up to 10 GP-SIPS doctors at an average of 6 sessions per week by March 2020. (TAR0002925)	There remains only one GP in the SiPs scheme. Being closely monitored and publicised widely amongst local networks. No further expressions of interest received to date.
Workforce - To deliver education standards, learning networks and career pathways in digital skills to support Domain D of the Digital Health and Care Strategy. (TAR0002917)	Business Case for funding to support of Technology Enabled Care learning resources by end of financial year was successful. This will support completion of these deliverables but does not address capacity gaps in respect of broader work on Domain D of Digital Health and Care Strategy. A further proposal for funding to provide dedicated resource for this broad and complex programme was submitted to SG in June as part of Comprehensive Spending Review. Outcome pending. We understand that in relative terms, progress with Domain D work is not significantly behind other Domains of the Strategy. Steering Group continues to meet, and via this route we are engaging in ongoing dialogue with Scottish Government about what leverage there may be to open up existing national funding to support this important cross sector work.
Workforce - 100% of eligible staff having meaningful appraisal discussions and 100% of eligible staff completing all Essential Learning. (TAR0003114)	Figures for the end of Q2 are: Appraisal - 70% Objective setting - 75% PDP - 74% Essential learning - 84%

Target	Comment
	(October add on - the situation is generally improving:) Appraisal - 86% Objective setting - 88% PDP - 87% Essential learning - 77% (this has reduced because of a revised definition of who is included in the corporate induction figures)

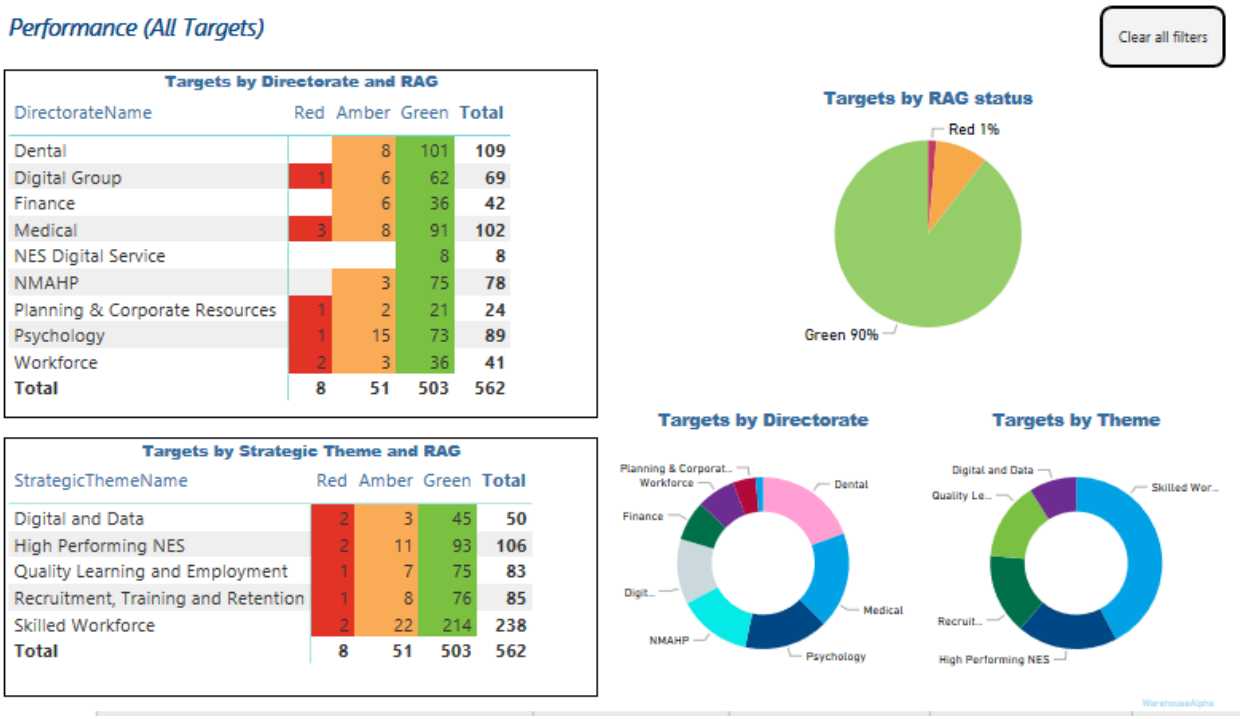
Table 2 – Amber priority targets Q2 2019/20

Target	Comment
Dental - Support approximately 16-18 Practitioner grade Clinical Physiology trainees will start training in Sep19 (2019 Cohort).(TAR0002467)	We have agreed year 1 sponsorship of 15 trainees which is just below target, with service likely to contribute additional posts. Recruitment still underway. 15 trainees supported.
Dental - The management of submissions for the 2019/20 mandatory training for optometrists in Scotland: acknowledgement of receipt within 10 days for a minimum of 95% of submissions and feedback within 3 months. (TAR0002496)	Business support routinely managing targets around delivery of 18/19 mandatory training. Additional tutors introduced to the workstream to ensure timely completion of feedback. 100% received feedback within 30 days, but 82.2% acknowledged within 10 days.
Dental - 94 Dental Core trainees and 45 Specialty and post Certificate of Completion of Specialist Training (CCST) trainees working towards the learning outcomes of the relevant curricula. Supported by relevant digital systems and trainers who can access support from NES. (TAR0002584)	86 of the 94 posts have been filled. We have attempted to fill the vacancies with the introduction of post DCT fellowships. Interviews yet to be held. However not all vacancies will be filled. Three specialty training posts were recruited to this year, two Orthodontic and one Special Care Dentistry post which will be split between Lothian and Fife.
Digital - Achieve accreditation with ISO27001 by October 2019 and Cyber Essentials Plus, completion by March 2020. (TAR0002652)	This is on hold until the Information Security Manager's post has been recruited.
Medical - Establish, evaluate and refine new processes for Recognition of Medical Trainers, using existing and new data management systems by end March 2020. (TAR0002557)	We are still experiencing difficulties using TURAS Trainers for Recognition of Trainers. This has again been communicated to the TURAS development team and we are awaiting further development of the system.
NMAHP - Test and evaluate innovative models for at least 5 Return to Practice placements across GPN/DN integrated teams	No progress to date as no interest from General Practices and no applications for Return to Practice from General Practices. Introduction of new employer model and revised Nursing & Midwifery Council standards for Return to Practice programmes has delayed introduction this year.

Target	Comment
with collaboration between general practices, NHS Boards and HEI providers by March 2020. (TAR0002766)	
PCG - Establish a long-term property option for the NES Digital Service and complete a new lease for Westport by end December 2019. (TAR0002476)	Business case for NDS to extend their lease at Bayes is currently with the Scottish Govt property Division for approval after having received Board approval in Sept 2019.Process to search for longer-term solution for the period from Nov 2020 now commencing.
Psychology - Recruit three trainee health psychologists in training to commence in May 2019 and support four current trainees to complete training by January 2020. (TAR0003000)	Within 10% of target, with two trainee health psychologists commenced in May 2019. Four trainees due to complete by the end of January 2020.
Psychology - Support 30 trainees for psychological therapies in primary care (PTPC) and 30 MSc trainees in applied psychology for children and young people (APCYP) to complete training by January/February 2020. (TAR0002999)	Within 10% of target, with 29 trainees to complete the MSc for psychological therapies in primary care by the end of January 2020. One trainee has withdrawn from training.
Psychology - Support 54 clinical psychology trainees to complete pre-registration training by the end of October 2019. (TAR0002998)	Within 10% of target, with 53 clinical psychology trainees to complete pre reg training by the end of October 2019. A further 2 trainees with extensions are expected to complete by the end of March 2020.
Workforce - Contribute to work across NHS Scotland on Agenda for Change reform that strengthens the link between Appraisal, Essential Learning and Incremental Progression, ensuring that outcomes of this work are reflected in development of Turas Appraisal and Learn, and our portfolio of OD&L national development programmes and resources. (TAR0002900)	Funding for development of Turas Learn/Appraisal secured and work commencing November 19. Further elements of the required funding (outwith NES digital responsibilities) expected to be secured very shortly.
Workforce - Widen opportunities for young people by supporting all Boards in Scotland to promote NHSScotland as an employer of choice, widening access routes and opportunities for under-represented groups, increasing the number of young people	Linking in with Skills Development Scotland to explore further support for Boards in delivering Foundation Apprenticeships. Exploring Founders 4 Schools as online platform for youth employability. Met with GJNH to engage in Programme Task force created to create core content for Boards currently not engaged in Programmes.

Target	Comment
entering the service, including apprentices. (TAR0002933)	

Diagram 2 – Summary of performance for all targets (Q2, 2019/20, n=562)



Overall, there are 562 targets, of which 8 are red, 51 are amber, and 503 are green. As part of quality control, all the red and amber targets were reviewed and approximately 10% (n=50) of the green targets were randomly selected to ensure the update accurately reflected the content of the target and that the RAG rating was correct. Of the targets reviewed, 10 were followed-up and of those: 5 were unchanged; 2 were changed from green to amber; 2 were changed from green to red; and 1 was changed from amber to green. The red non-priority targets are outlined in Table 3 *(Note: the priority targets have been excluded from this table to prevent duplication).*

Table 3 – Red non-priority targets Q2 2019/20

Target	Comment
Digital - Transfer all relevant functionality currently provided by TKN to the Turas Platform (TAR0002884)	A delay to recruitment of a developer to work on this programme, along with other priorities have realistically pushed this work back to commencing in Q4 FY 2019/20
PCG - Organise and deliver the NES Annual Review by December 2019. (TAR0002717)	Scottish Government have confirmed that we do not need to hold an annual review during 2019, so this work will no longer take place. Scottish Government have advised that our next Annual Review requirement will not be until 2020. We will not know whether the NES Annual Review will be ministerial or non-ministerial until nearer the time. Guidance will be issued circa May 2020. Target to be closed.
Psychology – To continue to increase supervision capacity in major psychological	Significant delay to starting FBT trainees due to negotiations around eligibility of faculty status effecting accreditation to lower costs, and due to health boards

Target	Comment
interventions: Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT) and Family Based Treatment (FBT). (TAR0003009)	withdrawing/ changing nominations. 11 clinicians attended CBT supervision training in Sep 2019. Refreshed CBT supervision module now on Turas.
Medical - Develop a pharmacy genetics website with educational support resources. (TAR0002513)	This is a duplicate of TAR0002512 which is on target and green. This target is a duplicate and was closed in Quarter 1 and therefore no further update.

NES
November 2019
KH

NES **NES/20/07**
Item 9c **(Enclosure)**
January 2020

NHS Education for Scotland

Board Paper Summary: Staff Governance Committee Minutes

1. Title of Paper

Minutes of Staff Governance Committee meeting held on 7th November 2019: 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 7th November 2019.

N.B. This meeting was chaired by Anne Currie, in the absence of the Committee Chair, Linda Dunion.

4. Items for noting by the Board

Item 7 – Leadership and Management Development

The committee received a useful paper and presentation; and endorsed the proposed plan for review of the provision of leadership and management development for NES line managers.

Items 8 and 9 – Key Performance Measures and Workforce Intelligence Insights

The committee received useful presentations on both of these developing pieces of work. A link to the live People & OD Dashboard will be circulated in advance of the committee's next meeting.

Item 10 – Personal Review & Planning and Essential Learning: Update

The committee received a helpful paper, was pleased to note the recent improvement in compliance rates in relation to PRP and Essential Learning and endorsed the proposed actions to be taken to achieve further improvement in these compliance rates.

Item 11 – Fair Work: Benchmarking

The committee received a useful presentation on how NES benchmarks

against the five key elements of the Fair Work Framework and endorsed the actions proposed in relation to taking matters forward.

Item 12 – Stress Survey

The committee noted a helpful paper in relation to the results of a Stress Survey commissioned by the Healthy Working Lives Group and endorsed the work proposed in relation to addressing the three areas for improvement identified in the survey results.

Item 13 – Employment Tribunals

The committee noted a confidential paper providing updates on two current Employment Tribunal cases.

5. Recommendations

None.

NES
November 2019
DJF

Unconfirmed

NHS Education for Scotland **NES/SGC/19/49**

Minutes of the Sixty-Sixth Meeting of the Staff Governance Committee held on Thursday 7th November 2019 at Westport 102, Edinburgh

Present: Anne Currie, Non-executive Board member (in the Chair)
Jean Ford, Non-executive Board member (via audio link)

In attendance: Dorothy Wright, Director of Workforce/Executive Secretary
Caroline Lamb, Chief Executive (via VC link)
Morag McElhinney, Principal Lead, HR
Gillian Strachan, Head of Programme, OL&ED
Ameet Bellad, Senior Specialist Lead, Workforce Infrastructure
Anne Campbell, Principal Lead, Organisational and Leadership Development
David Ferguson, Board Services Manager

1. Chair's welcome and introduction

Anne Currie welcomed everyone to the meeting. Anne had kindly agreed to chair the meeting in the absence of Linda Dunion (Committee Chair).

2. Apologies for absence

Apologies were received from Linda Dunion, Committee Chair, Liz Ford, Employee Director, David Cunningham, Staff Side (BMA) and David Garbutt, Board Chair.

3. Declaration of interests

There were no declarations of interest in relation to the items on the agenda, other than those logged previously.

4. Minutes of meeting held on 8th August 2019 (NES/SGC/19/37)

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

5. Action Status Report (NES/SGC/19/38)

It was noted that the action points had all been completed or were in hand and the following updates were provided:

- As there was a paper on Fair Work benchmarking on today's agenda, it may not be necessary to bring a paper on the Fair Work Vision 2025 to a meeting in early 2020. This point will be discussed with Kristi Long.
Action: DW

- The timing of an item on Risk Management on a Board Development Session will be discussed with Audrey McColl. **Action: CL**
- Links to the Our Way scenario videos will be sent to Jean Ford. **Action: AC**
- It was noted that a paper on the Lead Employer arrangements will be considered by the Chief Executives Group later in November 2019.
- It was agreed that the action from November 2018 on Workforce Metrics has been overtaken by events and should be removed. It may, however, be useful to discuss workforce planning data at a future meeting.

6. Matters arising from the minutes

None.

7. Leadership & Management: Current Overview (NES/SGC/19/40)

Gillian Strachan introduced a paper providing the background to and the focus of a review and refresh of NES's current internal provision for leadership and management development. A presentation, 'Leadership and Management Development Review', was also given, covering the following areas:

- A high-performing organisation: Effective line managers; Values-based leadership behaviours
- People Management in NES: Positive indicators in iMatter and Stress Survey; Potential gaps in how our managers understand their roles and in their capability and confidence; Consistent modelling of NES leadership behaviours
- Line Manager effectiveness: Leading successful teams; Developing others for success; Mentally healthy workplace training; Line managers induction; Coaching skills for managers; Digital resources
- Leadership behaviours: New Horizons; Leading for the future; Leadership Cubed; Leadership Links; Leadership and Management Zone
- Areas for enquiry: 1. Relevance; 2. Quality; 3. Accessibility

The following points were highlighted during the presentation;

- Participation in face-to-face training modules is low, with the exception of the module on coaching.
- A wider range of managers needs to be reached with the training, which can currently feel like 'preaching to the converted'.
- The webinar approach to training appears to be popular.
- The frequency and duration of training programmes/modules will be looked at as part of the review.

The following points arose in discussion:

- The availability of improved analytical data will enable a targeted approach to line manager development in some cases, perhaps involving development plans and bespoke interventions.
- There are around 215 staff in NES with line management responsibilities (ranging from Band 4 to Executive level).
- Peer support among line managers should be encouraged.

- Line managers need to be clear that they are required to demonstrate leadership qualities too.
- The HR Directors and OD Leads need to take ownership of the national picture in relation to leadership and management development, which is currently very fragmented.

Following discussion, Gillian Strachan was thanked for her useful presentation and the committee noted the paper and endorsed the plan to review the provision of leadership and management development for NES line managers. **Action: GS**

8. People & OD Dashboard: Key Performance Measures

Ameet Bellad gave a presentation on 'People Analytics – Insights: NES Organisational Performance', covering the following areas:

- NES People & OD Strategy Key Performance Indicators (KPIs) across the employee life-cycle: Attraction; Recruitment; Performance; Transition; Succession; Development
- Extraction Transformation Load Process
- Performance Overview: How is NES performing against each of the KPIs?: A first iteration of the data

Ameet then gave a demonstration of the live dashboard data, including a second iteration of the Performance Overview. The following points were noted during the demonstration:

- The performance review data enables comparison between quarterly figures, using a RAG approach. The data can be broken down by Directorate.
- The data model illustrates the complexity of the landscape of systems which feed in.
- Consideration could be given to setting baseline targets for each KPI.
- Work is in hand to make it possible to drill down into each KPI.

Discussion produced the following points:

- Work is ongoing to link the people analytics data with performance and finance data in an emerging corporate dashboard.
- It may be useful to add a KPI in relation to leadership and management development.

Following discussion, Ameet Bellad was thanked for his useful presentations and congratulated on the work to date on developing the People and OD dashboard and KPIs.

It was noted that, for the next meeting in February 2020, a link to the live People & OD dashboard will be issued in advance, for discussion at the meeting.

Action: AB

9. Workforce Intelligence: Second Insights (NES/SGC/19/41)

Morag McElhinney introduced a paper providing an update on the areas for improvement identified at the August meeting of the committee and further feedback on the work being progressed across the Workforce Directorate following further analysis of the data. The following areas were covered in the paper:

- Quarter 2 Headlines
- Indicators of high-performing teams
- Collective ownership of formal processes
- Differential application of policies
- Recruitment outcomes
- Workforce planning

It was noted that the review of people analytics data will continue on a regular basis, with a continued focus on where data is indicative of team culture, so that good practice can be modelled and continuous improvement achieved through early intervention and linking in with ongoing programmes of work being progressed across NES.

Discussion of the paper resulted in the following points:

- The review of this data will inform the forthcoming review of leadership and management development provision for NES line managers.
- Psychological safety is being looked at as part of the wider health and wellbeing agenda.
- The importance of interview feedback for unsuccessful candidates was underlined, particularly for candidates in the 16-24 age range. Line managers need to be equipped with the skills to provide this feedback.

Following discussion, the committee thanked Morag McElhinney for her useful paper and commended the direction of travel of this work.

10. Performance Report: Appraisal & Essential Learning: Update (NES/SGC/19/42)

Anne Campbell introduced a paper presenting the most recent data in respect of compliance rates for PRP and Essential Learning completion and highlighting actions aimed at supporting improvement. The following points were highlighted:

- While there is encouraging evidence of improvement in compliance since the committee's last meeting in August, there is still some way to go to achieve the corporate target of 100% of eligible staff having an appraisal, objectives set, a personal development plan and completing all essential learning.
- There is increased confidence in relation to the data around compliance rates.
- A number of actions have been identified to support further improvement, notably: a positively-couched corporate objective for all line managers in relation to meaningful appraisal within agreed timescales; ensuring that

staff, particularly line managers, are aware of the link between appraisal completion and incremental progression which will be introduced through Agenda for Change pay reform in April 2021; a 'First 90 days project' to improve the onboarding journey for new staff, including a process whereby new staff will be booked automatically onto Corporate Induction; and reinforcing in line manager induction the importance of full compliance with essential learning.
- There will be a focus on clarifying the expectations of line mangers and supporting them in undertaking their role.

Discussion generated the following main points:

- The committee welcomed the improved performance in relation to completion rates in relation to PRP and essential learning.
- More training and coaching is needed in relation to the closure of completion cycles for PRP.
- Based on the people & OD analytics data, it will be possible to take a more targeted approach to interventions in future.
- It was agreed that the completion of essential learning should be undertaken by new staff during the induction period, although it was noted that it would not be realistic to build time for completion into the current structure of the Corporate Induction day.
- It is intended that the new corporate objective for line managers will be introduced in time for the 2020/21 reporting year.
- In view of the recommendations of the Sturrock Report, it was suggested that a Once for Scotland approach should be taken to the introduction of the corporate objective for line managers.

Following discussion, the committee noted the paper and endorsed the actions recommended to support further improvement in compliance rates for PRP and essential learning. **Action: AC**

Anne Campbell was thanked for her helpful paper.

11. Fair Work: Benchmarking (NES/SGC/19/43)

A paper had been circulated to support a presentation outlining the key components of the Fair Work Framework and how NES benchmarks against that framework. This presentation was given by Morag McElhinney and covered the following areas:

- The 5 key elements of the Fair Work Framework: Effective Voice; Opportunity; Security; Fulfilment; and Respect
- How NES is performing against each of the 5 key elements
- What do we need to do next? A series of proposed actions in relation to: Embedding Our Way; Refreshing leadership and management development; Supporting effective staff use of communications channels; Improving staff involvement and engagement; Implementing values-based recruitment and linking this to induction; Using data analytics and insights to inform activity, resource and workforce planning; Progressing digital

capabilities development and the SMARTER Working Project outcomes; and reviewing job design to ensure a fit for future roles
- Conclusions: 1. NES performs very well against the Fair Work Framework; 2. NES's People & OD Strategy and associated plans are fully aligned to the framework and are designed to enable continuous improvement of performance.

Some discussion took place on the proposed introduction of Trickle, a digital employee engagement tool which can capture employee feedback and take 'temperature checks' in real time. This would be intended to complement the iMatter system. A short-life working group has been set up to consider the implications and practicalities of introducing Trickle and report in to the Executive Team with its findings and recommendations.

The committee thanked Morag McElhinney for her useful presentation and endorsed the actions proposed to take matters forward. **Action: MMcE**

12. Stress Survey (NES/SGC/19/44)

Morag McElhinney introduced a paper outlining the key areas for improvement identified in the Stress Survey commissioned by the Healthy Working Lives Strategy Group and sharing the draft summary report which will be made available to staff. This summary report sets out ongoing programmes of work which are contributing to areas identified for improvement.

The following points were highlighted:

- There were 399 responses to the Stress Survey: a response rate of 47% from a representative sample of staff.
- The survey outcome identified three areas for improvement: 1. Demands and workloads; 2. Change and uncertainty; and 3. General support, relationships and behaviours.
- There will be a key role for the SMARTER Working Project in taking forward areas 1, and 2. Above. The promotion of Our Way will be key to addressing area 3. above.

Discussion produced the following points:

- The survey results are consistent with iMatter results.
- Discussions will take place with John MacEachen (Head of Corporate Communications) on how best to feed the Stress Survey results back to staff in a readily-digestible form.

The committee noted the paper and endorsed the work being taken forward to address the three areas for improvement identified in the Stress Survey results.
Action: MMcE

13. Employment Tribunals (NES/SGC/19/45)

Dorothy Wright introduced a confidential paper providing information on two current Employment Tribunal cases. The paper was noted.

14. Lead Employer: Update (NES/SGC/19/46)

The committee noted a paper providing an update on NES's employment of doctors in training.

15. Equality and Diversity Update

It was noted that the Quarter 2 Equality and Diversity report will be circulated between this meeting and the next meeting in February 2020.

16. Policy Tracker: Update

It was noted that all PIN policies remain on hold pending roll-out of the national Once for Scotland PINs.

Dorothy Wright added that the first tranche of Once for Scotland PIN policies have been approved at national level and that consideration is being given to an associated communications and training plan.

17. Managing Health, Safety and Wellbeing Committee minutes
(NES/SGC/19/47)

The committee noted the minutes of this committee's meeting held on 24th July 2019.

In discussion, it was agreed to include the current Health and Safety Plan on the agenda for the next Staff Governance Committee meeting. **Action: DJF**

18. Change Management Programme Board (CMPB) minutes

The committee noted the minutes of this board's meeting held on 10th July 2019.

19. Any other business

The was no other business.

20. Date and time of next meeting

It was confirmed that the committee's next meeting will take place on Thursday 6th February 2020 at 10.15 a.m.

Anne Currie wished everyone all the best for the forthcoming festive season.

NES
November 2019
DJF

NES **NES/20/08**
Item 9d
January 2020

NHS Education for Scotland

Board Paper Summary: Educational & Research Governance Committee (E&RGC) Minutes

1. Title of Paper

Minutes of the Educational & Research Governance Committee (E&RGC) meeting held on 12 December 2019: copy attached.

2. Author(s) of Paper

Rob Coward, Principal Educator

3. Purpose of Paper

To receive the unconfirmed minutes of the E&RGC meeting held 12 December 2019.

4. Items for Noting

Minute 9. Sharing education practice
The Committee approved a proposal for enhancing sharing of NES's own education practice. This initiative responded to a request from the E&RGC to ensure that NES is continuously learning from its own good practice to improve the quality and performance of education products and services. The Committee noted the proposal was developed by a cross-directorate working group, which had identified key principles and a simple communications model. The recommended approach was focused on a reformed Education Leadership Group (ELG), which would invite relevant staff to contribute their experience and expertise.

Minute 10. Equality & Diversity mid-year report
The Committee received the Equality & Diversity mid-year report for information and comment. It was noted that most equality related targets were on track and measures are in hand to address exceptional items. E&RGC members noted that a short-life working group had been established to enhance progress in the equality impact assessments. This work would include the development of more directive and performance management-oriented staff guidance.

5. Recommendations

The Board is asked to note the unconfirmed E&RGC minutes and invited to ask questions.

NES
December 2020
RC

NHS Education for Scotland

EDUCATIONAL & RESEARCH GOVERNANCE COMMITTEE

Unconfirmed minutes of the thirty-seventh meeting of the Educational & Research Governance Committee held on Thursday 12 December 2019 at Westport 102, Edinburgh

Present: Mr Douglas Hutchens (Chair)
Dr Doreen Steele
Ms Sandra Walker
Mr David Garbutt
Ms Vicki Nairn (by videoconference)

In attendance: Professor Stewart Irvine, Acting Chief Executive
Ms Karen Wilson, Director, Nursing, Midwifery & AHPs/ Executive Lead
Dr Kristi Long, Equality & Diversity Adviser (items 1-3 and 11 only)
Mr Rob Coward, Principal Educator/Executive Secretary

1. Welcome and introductions

Douglas Hutchens welcomed everyone to the meeting, including Vicki Nairn who was attending her first E&RGC meeting. The Committee noted that Stewart Irvine was attending in his new capacity of Acting Chief Executive and Karen Wilson was now the Executive Lead for Educational and Research Governance.

2. Apologies for absence

All E&RGC members were in attendance.

3. Notification of any other business

3.1 Committee paper cover sheets

At the suggestion of the E&RGC Chair it was agreed that the quality of the Committee paper cover sheets would be considered. Members expressed concern regarding the significant inconsistency in the quality of information provided in cover sheets. It was observed that cover sheets provide an opportunity to highlight issues and implications relating to agenda items. Information relating to equality and diversity was considered particularly relevant to most business items. Members identified a number of cover sheet fields that had been marked as 'Not applicable.' This was considered inappropriate and insufficient and the E&RGC agreed that the reasons why fields are not deemed applicable (if appropriate) should be provided in the cover sheet. **Action: RC**

The Committee further agreed that E&RGC paper cover sheets should provide a summary abstract. **Action: RC**

It was resolved that papers submitted to future meetings where the cover paper had not been satisfactorily completed would not be considered. **Action: E&RGC**

The E&RGC and NES Board Chair indicated that the content and quality of report cover sheets would be addressed more generally for Board meetings and other Board sub-committees.

3.2 NES Bereavement Conference

Doreen Steele reported that she recently attended a NES Bereavement conference, which had been excellent. In discussion with delegates, she was informed by participating GP Specialty Trainees there was currently no peer support group in relation to bereavement. Stewart Irvine advised that there are support mechanisms for this staff group, and it was agreed that the specific support available on bereavement would be checked at an executive level. It was further agreed that similar queries and suggestions should be directed to relevant NES staff members. This would be communicated to all NES Board members. **Action: CEO's office**

Committee members emphasised the need to feedback on NES's good practice, such as a recent meeting between Vicki Nairn, Stewart Irvine and a NES colleague from the Remote and Rural Healthcare Education Alliance. This meeting provided a significant amount of information on NES's good practice and a file note on this meeting would be circulated to the E&RGC shortly. **Action: VN**

The importance of circulating information from this type of interaction was emphasised and it was agreed that the Chief Executive's office would be asked to provide a pro forma for this purpose. **Action: CEO's office**

4. Declaration of interests

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

5. Minutes of the Educational & Research Governance Committee (NES(E&RGC)19/35)

The Committee reviewed the unconfirmed minutes of the E&RGC meeting held on 9 October 2019 and confirmed them as an accurate record, subject an amendment of minute 7 relating to the quality assurance of digital learning resources hosted on Turas Learn. It was agreed that this minute should indicate that the Committee will continue to receive updates on the development and implementation of quality assurance arrangements and that this would be added to Action Status Report.

Action: RC

6. Action status report (NES(E&RGC)19/36)

The Committee reviewed the report on the status of actions agreed at previous meetings. It was noted that several actions had been completed and should be removed from the report. There were also outstanding actions of which most were not yet due. Members noted action items marked as 'ongoing' and it was agreed

these would be deleted when the Committee is confident that the agreed changes had been adopted as standard practice. **Action: RC**

Members discussed the need for a register for Educational and Research Governance related risks. It was noted that there were currently no such risks rated at the highest, primary level and that NES's internal auditors would shortly be conducting a review of risk management practices. It was expected that this 'Risk Maturity Assessment' would examine the consistency of risk identification and scoring across the organisation. Members were advised that educational programmes associated with elevated levels of risk, such as Project Lift, would be the subject of Educational Governance monitoring reports, which are routinely presented to the E&RGC.

It was agreed that the NES Assurance Framework would be checked to ensure it reflects the E&RGC discussion of risk management at the previous meeting.
Action: RC

7. Educational & Research Governance Lead Officer's report (NES(E&RGC)19/37)

The Committee considered the Educational & Research Governance Lead Officer's report, which provided information on new products and services, good practice and emerging issues relating to NES's education and research activities. Members commented that the report provided a helpful overview of the diverse activities in which NES is involved. No updates were provided for Dental, Psychology and Health Science, but there was a good balance of information presented.

Commenting on the Turas Learn update, members noted that some NES modules were being hosted on the LearnPro learning management system. Module sharing agreements were in place for 12 territorial Health Boards and NES was working hard to reach agreement with the two remaining territorial Boards.

8. Educational & Research Governance Executive Group minutes (NES(E&RGC)19/38)

The E&RGC received and noted the unconfirmed minutes of the Educational & Research Governance Executive Group (ERGEG) held on 12 November 2019 for information. It was observed that many of the ERGEG agenda items were on the E&RGC agenda and members sought assurance that there was not unnecessary duplication. Members were advised that the ERGEG was the 'engine room' for educational and research governance with the Committee acting as the 'bridge'. The ERGEG also provided a helpful forum for inter-professional learning.

9. Sharing education practice (NES(E&RGC)19/39)

Rob Coward presented a proposal for enhancing sharing of NES's own education practice. This initiative responded to a request from the E&RGC to ensure that NES is continuously learning from its own good practice to improve the quality and performance of education products and services. The Committee noted that the proposal was developed by a cross-directorate working group, which identified key principles and a simple communications model. The recommended approach was focused on a reformed Education Leadership Group (ELG), which would invite relevant staff to contribute their experience and expertise. Outputs from the ELG discussions would be shared using several communication channels, and participating staff would be encouraged to maintain dialogue through communities of practice. The proposed model would be implemented in 2020 and evaluated to measure the effects of the new approach.

The E&RGC welcomed the proposed sharing education practice model and noted the intention to attract NES colleagues to discussions and information that will be useful to them. Members indicated that communities of practice had been shown to work particularly well and, in time, have beneficial outcomes on quality and performance. It was agreed that a progress report on the sharing education practice model would be submitted to the E&RGC in six months' time.

Action: RC

10. Enhancing E&RGC scrutiny across all professions

The E&RGC Chair introduced a discussion concerning the balance of scrutiny across the different professional groups supported by NES. Although Committee scrutiny was distributed across all disciples, there was concern that insufficient attention could be paid to higher risk areas such as medical education, given that there was now a wider scrutiny across all groups. Stewart Irvine advised that this balance was addressed through the risk profiling process, which identified significant risks and was used to construct the Educational Governance reporting schedule. This process was designed to make the Committee's business more manageable while providing assurance on NES's larger and most strategically significant activities. The Lead Officer's report provided a further layer of assurance.

The Committee discussed the need to share information between Board sub-committees to ensure clarity regarding governance routes and to stimulate ideas. It was noted that committee business was shared at Board meetings through minutes, and it was suggested that meetings of committee chairs may also be useful for this purpose.

It was agreed that the E&RGC will maintain a watching brief on this issue and would use the Educational Governance risk profile to check the balance of business across professional groups. **Action: RC/E&RGC members**

11. Equality & Diversity mid-year report (NES(E&RGC)19/39)

Kristi Long presented the mid-year Equality and Diversity, which included summary data from the NES Performance Dashboard together with progress information on Equality Impact and Fairer Scotland assessments. An updated matrix of equality related duties and reporting requirements accompanied the report. Kristi highlighted the need to accelerate progress in producing equality impact assessments (EQIAs) and reported that a Short-Life Working Group (SLWG) had been established to develop more directive and performance management-oriented guidance on this subject. The SLWG, which would include representation from the NES Digital Service, would investigate the development of related e-learning resources. Kristi reported that a contract for developing a tracking tool for EQIAs would be awarded very shortly.

The Committee discussed the equality related performance targets presented in the report. In reply to a question on the GP Returners programme Stewart Irvine advised that the GMC was conducting a survey of all UK doctors on the register to canvass views of the registered medical workforce and investigate the potential for attracting leavers back to the service. It was noted that this report would be presented at a future E&RGC meeting when available. **Action: RC/Rowan Parks**

In relation to a performance target on the Digital Health and Care Strategy, Kristi Long advised that a funding proposal under Domain D is pending, subsequent to the outcome of the Comprehensive Spending Review. NES is continuing to work with the cross-sector partnership although further specific actions cannot be advised at this time.

The Committee noted the limited progress on a performance target relating to widening employment opportunities for younger people in NHS Scotland. Members expressed their interest in widening access to other under-represented groups such as men into nursing and returners to health care professions. It was agreed that a report on NES widening access initiatives should be provided to the Committee in due course. **Action: KL**

In reply to a question regarding NES's response to the Islands Act 2018, Kristi advised that the requirement for Islands Impact Assessment was not yet in force and the process for impact assessment had not been developed. Discussions were currently taking place to agree a proportionate response to the legislation. NES has conducted some practical work in this area through the Remote and Rural

Healthcare Education Alliance (RRHEAL) and may be well-placed to respond to the statutory duties.

E&RGC members thanked Kristi for her helpful report and requested that the spreadsheet on outstanding performance targets be re-issued in a more accessible format as soon as possible. **Action: KL**

12. Educational & Research Governance internal audit focus 2020 (NES(E&RGC)19/40)

The Committee considered the focus for the Educational and Research Governance internal audit 2020. Three options had been identified by the ERGEG for the consideration of members as follows:

- The responsiveness of programme teams to comments and recommendations made by the ERGEG in relation to Educational Governance monitoring reports (and the checking of progress on these recommendations by ERGEG)
- The standards and processes followed by NES teams in developing digital learning resources.
- The extent to which NES programme teams involve people with 'lived experience' in the design and review of education and training.

It was agreed that the focus of the 2020 Educational & Research Governance internal audit would be the standards and processes followed by NES teams in developing digital learning resources. **Action: RC/Dir. Finance**

13. NES-Scottish Funding Council Memorandum of Understanding (NES(E&RGC)19/41)

The E&RGC received the Memorandum of Understanding (MoU) and associated annual Joint Action Plan between NES and the Scottish Funding Council. These documents, which were due for consideration by the NES Board, were presented to enable consideration of any educational and research governance implications. It was noted that the MoU and Joint Action Plan committed NES to the joint funding of a liaison post, a jointly funded research fellowship for support work around career choices in medicine and other funding relating to Joint Action Plan commitments.

The Committee thanked Karen Wilson for providing the information and welcomed the MoU and Joint Action Plan as a way of strengthening the links between NES and SFC.

14. Educational Governance case study (NES(E&RGC)19/40)

Rob Coward presented a case study paper on the use of social media by the NMAHP Twitter Group. He explained that the Twitter Group had developed a systematic approach to using this social media channel to promote NMAHP

products, services and events. The Group had also used opportunities to promote Twitter by upskilling NMAHPs though a ’10-day challenge’ and Brown Bag lunches at events. The enterprising approach of the Twitter Group was recently recognised by a NES Star award.

E&RGC members welcomed the case study and congratulated the NMAHP Twitter Group on its NES Star award.

15. Identification of risks

The Committee identified the following risks arising from the business of the meeting where further assurance is required:

- Committee report cover sheets
- Ensuring the effective and risk-based balance of scrutiny between professional groups

Members did not require these risks to be added to the NES risk registers but reiterated that these issues would be monitored. It was agreed that the distribution of business between professional disciplines would be reviewed as part of the Committee’s annual report. **Action: RC**

16. Items for inclusion in the E&RGC annual report

The following items were identified for inclusion in the E&RGC annual report 2019-2020:

- Equality & Diversity mid-year report
- Sharing education practice
- Digital learning and Turas (as a cross-cutting theme)

17. Scheduled E&RGC workplan items not covered by the meeting agenda

There were no scheduled E&RGC annual workplan items not covered at the meeting.

18. Date and time of next meeting

The next meeting of the E&RGC will be held on Thursday 20 February 2020 at 10.15 a.m.

RC
December 2019

NES **NES/20/09**
Item 7e
January 2020

NHS Education for Scotland

Board Paper Summary: Committee Minutes

1. Title of Paper

Minutes of Digital Sub-Committee meeting held on 13th December 2019: copy attached.

2. Author(s) of Paper

Geoff Huggins, Director, NDS

3. Purpose of Paper

To receive the minutes of the Digital Sub-Committee meeting held on 13th December 2019

4. Items for Noting

The Board is asked to note the following item(s) of interest:

That the Dec 2019 meeting is the last planned Digital Sub-Committee meeting before transition to new Standing Committee arrangements for 2020.

That usual update information was provided to the DSC; staffing, finance, risk and overall workstream status within the NDS portfolio. Additionally, a number of substantive items were also discussed as reflected in section 5 of the minutes.

5. Recommendations

None: Paper for noting

NES
January 2020
GH

Unconfirmed

Minutes of the fifth meeting of the Digital Sub-Committee held on Monday 13 December at the Bayes Centre, Edinburgh

Present:
Professor Andrew Morris (Chair), Vice Principal Data Science, University of Edinburgh (AM)
Professor Stewart Irvine, Acting Chief Executive, NES (SI)
Mrs Audrey McColl, Director of Finance and Acting Deputy Chief Executive, NES (AMcCo)
Dr Liz Elliot, Chief Operating Officer, NDS (LE)
Mr Geoff Huggins, Director, NDS (GH)
Mr Angus McCann, Non-Executive Board Member, NHS Lothian (AMcCa)
Mr Colin Brown, Head of Governance (Digital), NES (CB)
Ms Vicki Nairn, Non-Executive Member, NES (VN)

Present via Microsoft Teams
Mr Geoff Mulgan, Chief Executive, NESTA (GM)
Mr Douglas Hutchens, Non-Executive Member, NES (DH)
Dr Alistair Hann, Chief technology Officer, NDS (AH)

In attendance:
Miss Aisha Cameron, Executive Officer NES (AC)
Dr Sameer Patel, Clinical Lead NES (SP)
Dr Alistair Ewing, Product Manager NES (AE)

Apologies:
Mr David Garbutt, NES Board Chair (DG)
Mr Christopher Wroath, Director of Digital, NES (CW)

1. Welcome, introductions, apologies

The Chair welcomed everyone to the meeting and introductions were made. Apologies had been received from Mr David Garbutt, NES Board Chair (DG) and Mr Christopher Wroath, Director of Digital, NES (CW). The group congratulated Stewart Irvine on his appointment as acting Chief Executive. The group also noted that this meeting would be the final with Geoff Mulgan as a member and the Chair passed on sincere thanks for Geoff's time, energy and wisdom given to NDS.

2. Chair's update

The Chair commented, as follows:

- Caroline Lamb has now begun her secondment from NES to a role in Scottish Government as Director of Digital Reform and Service Engagement. The chair advised that write to her on behalf of the DSC to congratulate her on her new role.
- April 2020 will be the second anniversary of Digital Strategy and we should expect an increased focus on what has been achieved. Over the last 18

months the focus and endeavour of NDS has been productive.
- The quality of papers produced for the DSC over this time period has improved significantly and that was noted with thanks.

3. Review of minutes and actions from the meeting held on 30th September

i. Minutes (NES/DSC/19/17)

The meeting confirmed that they were content with the minute of the last full meeting of the DSC on 30th September 2019.

All matters arising from the minutes will be covered in later agenda items for this meeting or were addressed by informational papers circulated ahead of this DSC.

ii. Actions (NES/DSC/19/18)

The action list from the previous meeting was reviewed and it was noted that all items were in hand or already addressed.

iii. DSC Full Action Record (NES/DSC/19/18)

The full action list for all previous DSC meetings was shared, this paper supported an illustration of progress, identified a very small number of uncompleted actions (relating to DSC Terms of Reference which is covered later this meeting, and a finance action with SG) and provided a base point for triage as we move in 2020 to a new format DSC. It was agreed that LE and GH should meet with the incoming Standing Committee Chair to triage actions for the new committee and to use to aid the discussion at a transition meeting into the new Standing Committee format.

ACTION - DG

4. Items for Information (NES/DSC/19/21)

i. Finance Update

The purpose of this paper is to update the DSC on the three elements of NDS; finance, risk, and staffing.

Staffing

- In terms of staffing, the core message is that progress has been made and active recruitment remains underway.
- The target NDS team size for 2019/20 was 56, however it was noted at the last meeting on the 30th September that this figure would not be achieved by the end of the current financial year.
- NDS advised that a review of staffing will take place in January 2020. The review will look at the implications of posts that are slower to recruit, how delays in 19/20 impact on the shape of the planned 20/21 team, as well as an

assessment of fitness against increasing deliverables.

Finance

- Recruitment challenges have contributed to an NDS underspend against indicative budget in 2019/20
- A meeting was held on the 2nd December with Scottish Government, who were content with the financial forecasts for 2019/20 and 2020/21. The December allocation letter is anticipated to include the full allocation amount.
- The process of an internal audit of NDS was initiated in November 2019. No written report is currently available but will be shared by LE with the DSC once received.

ACTION - LE

Risk

- NDS use the NES risk management processes as other directorates within the organisation.
- Updates are due to the Directorate risk register by January 3rd, 2020 – these have been completed but timing means could not be circulated as a paper at this meeting. A full risk update will be provided for the next DSC to include specific reference to over-commissioning of NDS by disparate SG groups.
- The priority of risks around recruitment and IG were noted as remaining key to success of NDS, this is reflected in their risk status

ACTION LE

A discussion was had around the following points ;

- Clarification was sought in relation to the causative factors for the recruitment delays and whether this was due to recruitment process timelines, or delays in finding the right people. GH explained that a common issue was where the recruitment involved the introduction of a new type of post there was a process required to establish the post prior to advertisement. Once a post type has been recruited to previously it is then relatively straightforward to advertise further in a manner consistent with the staffing plan. The recruitment planned in later part of 19/20 included a number of unfamiliar NDS posts which have taken longer to take through the process than expected.
- GH further noted that the quality of people we have been able to appoint is outstanding – Matthew Hill's work has helped.
- The growing level of demand for work means that the pace of recruitment in 20/21 will need to be greater than in 19/20.
- All roles are advertised with flexible base locations and as such, location has not been a barrier to recruitment.

ii. Deliverable: Status Updates and Summaries (NES/DSC/19/22)

This paper provides summary information for the slide set that covers NDS activity and progress across its workstreams. The format has been updated, following feedback from the last meeting on the 30th September to include a narrative of the work that NDS is doing as part of wider system change; delivering and co-ordinating change in an ecosystem context as well as deliverable-specific status updates.

A useful discussion was had, and the main points were noted;

- There is an opportunity to further enhance the utility of this summary information by including a short textual summary of status, for example to highlight any deliverables encountering delays, or to flag up those progressing well. The aim would be to facilitate members in seeing a portfolio overview as well as understanding deliverables at risk and being able to drill down into specifics as required. This document could also inform DSC agenda setting, LE and CB will consider this further.
- GM recommended consideration of three specific strands;
    - A short narrative to explain which work is on track and which is not
    - Clearer ranking of key projects ('what really matters')
    - And, as NDS product portfolio matures, how products and services are being experienced by the external user communities
- The group noted that was we move in to 20/21 the deliverable reporting is exactly aligned the information in the status updates with the operational plan and so this will include progress reporting and expenditure tracking within defined tolerances.
- The importance clear descriptions for lay folk paired with members of the committee being suitably assured that technical aspects of the work that NDS are doing are being looked at by the right people.
- A suggestion was made that the new chair consider the composition of the newly formed Digital Committee, in terms of technologists.

ACTION - CB &LE

ACTION - CB &DG

5. Items for Substantive Discussion

i. Respect (NES/DSC/19/23)

Dr Alistair Ewing, NES gave a presentation on the current status the ReSPECT application, the first product to be developed through the national digital platform. Copies of the slides are available with the minute.

From discussion, the following main points were generated;

- The Digital subcommittee might be able to assist with progressing / sharing info with Scottish Ambulance service (for example, with reference to KIS).

- There was discussion around adopting a ‘Once for Scotland’ approach – this was considered ass something the Portfolio Board would wish to look at.
- AE gave an introduction to the thinking on measuring the impact on the end person / citizen who's following their ReSPECT process - and how ReSPECT impacted their quality of life - this is the point of the NDP.
- ReSPECT helps people at different points in time - from when they first discover they need it, to when they have the conversation, to when the information is used 'in anger' by, for example, the Ambulance Service to help decide what's right for the person during their emergency.
- The product team are working on defining what's useful to measure at each stage, and how they might use this information to make better decisions for the next product that is built.

ii. Clinical Ophthalmology (NES/DSC/19/24)

SP gave a summary and background on the proposed work to align the Scottish Government National Ophthalmology workstream with the National Digital Platform.

Discussion generated the following main points:

- Need to think more broadly about what it means for the service in times of measurables (for example, released time for consultants) and realisable benefits more broadly.
- OpenEyes is an open source ophthalmology EPR, is designed by Ophthalmologists and is the most widely accepted product.
- It was agreed that this has the potential to be a great project, but it is important not to underestimate the risk nor the scale of required work.

iii. Genomics (NES/DSC/19/25)

An initial meeting facilitated by CSO in December 2018 first introduced the work of the NES Digital Service to National Services Division (NSD) at NSS. NSD commission the national clinical genetics laboratory service on behalf of NHS Scotland and exploratory work was been successfully completed to evaluate opportunities for the NES Digital Service (NDS) to host a shared data repository on behalf of the 4 national clinical genetics laboratories in Scotland.

The key points were noted:

- There has been lots of enthusiasm from the four labs across Scotland- the possibility of a shared, secure national data repository is warmly welcome by NSD and the laboratories.
- Labs vary in nature of their service provision and have never provisioned genetics data for research use; the potential for a research aspect to this work is noted by all parties.

- Dr Honghan Wu has recently joined NDS to work on this project, he will also retain a part-time personal fellowship at the University of Edinburgh and brings required technical expertise.
- That the prioritisation of the genomics project is not uniformly understood external to NES and so clarity about NDS product portfolio remains important.

iv. Partnership Working (NES/DSC/19/26)

LE gave an overview of the partnership strategy and current status that underpins the collective delivery of the National Digital Platform. The paper was warmly welcomed by the DSC as a clear status update and members invited comments on how they can help develop partnerships.

DH and GH will have an offline discussion around engagement with Social Security Scotland.

ACTION – GH & DH

v. Research (NES/DSC/19/27)

Supporting data driven research in Scotland and making appropriate use of information are is one of the key objectives of the National Digital Platform. The intention of the paper was to begin discussion of this longer-term aim.

Main point discussed were:

- That any action NDS or NES takes should be in complement to, not in competition with national initiatives.
- That in the context of the broader national research agenda SG may be optimally placed to convene. If Scotland is to be world leading in this area it needs three things;
    1. A good contract with the public
    2. Good data strategy
    3. Good governance and access structure.

- That the paper seeks to define, and arguably limit NDS role; NDS can address one point (2) of the above – contributing proactive work on a research data strategy for data assets that will ultimately be held on the National Digital Platform.
- ADM and SI will write to Caroline Lamb to ask the Scottish Government to take the convener role for this work

ACTION – ADM & SI

vi. Interim commission & Prioritisation

GH provided an update on the Interim Commission and Prioritisation. The main points discussed were:

- There has been no response from Scottish Government on the Interim Commission and a response is not expected before Christmas.
- One of the highest priorities is to have a process of prioritising. It is almost two years on from the Digital Health and Care strategy and this is crucial.
- The role of the DSC in protecting NDS from taking on too many things was stressed.

vii. Governance

CB gave an update on Governance. The main points were:

- Since the committee last met there have been changes at Scottish Government. Overall, there is a significant increase in leadership capability in digital health.
- The November 2019 Portfolio Board meeting was cancelled. The next meeting will likely be held at the end of January / early February. It is probable that the Portfolio Board will have refreshed membership; Caroline Lamb expected to provide clarity on a 'Once for Scotland ' approach at national level.
- Caroline Lamb intimated intention for expert panel to provide oversight/comment on the enaction of the 2017 Digital Health & Care Strategy
- NES board have confirmed the remit and Terms of reference for new 'Digital Standing Committee'.
- The NES Board will need another paper to confirm new Digital Standing Committee membership

6. Any other business

SI thanked AM on behalf of NES for chairing the DSC and GM for his time on the sub-committee.

AM thanked LE, GH and the NDS team for providing high quality papers for DSC meetings.

7. Date and time of next meeting

The next meeting is scheduled for the 2nd March 2020, 1pm – 4pm. This meeting will be the first meeting of the newly formed Digital Standing Committee.

NES
January 2020
AC/LE/AM/GH

NHS Education for Scotland

Board Paper Summary: Audit Committee Minutes

1. Title of Paper

Draft minutes of Audit Committee meeting held on 16 January 2020: copy attached.

2. Author(s) of Paper

Jenn Allison, Senior Officer (Planning & Corporate Governance)

3. Purpose of Paper

To receive the minutes of the Audit Committee meeting held on 16 January 2020.

4. Items for Noting

a) Item 8 – Internal Audit Reports

i) 8a- Status Update and Follow Up Summary
The Committee noted and were satisfied with progress of internal audit recommendations, the planned Audits for the remainder of financial year 2019/20 and the draft plan for 2020/21.

ii) 8b- Review of the NES Digital Service (Early Stage Review)
The Committee noted and were satisfied with the report which provided a review of the early stage development of the NES Digital Service (NDS).

iii) 8c- Review of Core Financial Control Framework
The Committee noted and were satisfied with the report which provided a reviewed NES's Core Financial Control Framework using KPMG's Financial Control Framework Assessment Tool.

iv) 8d- Talent Management Framework update
The Committee noted and were satisfied with the report which provided an update to the progress of Internal Audit Recommendations in relation to the Talent Management Framework audit.

b) Item 9 – External Audit Reports

i) 9a- External Audit Plan 2019/20
The Committee noted the materiality has remained at 2% of gross expenditure and were satisfied with the draft external audit plan.

v) 9b- External Audit Fee
The Audit Committee noted and were satisfied with the fees set by Audit Scotland.

c) Item 10 – Counter Fraud

i) Counter Fraud Update
The Committee noted the report and were satisfied with the and progress of actions.

ii) Self-Assessment tool review
The Committee reviewed the updated Self-Assessment tool and agreed to submit the actions proposed to Counter Fraud Services.

d) Item 11 – Annual Review of Audit Committee Effectiveness

The Committee reviewed each section of the self-assessment checklist and agreed rating and actions.

e) Item 12 – Assurance Framework Update

The Committee noted Assurance Framework Action Plan and approved the Assurance Framework for submission to the March Board, following agreed amendments.

f) Item 13 – Standing Financial Instructions (SFI) Review

The Committee noted the report and agreed that the proposed changes should be submitted to the Board for approval and agreed that a further review of SFIs should be added to the Audit Pan for 2019/20. See appendix 1.

g) Item 14 – Audit Scotland Report

The Committee noted the following reports: Preparing for withdrawal from the EU; NHS in Scotland 2019; Scotland's new Financial Powers: Operation of the Fiscal Framework 2018/19.

h) Private meeting between Auditors and Audit Committee Members

A private meeting was held between the Auditors and the non-executive Audit Committee members.

5. Recommendations

Board members are asked to note the Audit Committee minutes and to review the Standing Financial Instructions for approval.

NES
January 2020,
JA

IN CONFIDENCE **NES/AUD/20/08**

AUDIT COMMITTEE

Minutes of the seventy-second Audit Committee held on Thursday 16 January 2020 at Westport 102, Edinburgh, Room 5.

Present: Doreen Steele (Chair)
Linda Dunion
Sandra Walker
Anne Currie

In attendance: Stewart Irvine, Acting Chief Executive
David Garbutt, NES Chair
Audrey McColl, Director of Finance (via phone)
Janice Sinclair, Head of Finance
James Lucas, KPMG
Paul McGinty, KPMG
Claire Connor, KPMG
Joanne Brown, Grant Thornton
Rob Coward, Principle Educator
Jenn Allison, Senior Officer
Chris Duffy, Senior Officer

1. Welcome and introductions

The Chair welcomed everyone to the meeting, particularly Rob Coward who was in attendance regarding item 12 Assurance Framework and Chris Duffy who has recently joined the Planning and Corporate Governance team as Senior Officer and will be providing administrative support to other NES Committees. Audrey McColl was welcomed to the meeting via tele-conference.

2. Apologies for absence

There were no apologies received.

3. Declarations of interest

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

4. Any other business

There was no other business raised for discussion.

5. Minutes of the Audit Committee, 03 October 2019 (NES/AUD/19/42)

The minutes of the Audit Committee were approved as a correct record, subject to minor agreed amendment.

6. Action list of the Audit Committee, 03 October 2019 (NES/AUD/19/43)

Members noted that the actions were completed or in hand and the following was noted:

- The Committee noted the request raised by the Educational and Research Governance Committee (ERGC) on the 09th October to review NES's most significant risks to ensure they are being managed and reported to the appropriate committees. The ERGC had raised this request due to some concerns that no relevant Primary 1 risks have been reported to the ERGC. Audrey McColl informed the committee that NES's internal auditors will be working with NES colleagues to conduct a risk maturity assessment process. One of the areas this will cover is the consistency of risk recognition and scoring across NES. The Audit Committee will be updated on progress and outcomes of this review.

- A member raised a query regarding progress of the agreed amendments to the NES Business Continuity Plan (BCP) to include information on engagement with Board members. Audrey McColl noted she will follow up with Christopher Wroath regarding this for the April NES Audit Committee.

Action: AMcC

7. Matters arising

There were no matters arising from the minutes.

8. Internal Audit Reports

a) Status Update and Follow up Summary

Paul McGinty introduced the report which provided the Audit Committee with an update on progress against the plan and assurance that during Q3 2019/20 internal audit recommendations have been implemented satisfactorily or are in progress.

- The report highlighted that Internal Audit are on track with the number of completed, in progress and planned Audits according to the 2019/20 internal audit plan. The completion date of the review of IT Security and Resilience Arrangements has been deferred to April as more fieldwork is required for completion. There are three further audit reports due at the next Audit Committee in April regarding Corporate Governance, Property Transaction Monitoring and New Strategy Implementation / Business Change.

- 10 actions have been confirmed as closed during the third quarter of 2019/20 resulting in 5 open outstanding actions, 3 of which are not yet due, and 2 which are overdue.

- A member noted that 2 of the outstanding actions are from 17/18 and one outstanding action is from 16/17 and asked when it is expected they will be closed as complete. Janice Sinclair informed the committee that the recommendation from 16/17 regarding the Once for Scotland GP trainee policy as part of the Lead Employer model is in collaboration with other stakeholders therefore out of NES's complete control. Audrey McColl noted that the recommendation regarding the BCP is expected to be closed soon, once staff engagement is complete. Audrey will update the Audit Committee of progress via email. **Action: AMcC**

- The Committee noted that an update paper has been submitted under item 08d with an update to progress of the recommendations relating to Talent Management Framework.

- There are 11 new actions from the below reports, which will be added to the follow up summary report submitted to the Audit Committee in April 2020.

- The Committee noted the proposed Internal Audit coverage for 2020/21 which has been based on the approved three-year Internal Audit strategy. Indicative audits include Pharmacy, Allied Healthcare Professional, HR, Educational Governance and Communications and Stakeholder Management, Risk Management, Business Change and IT Security.

- Paul assured the Committee that there is scope to realign the plan as directed by the Audit Committee and a refined draft plan will be submitted to the April Audit Committee. Paul suggested that a further review of progress of NDS is conducted toward the end of financial year 20/21.

- A member queried if general horizon scanning into the wider sector would be included in the Audit plan and Paul McGinty advised that general horizon scanning would be considered as part of the risk maturity assessment.

The Committee noted the report and were satisfied that NES continues to make good progress in implementing outstanding audit recommendations and noted the planned Audits for the remainder of financial year 2019/20 and the draft plan for 2020/21.

b) Review of the NES Digital Service (Early Stage Review)

Paul McGinty introduced the report which reviewed the early stage development of the NES Digital Service (NDS). The objective of the audit was to undertake an initial high-level assessment of the setup, establishment and governance of NDS with the principle focus upon governance and management oversight arrangements as well

as consideration of the establishment of financial, operational and risk management arrangements.

- The report found that NDS has been established and incorporated into NES' financial, operational and governance arrangements in a structured manner and the revised governance arrangements of changing the Digital Sub Committee to the Digital Standing Committee will help to provide a clearer line of governance at NES Board level in line with Board standing orders.

- The report identified 1 high risk and 2 moderate risk improvement recommendations: produce a service level agreement document between NES and Scottish Government (high); seek confirmation from Scottish Government regarding funding allocations for NDS activity (medium); ensure membership of the new Digital Standing Committee is fully established and members attend regularly (medium).

- A member raised concerns regarding the uncertainty of funding arrangements and the potential impact this could have to core services. Audrey McColl informed the Committee that there are three separate funding elements, two of which have been received in the December 2019 allocation. It has been agreed that the third would be funded by NES on a non-recurrent basis in 2019/20. It is expected that the amount of funding available going forward will be less than the amount originally anticipated.

- Audrey McColl added that Scottish Government have asked NES to produce scenarios regarding what can be delivered and what the expected benefits are. NES has asked that the Scottish Government provide 3-4 key priority areas for them to guide the scenario planning. A meeting has been scheduled for 20th January between NES and Scottish Government to further discuss.

- A member noted that there is a reputational risk to NES if expectations are not met and added that communication to NHSS needs to be clear regarding what NDS will deliver.

The Audit Committee noted the report and the assurance provided and agreed that it would be worthwhile for the Internal Auditors to include a further audit regarding progress of NDS as the appropriate time. **Action: PMcG**

c) Review of Core Financial Control Framework

Paul McGinty introduced the report which reviewed NES's Core Financial Control Framework using KPMG's Financial Control Framework Assessment Tool. The tool is used to outline the key baseline financial controls expected to be in place across all of NES's core finance process areas.

- The report found that NES has a high proportion (130 out of 153 / 86%) of the key baseline financial controls which KPMG would expect to be in place with a further 10 controls partly in place and 11 controls which are not in place.

- A member queried how this result compares to other organisations and Paul McGinty confirmed that the financial controls in place in NES are good compared to other organisations.

- The report identified 2 moderate risk and 6 low risk improvement recommendations regarding: revising processes and conducting reviews of supplier changes; increasing regularity of reviews of access rights, Standing Financial Instructions and system access privileges; conducting further spot checks on expense claims from DDiT and payroll reconciliation checks; and increasing complexity of system passwords.

- Paul McGinty noted that the audit focussed on the policies and procedures in place and advised operations will be reviewed in more detail in subsequent years.

- A member raised a query regarding the recommendation to establish a more structured review of changes made to details in the supplier Masterfile, with a concern that this may increase workload of NES colleagues for something that is already in place. Janice Sinclair assured the Committee that the further review of the Supplier Masterfile recommended will not take up much more time and will strengthen an already robust process.

- A member raised concern about the number of vacancies in finance and asked what action was being taken. Janice Sinclair advised the Committee that 2 vacant posts in the Finance directorate have been filled and a further 2 are going through the recruitment process, this includes the approval of a new temporary 8a post to assist with workload during the annual accounts period and during the interim arrangements of the Director of Finance acting as depute to the Chief Executive. Part of the difficulty recruiting is the vibrant finance sector in Edinburgh, however, innovative ways of attracting candidates such as flexible working arrangements are considered as a mitigating action against this risk.

The Audit Committee noted the report and the assurance provided.

d) Talent Management Framework update (NES/AC/20/02)

Audrey McColl introduced the report, which provided the Committee with an update to the progress of Internal Audit Recommendations in relation to the Talent Management Framework audit, as requested by Audit Committee members during

the meeting on 03rd October 2019. The audit was conducted by Scott-Moncrief and the report was submitted to the Audit Committee on 14 June 2018.

- The audit report recommended that NES develop succession plans and complete medium- and long-term workforce planning so that NES will develop a knowledge and skills base that will be ready to meet future service demands.

- The Committee noted that recommendations remain open due to pressures and changes in staff, as well as interdependencies with Scottish Government reporting requirements and ongoing NES and NHSScotland Talent Management initiatives, (Project Lift and NHSS Talent Management Board). The Committee also noted that progress of the work relating to the recommendations is reported to the Staff Governance Committee (SGC).

- NES has met Scottish Government requirements to publish an annual Workforce Plan, however this has not been developed with a medium to long term focus. The Scottish Government have however recently advised of a change in practice and they now require Boards to publish a 3-year workforce plan by April 2021.

- Discussion have been held with the Senior Leadership Management Team (SLMT) and the Executive Team (ET) in November and December 2019, respectively. The following actions were agreed: engage with managers across NES regarding the development of the three-year NES Workforce Plan to be published April 2020; and produce a diagrammatic representation of a proposed pathway, linking all the various strands of talent management, succession planning, career development and workforce planning together.

- Five posts and succession plans have been put in place, however the ET have agreed to develop a pathway which includes succession planning as one of the components to be embedded in enhanced workforce planning processes.

- The ET and the SGC have been monitoring corporate targets for appraisal/objective setting and essential learning. Further discussions are due to take place with the ET and the SGC regarding the value of the qualitative assurance data and to agree a way forward to report on aggregated outcomes.

- After considerable discussion as to the way forward including assessing critical business requirements and a long-term HR Strategy the Committee thanked Workforce colleagues for the comprehensive report and recognised that there is a large workload in relation to the recommendations and their connected ongoing work in NES and NHSS regarding workforce planning, succession planning and talent management.

The Audit Committee noted the report and the assurance provided and noted that progress will be monitored by the Staff Governance Committee. Members requested

that a session regarding talent management is arranged for a future Board development session. **Action: JA**

9. External Audit Reports

a) External Audit Plan 2019/20

Joanne Brown introduced the External Audit Plan for financial year ending 31st March 2020.

- Materiality has been calculated at £10.34m (2% of gross expenditure based on 2019/20 budget), with performance materiality set at 75% of overall materiality. This has remained at the level previously adopted and is based on auditors' experience of auditing NES over the previous three years.
- Members noted the identified risks in relation to management override of controls and the risk of fraud in expenditure and Joanne Brown gave members assurance that appropriate mechanisms are in place in NES regarding monitoring the risk of fraud.

- Members noted the detailed Audit timeline highlighting submission dates for Draft and Final Audit Plan, Quarterly Fraud Returns, Annual External Audit Report and Assurance Statement. Joanne Brown noted members previous query regarding horizon scanning and will bring this into future reporting. **Action: JB**

- Members noted that Finance colleagues will arrange for 2019/20 Annual Accounts briefings and members will be informed of dates as soon as possible. **Action: JS**

The Audit Committee noted and were satisfied with the draft external audit plan for financial year 2019/20.

b) External Audit Fee for 2020/21

Joanne Brown informed the committee that the External Audit Fee for 2020/21 has been set at the base level available as recommended by Audit Scotland. There has been a slight inflationary increase, however no further increase from 2019/20.

The Committee noted the External Audit Fee for 2020/21.

10. Counter Fraud Update

a) Counter Fraud Update (NES/AUD/19/03)

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 up to September 2019.

- There were no new referrals to CFS from NES in Q2 and the review of the Gifts and Hospitality Registers has revealed no new declarations.

- The National Funding Initiative (NFI) review process for 2018/19 within NES is almost complete, with 5 data matches out of 803 remaining under review.

- The CFS conference in November 2019 provided some useful insights into the factors which influence behaviours and steps to protect organisations from threats. The conference also launched an Organised Crime impact assessment tool which is aimed at spending over £50k. Finance colleagues are looking into how this can be adopted in NES. It has been agreed that a CFS Board Development Session will be arranged. **Action: JS**

The Committee noted the report and progress of actions.

b) Self-Assessment tool review (NES/AUD/20/04)

Janice Sinclair introduced the Self-Assessment tool, which has been developed by Counter Fraud Services (CFS) to assist organisations to undertake a high-level assessment of their readiness to the risks posed by financial crime and to develop a time-bound improvement plan to increase resilience to fraud.

The Audit Committee reviewed the updated Self-Assessment tool and agreed to submit the actions proposed to Counter Fraud Services, following agreed changes. **Action: JS**

11. Annual Review of Audit Committee Effectiveness (NES/AUD/20/05)

Janice Sinclair led the annual review of Audit Committee Effectiveness.

The Committee reviewed each section of the self-assessment checklist and reviewed the proposed ratings, comments and actions. Further information regarding risk and the NES Assurance Framework, new Audit eLearning module, Internal Auditor KPI's and meetings with the Accountable Officer were added. The updated assessment will be presented to the Audit Committee in April.

Action: AMcC

12. Assurance Framework Update (NES/AUD/20/06)

Rob Coward introduced the paper which presented the proposed changes to the NES Assurance Framework, following suggested amendments provided by the Board in June 2019.

- NES has developed an Assurance Framework, setting out the sources of assurance against each of the information systems required by the Scottish Government's Blueprint for Good Governance.

- A full discussion of additional sources of assurance took place and several sources were added to the sections.

- A member suggested that wording regarding reviewing issues for quality improvement opportunities also makes reference to gathering examples of good practice. Members asked that information is added regarding Equality and Diversity and Directorate Performance reporting. A member also suggested adding a link to Committee Remits for information.

- The Committee agreed that the Assurance Framework should be added as a standing item to the Audit Committee. **Action: JA**

The Committee noted Assurance Framework Action Plan and approved the Assurance Framework for submission to the Board, following agreed amendments. **Action: JS**

13. Standing Financial Instructions (SFI) Review (NES/AUD/20/07)

Janice Sinclair introduced the paper which presented proposed changes to the SFI's for Audit Committee approval as part of their regular review cycle.

- The most recent amendments took place in January 2019 and focussed on changes in responsibility for tasks or changes in Business' Processes. This approach has been taken again as NES are waiting for templates for Standing Instructions and schemes of delegation from the Corporate Governance Steering Group (CGSG).

- The Committee noted the minor amendments made to the Standing Financial Instructions and discussions took place regarding producing a more interactive document however it was agreed that an interactive version of the NES SFIs can be produced once the template guidance documentation has been issued from the CGSG.

The Committee noted the report and agreed that the proposed changes should be submitted to the Board for approval and agreed that a further review of SFIs should be added to the Audit Pan for 2019/20. **Action: AMcC/JS**

14. Items for information

The following Audit Scotland Reports were noted by the Committee:

a) Preparing for withdrawal from the EU
b) NHS in Scotland 2019
c) Scotland's new Financial Powers: Operation of the Fiscal Framework 2018/19

15. Private meeting between Auditors and Audit Committee Members

A private meeting was held between the Auditors and the non-executive Audit Committee members.

16. Date and time of next meeting

The next meeting of the Audit Committee will be held on Thursday 09th April at 10:15am in Westport Room 6.

NES
Jan 2020
JA

Appendix 1

Board Paper Summary

1. Title of Paper

Standing Financial Instructions (SFI's)

2. Author(s) of Paper

Audrey McColl, Director of Finance
Janice Sinclair, Head of Finance

3. Purpose of Paper

To inform the Board of the changes to the Standing Financial Instructions (SFI's) , which were approved by the Audit Committee on Thursday 16th January.

4. Key Issues

The SFIs are subject to regular review and require agreement from the Audit Committee before being presented to the Board for approval.
The last time Significant changes were made to the SFI's was in late in 2016 which reflected the combined impact on the internal control environment from the introduction of a policy of 'No purchase order no payment' and the creation of a centrally managed single procurement team for NES.

The most recent update took place in January 2019 and focussed on changes in responsibility for tasks or changes in Business' Processes. There were also some minor amendments to correct factual inaccuracies. That approach was adopted then as we were awaiting the outputs from the Corporate Governance Steering Group (CGSG). The Group is expected to develop templates for Standing Instructions and schemes of delegation so that Boards are provided with a single point of reference as to what should specifically be included in SFIs.

We have adopted the same approach again this year as these templates have not yet been issued but are still anticipated.

4.1. Amendments to document

The number of changes this year are minimal and are highlighted in yellow on the attached document. They include following:

4.1.1. Renaming of the Audit Committee to Public Audit and Post-legislative Scrutiny Committee

4.1.2. Reinforcing the requirement not to put the Annual Accounts and Report into the public domain until after the accounts have been laid before the Scottish Parliament

4.1.3. Identifying the controls in place for the Payment on Behalf process between Boards which replaces the need for Purchase Orders and invoices to be raised

4.1.4. Updating the OJEU limit from £118k to £123k within the Procurement Thresholds table

4.1.5. Updating the SFIs to reflect the current processes for registering Gifts, Hospitality and Interests

4.1.6. Clarifying within the role of Internal Audit that they shall issue reports to the Director of Finance, and do not report to the Director of Finance

4.2. Outstanding Items

The records retention schedule included in the SFI's has not been updated as the revised SG Code of Practice for Records Management is currently out for consultation. Once the revised code is published, we will update the retention schedule accordingly.

5. Educational Implications

6. Financial Implications

It is essential that all financial activities are carried out within a strong internal control environment.

7. Which of the 5 Key Areas of Focus in the NES Strategy for 2019-24 does this align to?

Focus area 5 – A high performing organisation which aims for excellence in Governance.

8. Impact on the Quality Ambitions

9. Key Risks and Proposals to Mitigate the Risks

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.

N/A for this report.

11. Health Inequalities

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

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]

13. Recommendation(s) for Decision

The Board are asked to approve that the proposed changes. The Board is also asked to note that a further review is likely to be required during 2020/21.

NES
AMcC/JS
Jan 2020

STANDING FINANCIAL INSTRUCTIONS

JANUARY 2020

Approved by the Board: xxx 2020

APPENDIX 2A – RECORDS RETENTION SCHEDULE

APPENDIX 2B – GENERIC RECORDS RETENTION SCHEDULE

1. INTRODUCTION

1.1 Background

These Standing Financial Instructions are issued in accordance with the financial directions issued by the Scottish Government Health and Social Care Directorate under the provisions contained in the Regulation 4 of the NHS (Financial Provisions) (Scotland) Regulations, 1974 together with the subsequent guidance and requirements contained in NHS Circular No. 1974 (GEN) 88 and Annex, and NHS Circular MEL (1994) 80. Their purpose is to provide a sound basis for the control of NHS EDUCATION FOR SCOTLAND's (NES) financial affairs and shall have the effect as if incorporated in the Standing Orders of NHS EDUCATION FOR SCOTLAND (NES).

1.2 The purpose of such a scheme of control is:

- To ensure that NES acts within the law and that financial transactions are in accordance with the appropriate authority;
- To ensure that proper accounting records, which are accurate and complete, are maintained;
- To ensure that financial statements, which give a true and fair view of the financial position of NES and its expenditure and income, are prepared timeously;
- To protect NES against the risk of fraud and irregularity;
- To safeguard NES assets;
- To ensure that proper standards of financial conduct are maintained;
- To enable the provision of appropriate management information;
- To ensure that NES seeks best value from its resources, by making proper arrangements to pursue continuous improvement, having regard to economy, efficiency and effectiveness in NES's operations;
- To ensure that any delegation of responsibility is accompanied by clear lines of control and accountability, together with reporting arrangements.
- To ensure transparency and accountability in all procurement and contracting activities.

COMPLIANCE

1.3 All Board Members, officials, staff and agents of NES shall observe these Standing Financial Instructions. The Chief Executive, Directors and Members of the Executive Team shall be responsible for ensuring that staff and others within the organisation are aware of, and adhere to, the Standing Financial Instructions.

1.4 Failure to comply with these Standing Financial Instructions shall be regarded as a disciplinary matter.

1.5 Where these Standing Financial Instructions place a duty upon a person, this may be delegated to another person, subject to the Scheme of Delegation contained within the Standing orders of NES.

1.6 All references in these instructions to the masculine gender shall be read as equally applicable to the feminine gender.

1.7 Nothing in these Standing Financial Instructions shall be held to override any legal requirement or Ministerial Direction placed upon NES, its members or officers.

2. RESPONSIBILITIES OF THE CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 Under the terms of Section 14 and 15 of the Public Finance and Accountability (Scotland) Act 2000, the Principal Accountable Officer (PAO) for the Scottish Government has designated the Chief Executive of NES as its Accountable Officer.

2.2 Accountable Officers must comply with the terms of the Guidance to Accountable Officers and any updates issued to them from time to time by the Scottish Government Health and Social Care Directorate.

2.3 GENERAL RESPONSIBILITIES

2.3.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finances for NES.
The Accountable Officer must ensure that the NES Board, the Executive Team, and all other relevant decision making bodies as may be constituted from time to time, have drawn to their attention and take account of all relevant financial considerations, including any issues of propriety, regularity or value for money, in considering policy proposals relating to expenditure or income.

2.3.2 The Accountable Officer has a personal duty of signing the Annual Accounts of NES for which they have responsibility. Consequently, they may also have the further duty of being a witness before the Public Audit and Post-legislative Scrutiny Committee of the Scottish Parliament and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.

2.3.3 The Accountable Officer must also ensure that any arrangements for delegation promote good management, and that they are supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of special skills and services.

2.4 SPECIFIC RESPONSIBILITIES

The Accountable Officer must:

2.4.1 Ensure that proper financial systems are in place and applied, and that procedures and controls are reviewed annually to ensure their continuing relevance and reliability, especially at times of major changes;

2.4.2 Sign the Accounts assigned to them, and in doing so accept personal responsibility for ensuring that they are prepared under the principles and in the format directed by Scottish Ministers.

2.4.3 Ensure that proper financial procedures are followed incorporating the principles of separation of duties and internal checks and that accounting records are maintained in a form suited to the requirements of the relevant Accounting Manual, as well as in the form prescribed for published accounts;

2.4.4 Ensure that the public funds for which they are responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;

2.4.5 Ensure that the assets for which they are responsible, including land, buildings, fixtures, fittings, equipment and other assets are properly managed and safeguarded.

2.4.6 Ensure that, in consideration of policy proposals relating to expenditure, or income, for which they have responsibilities as Accountable Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account.

2.4.7 Ensure that any delegation of authority is accompanied by clear lines of control and accountability, together with reporting arrangements.

2.4.8 Ensure that effective management systems appropriate for the achievement of the organisation’s objectives, including financial monitoring and control; systems have been put in place;

2.4.9 Ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them;

2.4.10 Ensure that best value from resources is sought, by making proper arrangements to pursue continuous improvement having regard to economy, efficiency and effectiveness, and in a manner which encourages the observance of equal opportunities requirements;

2.4.11 Ensure that managers at all levels have a clear view of their objectives, and the means to assess and measure outputs or performance in relation to those objectives;

2.4.12 Ensure that managers at all levels are assigned well-defined responsibilities for making the best use of resources including a critical scrutiny of output and value for money;

2.4.13 Ensure that managers at all levels have the information, training and access to the expert advice which they need to exercise their responsibilities effectively.

2.4.14 Make judgements and estimates on a reasonable basis and prepare the accounts on a going concern basis.

2.5 REGULARITY AND PROPRIETY OF EXPENDITURE

2.5.1 The Accountable Officer has a particular responsibility for ensuring compliance with parliamentary requirements in the control of expenditure. A fundamental requirement is that funds should be applied only to the extent and for the purposes authorised by Parliament in Budget Acts (or otherwise authorised by section 65 of the Scotland Act 1998). Parliament's attention must be drawn to losses or special payments by appropriate notation of the organisation's accounts. In the case of expenditure approved under the Budget Act, any payments must be within the scope and amount specified in that act.

2.5.2 All actions must be able to stand the test of parliamentary scrutiny, public judgement on propriety and professional codes of conduct. Care must be taken to avoid actual, potential, or perceived conflicts of interest when employing management consultants and their staff.

2.6 ADVICE TO THE NHS EDUCATION BOARD, AND OTHER DECISION-MAKING BODIES

2.6.1 The Accountable Officer has a duty to ensure that appropriate advice is tendered to the Board, the Executive team and other decision-making bodies~~/~~ on all matters of financial propriety and regularity, and more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness

2.6.2 If the Accountable Officer considers that, despite his/her advice to the contrary, the Board or other decision making body is contemplating a course of action which he/she considers would infringe the requirements of regularity or propriety, and that, as a result, he/she would be required to take action that is inconsistent with the proper performance of their duties as Accountable Officer, he/she should, inform the Scottish Government Health and Social Care Directorate's Accountable Officer, so that the Department, if it considers it appropriate, can intervene, and inform Scottish Ministers. If this is not possible, the Accountable Officer should set out in writing his/her objection to the proposal and the reasons for the objection. If his/her advice is overruled, and the Accountable Officer does not feel that he/she would be able to defend the proposal to the Audit Committee of the Scottish Parliament, as representing value for money, he/she should obtain written instructions from the Board and send a copy of his/her request for instruction and the instruction itself as soon as possible to the External auditor and the Auditor General for Scotland.

2.6.3 The Accountable Officer must also ensure that their responsibilities as Accountable Officer do not conflict with those as a Board member. They should vote against any action that they cannot endorse as Accountable Officer, and in the absence of a vote, ensure that their opposition as a Board member, as well as Accountable Officer is clearly recorded.

2.7 ABSENCE OF ACCOUNTABLE OFFICER

2.7.1 The Accountable Officer should ensure that they are generally available for consultation and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, a senior officer is identified to act on their behalf if required.

2.7.2 In the event that the Accountable Officer would be unable to discharge their responsibilities for a period of four weeks or more, NES will notify the Principal Accountable Officer of the Scottish

Government, in order that an Accountable Officer can be appointed pending their return.

2.7.3 Where an Accountable Officer is unable by reason of incapacity or absence to sign the Accounts in time for them to be submitted to the Auditor General, the Board may submit unsigned copies, pending the return of the Accountable Officer.

3. RESPONSIBILITIES OF THE BOARD

3.1 The Board has key functions for which it is held accountable by Scottish Government Health and Social Care Directorate on behalf of the Scottish Ministers:

- To set strategic direction of the organisation within the overall policies and priorities of the Government and NHSScotland, define its annual and longer-term objectives and agree plans to achieve them;
- To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- To ensure that there is effective dialogue within the organisation and between the organisation and key stakeholders on its plans and performance and that these are responsive to the stakeholders needs
- To ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; and
- To appoint, appraise and remunerate senior executives.

3.2 In fulfilling these functions, the Board should:

- Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully understand its responsibilities;
- Be clear what decisions and information are appropriate to the Board and draw up standing orders, a schedule of decisions reserved to the Board and standing financial instructions to reflect this;
- Establish performance and quality targets that maintain the effective use of resources and provide for money;
- Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior officers for the main

programmes of action and for performances against programmes to be monitored and senior officers held to account;

- Establish committees, including audit and remuneration committees, on the basis of formally agreed terms of reference which set the membership of the committees, the limit to their powers, and the arrangements for reporting back to the Board; and
- Act within the statutory, financial and other constraints.

4. RESPONSIBILITIES OF SENIOR MANAGERS AND ALL OFFICERS IN NES

4.1 The Chief Executive shall have delegated authority from the NES Board to secure the efficient operation and management of the full range of NES activities in accordance with the current policies of NES and within the limits of the resources available.

4.2 Directors of NES have collective responsibility to exercise financial supervision, control and monitoring by requiring the submission and approval of budgets within approved allocations, by defining and approving essential features of financial arrangements in respect of important procedures and financial systems, including the need to obtain value for money, and by defining specific responsibilities placed on officers.

4.3 All staff individually and collectively are responsible for the security of NES's property, for avoiding loss, for economy and efficiency in the use of resources, for identifying and managing risk, and for complying with the requirement of Standing Orders, Standing Financial Instructions and other financial procedures which the Director of Finance may issue.

4.4 It shall be the duty of the Chief Executive to ensure that arrangements are made for existing staff and all new employees to be notified of their responsibilities within these instructions.

4.5 The Chief Executive shall be responsible for the implementation of NES's financial policies and for ensuring whatever corrective action is necessary to further these policies after taking account of advice given by the Director of Finance on all such matters.

4.6 Without prejudice to the functions of any other officers of NES, the duties of the Director of Finance shall include the provision of financial information to NES and its officers; the design, implementation and

supervision of systems of financial control and the preparation and maintenance of such accounts, certificates, estimates, records and reports as NES may require for the purpose of carrying out its statutory duties and responsibilities.

4.7 The Director of Finance shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal control to supplement these instructions. The Director of Finance shall require any officer who carries out a financial function to ensure that the form in which the records are kept and the manner in which the officer discharges their duties shall be to the satisfaction of the Director of Finance.

4.8 Where a fundamental organisational change occurs the Director of Finance should initiate a review of the relevant Standing Financial Instructions to ensure that if any amendments are required these are implemented timeously. This review would then be subject to the approval of the Board.

4.9 Wherever the titles Chief Executive, Director of Finance or other nominated officer is used in these instructions, it shall be deemed to include such officers who have been duly authorised to represent them.

5. REVENUE RESOURCE LIMIT

5.1 NES, as a Special Health Board, is required by statutory provision made under Section 85 of the National Health Service (Scotland) Act 1978, as amended by the Health Services Act 1980, to perform its functions within the total of funds allocated by the Scottish Government Health and Social Care Directorate.

The financial measures which NES must operate within are the:

- Revenue Resource Limit (RRL)
- Capital Resource Limit (CRL)
- Cash Requirement

5.2 The Director of Finance shall ensure that all income and expenditure is identified correctly and accounted for in the relevant financial year.

5.3 The Director of Finance shall, on behalf of the Chief Executive, request an appropriate level of Capital resource from the Scottish Government Health and Social Care Directorate. This may be in the format of a funding transfer from Revenue to Capital.

5.4 The Director of Finance shall ensure that amounts drawn for NES against the agreed cash limit are required for approved expenditure only.

5.5 The Director of Finance will ensure that the cash balances held by NES are not excessive but are sufficient to meet immediate liabilities. The Director of Finance shall therefore ensure that due receipts are collected promptly and shall pay invoices in accordance with targets set by the Scottish Government Health and Social Care Directorate. Payments of due debts shall not be delayed artificially to a following financial year where the expenditure is properly attributable to the current year.

5.6 In submitting the final requisition for a fiscal year, the Director of Finance shall ensure that sufficient resources are available to meet financial commitments at the end of the year. The balances of accounts holding public funds will be maintained at the lowest practicable levels.

5.7 The Director of Finance will review the RRL/CRL and Cash positions regularly to ensure that NES remain on target to meet its financial objectives.

5.8 The Director of Finance shall provide monthly reports to the Scottish Government Health and Social Care Directorate in the form requested.

6. PLANNING AND BUDGETING

6.1 The Chief Executive shall carry out their duties within the total of funds allocated by Scottish Ministers and shall not exceed the budgetary limits set for NES. All plans and financial approvals and control systems shall be designed to meet this obligation.

6.2 The Chief Executive, with the assistance of the Director of Planning and Corporate Resources, shall compile and submit to NES Board and the Scottish Government Health and Social Care Directorate, an Annual Operating Plan in accordance with the guidance issued by the Scottish Government Health and Social Care Directorate.

6.3 Officers shall provide the Director of Finance with all financial, statistical and other relevant information as necessary for the compilation of such estimates and forecasts that the Director of Finance may need to fulfil the requirements of NES and the Scottish Government Health and Social Care Directorate.

6.4 The Director of Finance shall, on behalf of the Chief Executive, prepare and submit budgets (by Directorate and category, within the limits of available funds) to NES Board for its approval.

6.5 The Director of Finance shall provide periodic reports to the Chief Executive and NES Board, comparing actual expenditure and income with approved budgets. The Director of Finance shall report to NES Board any significant in year variance from the financial plan and shall advise the Board on action to be taken.

6.6 The Director of Finance shall also compile and submit to the Board such financial estimates and forecasts as may be required from time to time. As a consequence, the Director of Finance shall have a right of access to all budget holders on budgetary related matters.

6.7 The Director of Finance shall ensure that a system of budgetary control is maintained and that all officers whom NES may empower to engage staff or otherwise incur expenditure, collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, expenditure variances from budget.

6.8 The Chief Executive may delegate responsibility for budgets to officers to permit the performance of defined activities. The terms of delegation shall include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of service and the provision of regular reports upon the discharge of these delegated functions to the Chief Executive. The Director of Finance will be responsible for providing budgetary information and advice to the Chief Executive and budget holders to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

6.9 In carrying out their duties:

- the Chief Executive shall not exceed the budgetary or virement limits set by NES Board;
- officers designated as budget holders shall not exceed the budgetary or virement limits set for them by the Chief Executive;
- the Chief Executive may vary the budgetary limit of an officer within the Chief Executive's own budgetary limit.

6.10 Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by delegated powers of virement, see Section 19.

6.11 Expenditure, for which no provision has been made in an approved budget and not subject to funding under the delegated powers of virement, shall only be incurred after authorisation by the Chief Executive or NES Board, as appropriate.

6.12 The Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

For information relating to authorisation limits and budget virements, see Section 19.

7. ANNUAL ACCOUNTS AND REPORTS

7.1 NES is required under the terms of Section 86(3) of the National Health Services (Scotland) Act 1978 and the Public Finance and Accountability (Scotland) Act 2000 to prepare and transmit Annual Accounts to Scottish Ministers.

7.2 Scottish Ministers have issued an Accounts Direction in exercise of the powers conferred by Section 86(1) of the National Health Service (Scotland) Act 1978 which contains provisions covering the basis of preparation and the form of accounts. NES shall comply with all these provisions.

Subject to the foregoing requirement, the Annual Accounts shall also contain any disclosure and accounting and requirements which Scottish Ministers may issue from time to time.

7.3 The Director of Finance shall maintain proper accounting records which allow the timeous preparation of Annual Accounts, in accordance with the timetable set by the Scottish Government Health and Social Care Directorate, and which give a true and fair view of NES and its expenditure and income for the period in question.

7.4 Annual Accounts, Supplementary Notes and other financial returns required by the Scottish Government Health and Social Care Directorate shall be prepared by NES in accordance with the guidance and the timetables contained within the NHS Board Accounts Manual for the Annual Report and Accounts of NHS Boards as amended from time to time.

7.5 Under the terms of the Public Finance and Accountability (Scotland) Act 2000, the Auditor General for Scotland is responsible for the appointment of the External Auditors of NES.

7.6 The Director of Finance shall agree with the External Auditor a timetable for the production, audit, adoption by the Board and submission of accounts to the Auditor General for Scotland and the Scottish Government Health and Social Care Directorate. This timetable shall be consistent with the requirements of the Scottish Government Health and Social Care Directorate.

7.7 The Chief Executive shall be responsible for preparing a Governance Statement as parts of their duties as an Accountable Officer, and in so doing shall seek appropriate assurances, including that of the Chief Internal Auditor, with regard the adequacy of internal control throughout the organisation, including the performance of the non-executive committees.

7.8 The Annual Accounts of NES shall be reviewed by the Audit Committee, which has the responsibility of recommending adoption of the accounts by the NES Board. Under the terms of the Public Finance and Accountability (Scotland) Act 2000, Annual Accounts may not be placed in the public domain, prior to them being formally laid before Parliament.

7.9 Following the formal approval of the motion to adopt the accounts by NES Board, the Annual Accounts and relevant certificates shall be duly signed on behalf of the Board and submitted to the External Auditor for completion of the relevant audit certificates.

7.10 Signed sets of NES's Annual Accounts shall then be submitted by the External Auditor to the Scottish Government Health and Social Care Directorate, and to the Auditor General in the required format

7.11 The Chief Executive shall arrange for the production and circulation of an Annual Report for NES in such form as may be determined by the Scottish Government Health and Social Care Directorate. The Annual Report, together with an audited financial statement, shall be presented at a public meeting which must take place no later than six months after the relevant accounting date, subject to confirmation that they have been formally laid before Parliament.

8. BANKING ARRANGEMENTS AND OPERATION

8.1 All arrangements with NES's bankers will be made in accordance with directions and advice from the Scottish Government Health and Social Care Directorate.

8.2 NES is obliged to comply with instructions from Scottish Ministers and Her Majesty's Treasury in relation to the operation of bank accounts. All bank accounts will only be opened on the instruction of the Director of Finance. The Scottish Government commercial banking arrangements provide for public bodies to hold a commercial bank account with the Royal Bank of Scotland. During financial year 2015/16, HM Treasury implemented new arrangements for the Government Banking Service (GBS). Previously, Public Sector organisations were obliged to use both Citibank and RBS, however under the revised arrangements, all NHSScotland bodies are obliged to use accounts provided by NatWest, part of RBS Group As at 31st December 2018 the following bank accounts were in operation: -

Bank	Account Description	Services Provided
Royal Bank of Scotland	Commercial Account under the terms of the Scottish Government contract for commercial Bank Accounts	BACS sponsorship; BACS rejects and recalls; Income receipts from Portal; and Local Pay-Ins
NatWest	Account provided under existing GBS contract	Payable Orders (cheques); BACS payments; Receipt of Income from Debtors; Receipts and payments from/To Other Public Sector organisations

Any new accounts or changes to existing arrangements for the accounts must be approved by the Director of Finance.

8.3 Payable Orders are printed with the signature of the Assistant Paymaster General added at the time of processing.

8.4 All other payments are authorised electronically on the above accounts. For payments generated from the Finance System, only one authoriser is required to approve payments using secure on-line access. However, manual payments which exceed £50,000 require on-line approval from two authorisers. The Director of Finance will specify all officers approved to authorise payments and BACS files

8.5 The signatory(ies) will satisfy themselves that payments are correctly substantiated and are in respect of sums properly payable by NES.

8.6 All Payable Orders (cheques) (which shall be crossed with "Not Negotiable – Account Payee Only") shall be treated as controlled stationery in the charge of a duly designated officer controlling their issue.

The Director of Finance is responsible for ensuring the system of control of access to and authorisation of payments from all bank accounts is robust and administered appropriately using the systems provided by the banks. This system of administration will cover creation and prompt deletion of users as necessary to ensure the security of access and efficient management of the accounts.

8.7 The Director of Finance shall ensure that NES does not, without the approval of Scottish Government given as appropriate with the consent of Treasury, borrow or lend money nor give any guarantee, indemnity, nor letter of comfort

9. FINANCIAL ARRANGEMENTS

9.1 The Director of Finance shall ensure that detailed written procedures relating to financial systems are designed, including specific reference to duties of officers under these systems and that these systems, incorporating internal control principles, duly approved by the Director of Finance, are maintained, reviewed annually and updated as necessary.

9.2 Any authorisation for expenditure outside of the approved plans, policies or regulations and for which no budget has been provided under the powers of virement must have the written approval of the Director of Finance before payment.

SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS:

9.3 All means of officially acknowledging or recording amounts received or receivable shall be in the form approved by the Director of Finance. These stationery items shall be subject to the same precautions as are applied to cash, in accordance with the requirements of the Director of Finance.

9.4 All officers, whose duty it is to collect or hold cash, shall be provided with a safe or with a lockable cash box which will normally be deposited in a

safe or other secure location. The officer concerned shall hold only one key with one duplicate being held by another officer authorised by the Director of Finance and suitable receipts obtained. The loss of any key shall be reported immediately to the Head of Finance. The Director of Finance shall arrange for all new keys to be despatched directly to them from the manufacturers and shall be responsible for maintaining register of authorised holders of safe keys.

9.5 The safe key holder shall not accept unofficial funds for depositing in their safe unless deposits are in sealed envelopes or locked containers. It shall be made clear to the depositor that the NES Board is not held liable for any loss and written indemnity must be obtained from the organisation or individual absolving NES from responsibility for any loss. During the absence of the holder of a safe or cash box key, the officer who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe/cash box contents on the transfer of responsibilities and the discharge document must be retained for audit inspection.

9.6 All cash, cheques, postal orders and other forms of payment shall normally be received by more than one officer and shall be entered in an approved form of register which should be signed by both. All cheques and postal orders shall be crossed immediately “Not Negotiable”. The remittances shall be passed to the Operational Assistant from whom a signature shall be obtained.

9.7 Any cash collected from fund raising events will be counted by two staff members in the Directorate where the funds have been collected. If passing to Finance for onward payment to the charity, the directorate team must complete a form with the breakdown of cash, signed by the two staff members before passing the form and cash to Central Finance. Finance will bank the income and issue a cheque to the Charity. Cash will be banked by finance, no later than the following working day. Any cash held overnight will be kept in the safe.

9.8 The opening of mail and the counting and recording of any takings shall be undertaken by two officers together.

9.9 Official monies shall not under any circumstances be used for the encashment of private cheques.

9.10 All cheques, postal orders, cash etc. shall be banked intact promptly in accordance with the approved procedures of the Director of Finance. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

9.11 All unused payable orders shall be kept in the safe.

9.12 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses.

9.13 Petty cash reconciliations shall be prepared prior to requesting cash reimbursement for expenses.

SECURITY OF PHYSICAL ASSETS

9.14 Each employee has a responsibility to exercise a duty of care over the property of NES and it shall be the responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Persistent breach of agreed security practices shall be reported to the Chief Executive.

9.15 Wherever practicable, items of equipment shall be marked as NES property. Items to be controlled shall be recorded and updated in an appropriate register including all capital assets

9.16 Nominated officer(s) designated by the Chief Executive shall maintain an up-to-date asset register of those items which are capital by definition. Items falling into the following categories are capital by definition:

- Property, plant and equipment assets which are capable of being used for a period which could exceed one year and have a cost equal to or greater than £5,000.

- In cases where a new development would face an exceptional write off of items of equipment costing individually less than £5,000 the Board has the option to capitalise initial revenue equipment costs with a standard life of 10 years.

- Assets of lesser value may be capitalised where they form part of a group of similar assets purchased at approximately the same time and cost over £20,000 in total, or where they are part of the initial costs of equipping a new development and total over £20,000.

9.17 The items on the register shall be physically checked at least annually by the designated officer and all discrepancies shall be notified in writing to the Director of Finance, who may also undertake such other independent checks as they consider necessary. On the closure of premises, a check shall be carried out and a designated officer shall certify a list of items held showing eventual disposal.

9.18 A separate register of items of a specialist nature which do not meet the formal definition of capital assets e.g. Laptops, PCs, mobile phones shall be maintained by nominated officers. The Director of Finance shall approve the form of all registers and the methods of updating.

9.19 Any damage to premises, vehicles and equipment, or any loss of equipment or supplies shall be reported by staff in accordance with the agreed procedure for reporting losses (Also see Losses section).

9.20 Registers shall also be maintained by responsible officers and receipts retained for:

- Equipment on loan; and
- Leased equipment;

9.21 The Chief Executive will ensure that NES does not dispose of any assets, unless Scottish Government otherwise agrees, except at current market values and in accordance with the practices applicable to assets purchased out of public funds as laid down in Government Accounting.

9.22 The Chief Executive shall ensure that assets having a net book value or realisable value, whichever is the higher, in excess of £50,000, are not disposed of without prior Scottish Government approval.

INCOME

9.23 The Director of Finance shall be responsible for designing and ensuring maintenance of systems for the proper recording and collection of all monies due.

9.24 All officers shall inform the Director of Finance of monies due to NES arising from transactions they initiate, including all contracts, leases, tenancy agreement and any other transactions in order that an official invoice is raised to the customers.

9.25 The Director of Finance shall take appropriate recovery action on all outstanding debts including the establishment of procedures for the write off of debts after all appropriate recoverable steps have been taken to secure payment (see Losses section).

9.26 In relation to Income Generation Schemes, the Director of Finance shall ensure that there are systems in place to identify all costs and services attributed to each scheme before implementation and such schemes should only proceed on the basis of providing income in excess of the cost of the scheme.

All fees and charges must be approved in advance by the Director of Finance.

All fees and charges must be reviewed annually by the Budget Holder to ensure they are still appropriate and agreed by the Director of Finance.

PAYMENT OF ACCOUNTS

9.27 The Director of Finance shall ensure that up to date lists of authorised signatories are maintained and reviewed regularly, at least annually.

9.28 The Director of Finance shall be responsible for the payment of all accounts, invoices and contract claims in accordance with contractual terms and/or targets set by the Scottish Government Health and Social Care Directorate. Payment systems shall be designed to avoid payments of interest arising from non-compliance with the Late Payment of Commercial Debts (Interest) Act 1998.

9.29 All officers shall inform the Director of Finance promptly of all monies payable by NES arising from any transactions related to leases or tenancy agreements. All expenditure should be consistent with approved spend from the budget process. Suppliers shall be informed to send all invoices to the Finance Department for processing, quoting a valid Purchase Order number where appropriate. Is this still the case?

9.30 All other requests for payment not covered by a Purchase order, should, wherever possible, have relevant invoices or contract payment vouchers attached and shall be authorised by an approved officer from a list of authorised signatories.

9.31 The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable. The system shall provide for certification that:

- Goods have been duly received, examined, are in accordance with specification and order, are satisfactory and that prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order; that were applicable the materials used were of the requisite standard and that the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, that the rates of labour are in accordance with the appropriate rates, that the materials have been checked as regards quantity, quality and price and that the charges for the use of the vehicles, plant and machinery have been examined;

- Where appropriate, the expenditure is in accordance with regulations and that all necessary Board or appropriate officer authorisations have been obtained;
- The account/claim is arithmetically correct;
- The account/claim is in order for payment;
- VAT has been recovered as appropriate;
- Payments are processed timeously in order to secure discounts available; and
- A timetable and system for submission of accounts for payment is maintained to ensure prompt payment to suppliers

9.32 Budget Holders shall ensure, before a requisition for goods and service is placed, that the purchase has been properly considered and forms part of the department's allocations, agreed business plans, or other known and specific funds available to the department.

9.33 The Director of Finance shall ensure that payment for goods and services is only made once the goods and services are received other than under the terms of a specific contractual agreement. (e.g. Venue Hire where a deposit may be required)

9.34 Where an officer certifying accounts or claims relies upon other officers to do preliminary checking, he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed order and negotiated prices and terms. Budget Managers must therefore ensure that there is effective separation of duties between:

- The person placing the order;
- The person certifying receipt of goods and services, and;
- The person authorising the invoice

No single person should undertake all three functions. The Director of Finance must approve the list of officers authorised to certify invoices, non-invoice payments and payroll schedules, including where required by the Director of Finance, financial limits to their authority. The Director of Finance will maintain details, together with their specimen signatures.

9.35 In the case of contracts for building or engineering works which require payment to be made on account during progress of the works, the Director of Finance shall make payment on receipt of certificate from the appropriate technical consultant or officer. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractors account shall be subject to such financial examination by the Director of Finance and such general examination by a works officer as may be considered necessary, before

the person responsible for the contract issues the final certificate. To assist financial control, a contracts register should be created.

9.36 The Director of Finance may authorise petty cash as required. Individual payments must be restricted to the amounts authorised by the Director of Finance and appropriate vouchers obtained and retained in accordance with the policy on culling and retention of documents.

9.37 When commissioning contractors to carry out work on behalf of NES, the responsible officer must check the employee/employer status of the individual concerned. Claims of self-employed status on behalf of the individual need to be verified for every project undertaken. The HMRC Employment Status Indicator tool should be completed by the officer commissioning the individual (http://www.hmrc.gov.uk/calcs/esi.htm). The result should be kept by the officer to produce in the event of an audit from HMRC. If the result confirms that there is no employee/ employer relationship, then the contractor should be asked to provide an invoice for their fees. However, if the result indicates that there is a relationship then the contractor should be asked to complete a fee form and will be paid through the NES payroll.

9.38 Advance payment for supplies, equipment or services out with normal business practices shall not be normally permitted. Advance payment in all exceptional circumstances shall be subject to the express approval of the Director of Finance

9.39 The budget holder is responsible for ensuring that all items due under a payment in advance contract are received and they must inform the Director of Finance immediately problems are encountered.

9.40 NHSScotland operates a “Payment on Behalf” process which eliminates the need for the transfer of cash between boards for the payment of services. The process removes the need for boards to raise Purchase Orders and invoices to one another, and instead recognises the payments as a non-cash transfer. The system is managed by NHS National Services Scotland on behalf of Scottish Government and the transfers are processed monthly. Where payments to other Boards are managed through this process, the Director of Finance is responsible for ensuring that there is an authorisation process in place which assures that services have been received and payment authorised prior to the transfer being made. The Head of Finance/Deputy Director of Finance has delegated authority to approve the Transfer request to NSS on behalf of the Director of Finance.

9.41

PAYMENT OF STAFF

9.42 Staff may be engaged or re-graded only by authorised officers within the limit of the approved budget and establishment when agreed by the Chief Executive or other authorised officer unless following successful grading appeals. The Remuneration Committee shall approve any changes to the remuneration, allowances and conditions of service of the Chief Executive and other Directors in accordance with the Code of Corporate Governance, subject to advice from the Director of Workforce

9.43 Each employee shall be issued with a contract which shall comply with current employment legislation and be in a form approved by NES.

9.44 Completion and signing of engagement forms and such other documents necessary for the payment of staff as they may require shall be co-ordinated by appropriate HR Officers and approved forms forwarded, as close to the new member of staff commencing with NES, to NSS Payroll and copied to the Operational Advisor within the Finance Department.

9.45 A termination of employment form and such other documents as may be required, for payment purposes, shall be completed, signed and approved through the appropriate Line Manager and HR Officers and submitted to NSS Payroll and copied to the Operational Advisor within the Finance Department. Where an employee fails to report for duty in circumstances which they have left without notice and this has been confirmed, NSS Payroll and Payroll Liaison Officer shall be informed immediately.

9.46 Completion and signing of notification of change forms and such other documents necessary for the payment of staff following changes in employment status or terms and conditions of service shall be co-ordinated between the appropriate HR Officers and approved forms forwarded, as close to the effective date of change to NSS Payroll and copied to the Payroll Liaison Officer within the Finance Department.

9.47 Where the personnel and payroll systems are connected by an electronic interface the requirement for contract/engagement forms, termination of employment forms and notification of change forms to be sent to the Head of Payroll Services may be altered to allow for such information to be transmitted by electronic means providing always that appropriate procedures for such transmissions are agreed by the Director of Finance.

9.48 All time-records, staff returns, and other pay records and notifications shall be in a form approved by the Director of Finance and shall be certified and submitted in accordance with their instructions. Where this

information is transmitted by electronic means, appropriate procedures covering such transmissions require to be agreed with him/her.

9.49 Subject to the limits laid down in the Scheme of Delegation, all early retirals which result in additional costs being borne by the employer will be submitted to the Remuneration Committee for consideration and recommendation to the NES Board. The Chair shall personally authorise payments in respect of Chief Executive and the Chief Executive shall personally authorise payments in respect of all other employees, following approval by the NES Board.

9.50 The Director of Workforce and the Director of Finance shall be jointly responsible for ensuring that rates of pay and relevant conditions of service are in accordance with current agreements as advised by the Scottish Government Health and Social Care Directorate and agreed by the Board. The Chief Executive, or Board in appropriate circumstances, shall be responsible for the final determination of pay but subject to the statutory duty of the Director of Finance who shall issue instructions regarding:

- Verification of documentation of data;
- The timetable for receipt and preparation of payroll data and payment of staff;
- Maintenance of subsidiary records for Superannuation, Income Tax, National Insurance and other authorised deductions of pay;
- Security and confidentiality of payroll information in accordance with the principle of the Data Protection Act, 1984;
- Checks to be applied to completed payroll before and after payment;
- Methods of payment available to various categories of staff;
- Procedures for payment to staff;
- Procedures for unclaimed wages which should not be returned to salaries and wages staff;
- Pay advances authorised and their recovery;
- Maintenance of regular and independent reconciliation of adequate control accounts;
- Separation of duties of preparing records and handling cash;
- A system to ensure the recovery from leavers of any sums due by them to NHS Education.

9.51 All employees shall be paid by bank credit transfer, unless otherwise agreed by the Director of Finance.

9.52 After approval by the Remuneration Committee, the Chair will personally authorise for payment the Performance Related Pay (PRP) of the Chief Executive and the Chief Executive will personally authorise for payment the PRP of all other NES staff.

9.53 The Director of Finance shall ensure salaries and wages are paid on the currently agreed dates but may vary these when necessary due to special circumstances (e.g. Christmas or other Bank Holidays). Payment to an individual shall not normally be made in advance of the normal pay date.

10. TRAVEL, SUBSISTENCE AND OTHER ALLOWANCES

10.1 The Director of Finance shall ensure that all expense claims by employees of NES are reimbursed in line with the relevant NHS regulations, and in line with the NES Travel and Subsistence Policy.

10.2 The Director of Finance shall issue additional guidance on the submission of expense claims, specifying the documentation to be used, the timescales to be adhered to and the required level of authorisation.

11. CONTRACTING AND PURCHASING

11.1 All procurement must be undertaken in line with the requirements of the Public Contracts (Scotland) Regulations 2015, the Procurement Reform (Scotland) Act 2014, the Procurement (Scotland) Regulations 2016 and the principles set out in the Scottish Governments Scottish Procurement Policy Handbook 2008, and the Scottish Governments published Procurement Journey, including any subsequent revisions.

11.2 In all circumstances officers of NES shall seek to obtain Best Value through the application of the NES Policy and Procedures.

11.3 NES shall comply as far as is practicable with the Scottish Capital Investment Manual and Scottish Procurement Policy Notes.

11.4 European Union Procurement Directives shall have an effect as translated through Public Contracts (Scotland) Regulations 2015 and any subsequent revisions

11.5 In accordance with CEL 05 (2012) where national, regional or local contracts exist (including framework agreements) NES will use these contracts. Only in exceptional circumstances and with the authority of the Head of Procurement and Commissioning, the Head of Finance or

the Director of Finance, based on the scheme of delegation, can goods or services be ordered out-with such agreements.

THRESHOLDS FOR PURCHASING/ORDERING

11.6 The central Procurement team are responsible for all Procurement activities. The thresholds (excluding VAT) for the purchasing/ordering of goods and services are as follows: -

Thresholds (ex-VAT)	**Purchasing Process**
Order value ≤ £10,000	Achievement of value for money should be demonstrated.
Order value > £10,000 and ≤ £25,000	Three competitive written quotations to be received from reputable suppliers.
Order value ≥ £25,000	Tendering process applies

Value for Money (VFM), Public Contracts Scotland (PCS), including PCS Quick Quote and the EU/GATT Directives must be applied when the estimated contract value exceeds the procurement thresholds set out in the table below. In case of any doubt, advice must be sought from the Procurement Department

Spend £k	≥123*	OJEU	OJEU	OJEU	OJEU	OJEU
	>50 <123*	PCS-T	PCS-T	PCS-T	PCS-T	PCS-T
	>25 ≤50	PCS	PCS	PCS	PCS	PCS
	>10 ≤25	PCS Quick Quote	PCS Quick Quote	PCS Quick Quote	PCS Quick Quote	PCS
	>0 ≤10	VFM	VFM	VFM	VFM	PCS Quick Quote
		Very Low	Low	Medium	High	Very High
		Risk/Complexity				

* revised bi-annually by EU directive

Order value refers not only to individual orders but also to the total estimated value of recurring orders for like goods/services.

ACCEPTANCE AND AWARD BY CHIEF EXECUTIVE

11.7 The Chief Executive, acting with the Director of Finance are authorised on behalf of the organisation to accept tenders and award contracts.

This responsibility can be assigned to those who have delegated financial authority

11.8 The limits for delegation for the acceptance of tenders shall be approved by NES Board and the Executive Team from time to time.

11.9 Formal tendering procedures may be waived with the recorded approval of the Director of Finance where;

- For values below the OJEU limits, the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; and
- Specialist expertise is required, and evidence is provided to demonstrate that this is available from only one source; and
- The task is essential to complete the project, and arises as a consequence of a recently completed assignment and engagement of different consultants for the new task would be inappropriate; or
- There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or
- Article 19 of the EU public procurement directive 2004/18/EC enacted by Part 2, Section 2, Clause 21 of the Public Contracts (Scotland) Regulations 2015, allows any public sector body to restrict the tendering process for goods or services to supported factories and businesses only. The directive only applies as a matter of law to contract opportunities which have a financial value greater than the OJEU threshold values.
- Where provided for in the Scottish Capital Investment Manual.

11.10 Where competitive tendering is waived by the Director of Finance the waiver and the reasons should be documented and the record retained by Procurement. Waivers above the delegated authority limit of the Director of Finance should be authorised by the Chief Executive.

SINGLE TENDER

11.11 Where only one tender is received, NES must ensure, as far as practicable, that the price to be paid is fair and reasonable. If this situation arises the reasons for accepting the single tender should be formally documented and submitted to the Head of Procurement.

OFFICIAL ORDERS

11.12 No goods, services or works other than works and services executed in accordance with a contract or a` NES Purchasing Card shall be ordered except on an official order, whether hardcopy or electronic, and contractors shall be notified that they should not accept orders unless on an official order form or processed via an approved secure electronic medium. Oral (Verbal) orders shall be issued only by an officer designated by the Chief Executive and only in accordance with the Business Continuity Plan. These shall be confirmed by an official order issued no later than the next working day, except for in exceptional circumstances, and clearly marked "Confirmation Order". National contracts must be used unless express permission, within the scheme of delegation, has been obtained from the Head of Commissioning and Procurement, the Head of Finance or the Director of Finance.

11.13 Official orders shall be issued by the NES Purchase Order system in a form approved by the Director of Finance and shall include such information concerning prices or costs as he/she may require. All orders shall incorporate an obligation on the contractor to comply with NES terms and conditions as regards delivery, carriage, documentation, variations etc.

11.14 Orders will be processed and transmitted by electronic methods in place of signed numbered paper-based orders providing always that appropriate procedures for such orders are agreed by the Director of Finance.

11.15 Official order forms, supported by appropriate requisition requests, shall only be approved officers authorised by the Chief Executive. Lists of authorised officers shall be maintained and a copy of such list supplied to the Director of Finance.

11.16 No order, contract, lease shall be issued for any items for which there is no budget provision or for which no funding has been provided under the delegated powers of virement unless authorised by the Director of Finance on behalf of the Chief Executive. Members and officials must ensure that all contracts, leases, tenancy agreements and other commitments they enter into on behalf of NES for which a financial liability may result but without secured funding or budget provision are notified to the Director of Finance in advance of commitment being made.

MANAGEMENT CONSULTANTS

11.17 NHS Circular MEL (1994) 4 advises NHS Boards and Special Health Boards of the results of a review of the use of Management Consultants and sets out a course of action to be adopted. Management Consultants should only be used when documentary evidence of a benefit to NES has been prepared.

11.18 In choosing a Management Consultant, steps should be taken to ensure that they are capable of carrying out the assignment; that Best Value is obtained; and that due probity is demonstrated in awarding the contract.

Appointment of Management Consultants must normally be by Competitive Tender.

11.19 Where successive assignments beyond the scope and terms of an appointment made by competitive tender arise, these should also be subject to tender arrangements. Where it is expected that there may be follow on assignments, it may be more appropriate for the tendering exercise to appoint Management Consultants under a call off arrangement.

CONTRACTS

11.20 NES may only enter into contracts within its statutory powers and shall comply with:

- Standing Orders;
- NES Standing Financial Instructions;
- EU Directives and other statutory provisions
- Any relevant directions including the Scottish Capital Investment Manual, Scottish Public Finance Manual and guidance on the use of Management Consultants.
- Such NHS Standard Contract conditions as are applicable.

11.21 Where specific contract conditions are considered necessary by the lead officer, these will be drafted by the Head of Procurement and Commissioning and where appropriate, advice shall be sought from suitably qualified persons and/or the Central Legal Office part of National Services Scotland (NSS).

11.22 In all contracts made by NES, the Procurement team shall endeavour to obtain Best Value. All tenders are awarded on the basis of MEAT (Most Economically Advantageous Tender) All supporting evidence is documented and held in accordance with Appendix 2: Retention Policy

11.23 Any contractual aspects will be managed by the Procurement team in addition to a nominated Point of Contact who shall oversee and manage deliverables.

11.24 All contracts entered into shall contain standard clauses empowering NES to:

- Cancel the contract and recover all losses in full where a company or their representative has offered, given or agreed to give, any inducement to members or officials;
- Recover all losses in full or enforce specific performance where goods or services are not delivered in line with contract terms.

11.25 The Director of Finance shall ensure that arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within SCOTCONCODE and SCIM. The Technical audit of these contracts shall be the responsibility of the relevant Director.

IN HOUSE SERVICES

11.26 The Chief Executive shall be responsible for ensuring that Best Value can be demonstrated for all services provided under contract or in-house. The Board or appropriate committee may also determine from time to time that in-house services should be market tested by competitive tendering.

REGISTER OF INTEREST

11.27 Acceptance of Financial Assistance, Gifts and Hospitality and Declaration of Interest.

- The principles relating to the acceptance by Health Service staff of financial assistance, gifts and hospitality from commercial sources and declaration of interest are stated in NHS Education for Scotland Hospitality Policy which references NHS Circular MEL 1994(48) Annex 7 and NHS Circular MEL 1994(80). This policy has been widely circulated and should be read as part of the Standing Financial Instructions.

- The policy covering acceptance of financial assistance, gifts and hospitality and declaration of interest is updated by the Workforce Directorate on behalf of the Chief Executive

- A register covering acceptance of financial assistance, gifts and hospitality is maintained by the Finance Directorate and the register of

and declaration of interest is maintained by Board Services on behalf of the Chief Executive.

- No order shall be issued for any item or items for which an offer of gifts (other than low cost items e.g. calendars, diaries, pens and like value items), or hospitality has been received from the person interested in supplying goods or services. Any employee of NES receiving such an offer shall notify their line manager as soon as is practicable.

- Visits at supplier's expense to inspect equipment, goods or services must not be undertaken without the prior approval of the Chief Executive.

12. LOSSES AND SPECIAL PAYMENTS

12.1 Any officer discovering or suspecting a loss of any kind shall forthwith inform their line manager, who shall immediately inform the Fraud Liaison Officer. Where a criminal offence is suspected, the Counter Fraud policy in operation at NES must be applied, in accordance with the partnership agreement between NES and Counter Fraud Services.

12.2 The Director of Finance shall maintain a losses and compensation register in which details of all losses shall be recorded, as they are known. Write off action shall be recorded against each entry in the register.

12.3 Losses are classified according to details issued by the Scottish Government Health and Social Care Directorate.

12.4 In accordance with the Scheme of Delegation, the Chief Executive, acting together with the Director of Finance, may approve the writing off of losses within the limits delegated to the Board / Executive team by the Scottish Government Health and Social Care Directorate, as per NHS Circular CEL 10 (2010) (Appendix C): -

Item number	Category of Loss	Delegated Authority (per case) £
	Theft / Arson / Wilful Damage	
1	Cash	10,000
2	Stores/procurement	20,000
3	Equipment	10,000
4	Contracts	10,000
5	Payroll	10,000
6	Buildings & Fixtures	20,000
7	Other	10,000
	Fraud / Embezzlement / Corruption / Theft (where documentation has been falsified) & attempts to perpetuate any of these activities	
8	Cash	10,000
9	Stores/Procurement	20,000
10	Equipment	10,000
11	Contracts	10,000
12	Payroll	10,000
13	Other	10,000
14	**Nugatory & Fruitless Payments**	10,000
15	**Claims Abandoned**	
	(a) Private Accommodation	10,000
	(b) Road Traffic Acts	20,000
	(c) Other	10,000
	Stores Losses	
16	Incidents of the Service: - - Fire	20,000
	- Flood	20,000
	- Accident	20,000
17	Deterioration in Store	20,000
18	Stocktaking Discrepancies	20,000
19	Other Causes	20,000
	Losses of Furniture & Equipment and Bedding & Linen in circulation	
20	Incidents of the Service: - - Fire	10,000
	- Flood	10,000
	- Accident	10,000
21	Disclosed at physical check	10,000
22	Other causes	10,000
	Compensation Payments – Legal Obligation	
23	Clinical	250,000
24	Non-clinical	100,000
	Ex-gratia payments	
25	Extra-contractual payments	10,000
26	Comp payments – ex-gratia –Clinical	250,000

Item number	Category	Delegated Authority (per case) £
27	Compensation payments – ex-gratia – Non-clinical	100,000
28	Compensation payments – ex-gratia – Financial Loss	25,000
29	Other Payments	2,500
	Damage to Buildings and Fixtures	
30	Incidents of the Service: - - Fire	20,000
	- Flood	20,000
	- Accident	20,000
	- Other Causes	20,000
31	**Extra-Statutory & Extra-regulationary Payments**	Nil
32	**Gifts in cash or kind**	10,000
33	**Other losses**	10,000

12.5 The exercise of powers of delegation in respect of losses and special payments will be subject to the submission of annual reports to NES Audit Committee identifying which powers have been exercised and the amount involved.

12.6 The Audit Committee will formally consider and approve all Losses annually when recommending adoption of the Statutory Annual Accounts.

12.7 No special payments exceeding the delegated limits laid down, and subsequent amendments thereto shall be made without prior approval of the Scottish Government Health & Social Care Directorate.

12.8 The Director of Finance shall be authorised to take any necessary steps to safeguard NES's interests in bankruptcies and company liquidations.

12.9 All articles surplus to requirements or unserviceable shall be condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance.

12.10 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance and the Chief Executive who shall take the appropriate action.

13. RISK MANAGEMENT

The Chief Executive Officer shall ensure that NES has a Risk Management Strategy that is approved and monitored by the Audit Committee.

The Risk Management Strategy shall include:

A Statement on the NES approach to Risk Management
A summary of the NES Strategy for Risk Management
Details of the Structures in place to implement the strategy
Details of the processes in place supporting the risk management structures
Definition of the Risk Appetite i.e. the level of risk the board is willing to accept
Definition of responsibilities with regard to risk management

The Audit Committee shall have oversight of the Risk Management Strategy and of the implementation and monitoring of risk management structures and processes.

The Director of Finance shall ensure that appropriate insurance and indemnity arrangements are in place in support of the risk management strategy.

14. STANDING COMMITTEES

The Board has established standing committees to which it delegates responsibilities. The remit of all committees will be reviewed annually and is published within the Corporate Induction Handbook

15. SPECIFIC ROLES & RESPONSIBILITIES

ROLE OF THE DIRECTOR OF FINANCE

15.1 The Director of Finance is responsible for:

- Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function;
- Ensuring that the effectiveness of Internal Audit is reviewed by the Audit Committee and meets the NHS mandatory audit standards;
- Liaising with Counter Fraud Services as appropriate to determine at what stage to involve the police in cases of fraud, misappropriation, and other irregularities;

15.2 The Director of Finance, designated auditors and representatives from Counter Fraud Services (CFS), are all entitled without necessarily giving prior notice to require and receive:

- Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- Access at all reasonable times to any land, premises or employee of the organisation;
- The production of any cash, stores or other property of the organisation under an employee's control;
- Explanations concerning any matter under investigation.

ROLE OF INTERNAL AUDIT

15.3 The role, objectives and scope of Internal Audit are set out in the NHS Internal Audit Manual.

15.4 The Internal Auditor shall have specific responsibility to review, appraise and report upon:

(a) Controls to ensure achievement of NES's objectives;

(b) The extent of compliance with established policies, procedures, plans, regulations and laws etc;

(c) The extent to which NES's assets and interests are accounted for and safeguarded from loss of any kind arising from: fraud and other offences, theft, accident, waste, extravagance, inefficient administration and poor value for money or other causes;

(d) The suitability, reliability and integrity of management information systems;

(f) The adequacy of follow-up action to their reports.

15.5 The Internal Auditors shall be accountable to the Audit Committee of NES. The reporting and follow up systems for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit manual. The reporting system shall be reviewed at least every 3 years.

15.6 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property of NES or any

suspected irregularity in the exercise of any function of a pecuniary nature; the Director of Finance shall be notified immediately. (See also Section 13 – Losses and Special Payments).

15.7 The Director of Finance, normally via the Internal Auditor, shall investigate cases of fraud, misappropriation or other irregularities, in compliance with the approach agreed in the partnership agreement with NHS Counter Fraud Services.

15.8 The Internal Auditors shall issue reports to the Director of Finance, who shall refer audit reports to the appropriate officers designated by the Chief Executive. Failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive.

15.9 Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, or where sufficient action is not taken on matters of consequence, the Internal Auditor shall have direct access to the Audit Committee. In exceptional circumstances, where they deem necessary, the Internal Auditor shall have the right to report direct to the Chief Executive, NES Chair or the Chair of the Audit Committee.

15.10 At each meeting of the Audit Committee the opportunity should be given for the Chair of the Committee to meet with Non-Executive Members privately. At least twice a year the Chair of the Audit Committee and the Non-Executive Members should be provided with the opportunity to meet with the Chief Internal Auditor and External Auditors privately.

EXTERNAL AUDIT

15.11 The External Auditor is concerned with providing an independent assurance on financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NES accounts. Responsibility for securing the audit of NES rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000.

15.12 The appointed auditor has a general duty to satisfy himself that:

- The organisation's accounts have been properly prepared in accordance with directions given under the Public Finance and Accountability (Scotland) Act 2000;
- Proper accounting practices have been observed in the preparation of the accounts;

- The organisation has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

16. INFORMATION TECHNOLOGY

16.1 The Director of Digital shall be responsible for the overall maintenance and security of networked systems within NES. The Director of Finance shall be primarily responsible for the accuracy of data and the maintenance of appropriate security levels within the financial systems of NES.

16.2 The Director of Digital shall devise and implement any necessary procedures to protect NES and individuals from inappropriate use or misuse of any financial or other information held on computer files for which they have responsibility and shall take account of the provisions of the Data Protection Act 1998.

16.3 The Director of Finance shall satisfy himself that such computer audit checks and reviews as they may consider necessary are being carried out.

16.4 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another NHS Board or any other agency, assurances of adequacy will be obtained from them prior to implementation.

16.5 The Director of Finance shall ensure that contracts for computer services for financial applications with another NHS Board or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing and storage. The contract should also ensure rights of access for audit purposes.

16.6 Where another NHS Board or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.7 Where computer systems have an impact on corporate financial systems the Director of Finance shall ensure that:

(a) Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists; and

(c) Director of Finance staff have access to such data.

17. FIXED ASSETS

17.1 The Chief Executive and Director of Finance shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the financial plans for each organisation.

17.2 The Director of Finance shall ensure that every capital expenditure proposal meets the following criteria:

- Potential benefits have been evaluated and compared with known costs;
- The cost consequences of the developments have been evaluated and included in future budgets;
- Complies with the guidance in the NHSiS Scottish Government Scottish Capital Investment Manual and subsequent disclosure complies with International Financial Reporting Standards (IFRS).

17.3 Consideration should be given to the use operating leases where appropriate.

17.4 In the case of large capital schemes, a system shall be established for progressing the scheme and authorising necessary payments up to completion. Provision should be made for regular reporting of actual expenditure against authorisation of capital expenditure.

17.5 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Where land and property are disposed of, the requirements set out in the NHSiS Scottish Government Property Transactions handbook, together with any subsequent amendments, shall be followed.

17.6 There is a requirement to achieve best value when disposing of assets belonging to NES. Competitive Tendering should normally be undertaken in line with requirements of the organisation's tendering procedure.

17.7 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

- Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined by the Chief Executive;
- Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the organisation;
- Items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed annually
- Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
- Land or buildings concerning which Scottish Government guidance has been issued but subject to compliance with such guidance.

17.8 The overall control of fixed assets shall be the responsibility of the Chief Executive advised by the Director of Finance.

17.9 All assets must be disposed of in accordance with MEL (1996) 7 “Sale of Surplus and obsolete goods and equipment”. The Director of Finance shall be notified of the disposal of any fixed assets. All proceeds from the disposal of fixed assets are notified to the Director of Finance.

17.10 NES shall maintain an asset register recording NES’s fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Asset Accounting Manual (Section 13) as issued by the Scottish Government Health and Social Care Directorate. The organisation shall maintain a register of assets held under the operating leases or PFI contracts.

17.11 A fixed asset control procedure shall be approved by the Director of Finance. This procedure shall make provision for:

- recording managerial responsibility for each asset;
- identification of additions and disposals;
- identification of all repairs and maintenance expenses;
- physical security of assets; periodic verification of the existence of, condition of and title to assets recorded;
- Identification and reporting of all costs associated with the retention of an asset.

17.12 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

17.13 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

17.14 The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual

17.15 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual.

17.16 The Director of Finance shall approve a procedure for the calculation and payment of capital charges as specified in the Capital Accounting Manual.

18. FINANCIAL IRREGULARITIES

This section should be read in conjunction with the NES Fraud and Corruption policy.

18.1 Guidance on the approach to various forms of financial irregularities is contained in the following Scottish Government Health and Social Care Directorate Circulars which draw a clear distinction between treatment of suspected (a) theft and (b) fraud, embezzlement, corruption and other financial irregularities (hereafter referred to as “fraud etc”):

- CEL(2010)10 Revised Scottish Financial Return (SFR) 18: Enhanced reporting of NHS frauds and attempted frauds 29/03/2010
- NHSScotland Counter Fraud Services: National Services Scotland: partnership agreement with health boards 27/08/2009
- CEL(2009)18 Partnership agreement between NHSScotland Counter Fraud Services and NHS Boards and Special Health Boards 05/05/2009
- CEL(2008)03 Strategy to combat NHS fraud in Scotland 28/01/2008

Fraud is defined as:

- Deception
- bribery
- forgery
- extortion
- corruption
- theft
- conspiracy
- embezzlement
- misappropriation
- false representation
- concealment of material facts & collusion

For practical purposes fraud may be defined as the use of deception with the intention of obtaining an advantage, avoiding an obligation or causing loss to another party.

18.2 Any officers suspecting theft and/or fraud should immediately inform their line manager who shall in turn inform the Fraud Liaison Officer, who will

immediately comply with the requirements of the partnership agreement with NHS Counter Fraud Services.

18.3 The Fraud Liaison Officer will also prepare a report for the first appropriate meeting of the Audit Committee setting out the full circumstances of the incident and any implications for management, including changes to internal control systems which may require to be made.

18.4 Careful consideration should be given to payment claims which arise from organisations or individuals who are under investigation or against who proceedings are being taken for suspected fraud, etc. Legal advice should be sought where necessary.

18.5 The Chief Executive should report the matter to the Scottish Government Health and Social Care Directorate in cases where the nature, scale or the persons involved in the suspected offence could give rise to national or local controversy or publicity, or where the offence may be widespread.

19. AUTHORISATION LIMITS

19.1 The purpose of Standing Financial Instructions is to ensure adequate controls exist for the committing and payment of funds on behalf of the Board.

SCHEME OF DELEGATION FOR SERVICE LEVEL AGREEMENTS

19.2 Provided the service or activity has been approved in the Operational Planning process or virement approval has been obtained, and once verified by the designated Finance Manager one of the signatories on a Service Level Agreement must be in accordance with the following:

OFFICER	AUTHORISATION LIMIT
Senior Managers and Assistant Directors	Up to or equal to £25,000
Associate Directors	£25,000 to £50,000
Directors and Post Graduate Deans	£50,000 to £250,000
Director of Finance	Over £250,000
Chief Executive	Over £500,000

19.3 Provided the service or activity has been approved in the Operational Planning process or virement approval has been obtained, and once

verified by the designated Finance Manager one of the signatories on a Service Level Agreement must be in accordance with the following:

OFFICER	AUTHORISATION LIMIT
Senior Managers and Assistant Directors	Up to or equal to £25,000
Associate Directors	£25,000 to £50,000
Directors and Post Graduate Deans	£50,000 to £250,000
Director of Finance	Over £250,000
Chief Executive	Over £500,000

SCHEME OF DELEGATION FOR CONTRACTS

19.4 Contracts and other agreements with non-NHS Bodies must have two signatories, one of which will be a Directorate officer and the other an authorised buyer, with specific delegated authority in accordance with the following table. The "List of Authorised Buyers" will be held by the Finance Department. The total contract value must also be verified by the designated Finance Manager to ensure this is in line with Operational Plans and budgets.

OFFICER	AUTHORISATION LIMIT
Administrator, Coordinator, Officer	Up to the level of their designated authority, which shall be no greater than £10,000
Senior Managers and Assistant Directors	£10,000 to £25,000
Associate Directors	£25,000 to £50,000
Directors and Post Graduate Deans	Over £50,000

AUTHORISED BUYER	AUTHORISATION LIMIT
Procurement Officer	Up to the level of their designated authority, which shall be no greater than £50,000
Procurement Manager	Up to or equal to £100,000
Head of Procurement	Up to or equal to £200,000
Director of Finance	£200,000 to £500,000
Chief Executive	Contractual and other commitments over £500,000

Contractual and other commitments with non-NHS Bodies over £1,000,000 in total should be reported to the Board.

SCHEME OF DELEGATION FOR PURCHASES (PURCHASE ORDERS AND INVOICES)

19.5 Purchase requisitions and invoices must be authorised by budget holders, or staff with delegated authority from budget holders, and verified by the designated Finance Managers up to the following levels:

OFFICER	AUTHORISATION LIMIT
Administrator, Coordinator, Officer	Up to the level of their designated authority, which shall be no greater than £10,000
Senior Managers and Assistant Directors	Up to or equal to £25,000
Associate Directors	Up to or equal to £50,000
Directors and Post Graduate Deans	Up to or equal to £250,000
Director of Finance	Up to or equal to £500,000
Chief Executive	Contractual and other commitments over £500,000

19.6 All orders (or invoices without a purchase order) over £100k require second authorisation to provide assurance that the spend is in line with contractual and other commitments and ensures that orders have already been authorised by another senior member of staff, responsible for the budget concerned.

SECONDARY APPROVAL	AUTHORISATION LIMIT
Head of Procurement	Up to or equal to £250,000
Director of Finance	Up to or equal to £500,000
Chief Executive	Contractual and other commitments over £500,000

19.7 In order to ensure that Purchase Orders can be processed through eFinancials and PECOS, it will be necessary to give Directors and Post Graduate Deans a higher limit of £500,000 within the background tables of the Finance Systems. This enables the system workflow to operate in a way that assures the buyer (providing the second level of approval) that the order has been approved by the person responsible for the budget. However, the controls in both systems will ensure that all Purchase Orders above £100,000 will require approval by a buyer, thus ensuring that the above limits are applied in practice. The same limits and dual authorisation process apply to all invoices without purchase orders.

19.8 Special arrangements exist for payments to other Boards in relation payments made through the Payment on Behalf Process as outlined in Section 9.40. These include payments in respect of Training Grades and the Additional Costs of Teaching (ACT). These payments are covered by approved SLAs and individual monthly payments are processed subject to confirmation from nominated senior officers within the relevant Directorate who have delegated authority from their director. All submissions are reviewed and authorised by the Head of Finance before being processed.

SCHEME OF DELEGATION FOR VIREMENTS

19.9 It is the responsibility of the Chief Executive and the Director of Finance to ensure all financial commitments entered into on behalf of the Board are in line with approved budgets and management plans. The authority to vire between budgets is covered through a scheme of financial delegation as set out below.

Virement is the agreed transfer of revenue budget provision from one income or expenditure line to another within a financial year, within the same Directorate.

During the operational planning process, the Executive Team approve the allocation of budgets on the basis of the information on inputs, outcomes and impact provided to them at that time. A key part of the governance process in NES is a robust system of budget monitoring and review to ensure that:

- Budgets are used for the purposes for which they are allocated;
- Any planned change in the purpose for which funds are used supports the strategic direction of NES; and
- There is no duplication in the use of funds across the organisation.

It is these criteria which must be taken into account when any budget virement is being considered.

The following adjustments are not subject to the Scheme of Delegation for Virements:

- Actual receipt of allocations which were anticipated and included as part of the operational planning process and therefore use has been approved. This transaction merely confirms receipt of pre-agreed funds and will be noted and approved at the next Executive team meeting.
- Training grade adjustments - where the number of trainees is set by Scottish Government and the total funding allocation agreed. Budget adjustments which reallocate funds within the pre-agreed total and on the approval of the

appropriate governance group (National Reshaping Workforce Group) are not subject to virement rules.

- Budget allocations made by finance to release pre-agreed provisions (example – a provision created for a potential pay award).
- Enactment of structural change within the organisation. Where organisational change has been approved by the Change management Board and/or the Executive team which necessitates the reallocation of budget this will not also be subject to the Virement rules (example – consolidating budgets which are currently split across cost centres into one single budget).

OFFICER	VIREMENT LIMIT	AUTHORITY REQUIRED
Chief Executive	0 to £250,000	Totally Delegated (inform DoF)
	£250,000 to £500,000	Delegated but inform the Board
	over £500,000	Seek prior approval from Board
Director of Finance	0 to £100,000	Totally delegated (Inform Relevant Finance Manager)
	£100,000 to £250,000	Delegated but report to Chief Executive
	over £250,000	Seek prior approval from Chief Executive
Principal Lead, Finance Business Partnering (FBP) and Head of Finance	0 to £25,000	Delegated (Inform Relevant Finance Manager)
	£25,000 to £100,000	Delegated but report to Director of Finance
	Over £100,000	Seek prior approval from DoF
Budget Holders	0 to £25,000	Delegated (Inform Finance Manager)
	£25,000 to £100,000	Seek prior approval from Principal Lead FBP or Head of Finance
	over £100,000	Seek prior approval from Director of Finance
The base materiality level for the use of virement will be 10% of the original budget allocation. For example, where a cost centre/project has an original budget of £10,000 it is not envisaged that budget virements would be carried out for sums less than £1,000.		

19.10 Once the Board has approved the budget, plans and performance targets for the year and taken account of all reserves and anticipated contingencies, the Directors and Budget Holders will be responsible for managing their affairs within the budget allocated to them. This will include dealing with planned or unplanned expenditure on an individual basis and virement within the rules stated above. The virement rules stated above may be suspended with the agreement of the Executive Team

19.11 Any savings generated during the year must be quantified and disclosed to the Director of Finance as soon as possible prior to distribution under the virement rules stated above.

19.12 The Chief Executive in consultation with their Director of Finance should set authorisation limits for any other expenditure.

RESERVATION OF POWERS AND SCHEME OF DELEGATION

19.13 Matters on which decisions on, and/or approval of, are retained by the Board:

- Policy;
- Strategy, business plans and budgets;
- Standing Orders;
- Standing Financial Instructions;
- The establishment, terms and reference and reporting arrangements for all Committees and Sub Committees (including Standing Committees);
- Significant items of Capital Expenditure or disposal of assets
- Recommendations from all Committees and Sub-Committees (Where powers are Delegated)
- Annual Report and Annual Accounts;
- Financial and performance reporting arrangements;
- Investment Policy for exchequer and endowment funds;
- Constitution and Terms of Reference for statutory Committees.

19.14 Powers delegated by the Board to the committees are detailed in the Corporate Governance Handbook which is available here

19.15 All other decisions other than those referred to in paragraphs mentioned above, are delegated by the Board to officers of the Board through the Chief Executive as detailed in Appendix 1.

Authorisation limits related to the scheme of delegation and, where indicated, details of the officers who have been delegated responsibility are included within the Standing Financial Instructions.

20. ENDOWMENT FUNDS & GENERAL NURSING COUNCIL (GNC) FUND

20.1 The foregoing sections of these Standing Financial Instructions shall also apply equally to the GNC fund and the Endowment funds of the NES's Post Graduate Centres, except that expenditure from Endowment Funds shall be restricted to the purposes of the appropriate Fund and made only with the approval of the respective Trustees.

20.2 All Members of NES appointed by Scottish Ministers, are "ex officiis" Trustees of the Endowment Funds. The NES Board is responsible for the appointment of the Trustees of the GNC Fund.

The Trustees have specific responsibilities:

- Acting together and individually with all other trustees;
- Control cannot be delegated to staff or fund holders;
- Must have an understanding of ideals and purposes of the Endowment Fund;
- Cannot carry out activities beyond the remit within the appropriate legislation;
- Money can only be spent for charitable purposes within the remit of the charity or the purposes of a restricted fund;
- Transactions entered into by Trustees, which although legal but are out with the Charity's objectives and are deemed "ultra vires", could lead to the trustees being personally liable for any loss incurred by the Endowment Fund and the GNC Fund.

20.3 Under the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990 the Trustees have a responsibility to:

- Provide on request an up to date annual report and set of accounts in a form and content consistent with the requirements of the Act;
- Control and manage the finances of the GNC Fund and the Endowment Fund, ensure proper accounts are kept as required by the Office of the Scottish Charity Regulator.
- Control the investment policy and monitor the performance of the investments within that policy on a regular basis;
- Prepare an annual statement of accounts comprising an Income and Expenditure Statement, Balance Sheet and Cash Flow Statement,

together with additional information by way of notes, all consistent with the requirements laid down by the Officer of the Scottish Charity Regulator.

- The annual statement of accounts must be approved by the Trustees and signed by one of their members on their behalf and as authorised by them;

20.4 Trustees of Endowment Funds within NES may appoint an Endowment Advisory Committee to provide advice to Trustees of all funds in the exercise of all their responsibilities.

20.5 The Director of Finance shall ensure that annual accounts are prepared as soon as possible after the year end and in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and the Charities Accounts (Scotland) Regulations 2006, and that proper arrangements are made for these to be audited by a separately appointed External Auditor, and submitted to the Office of the Scottish Charity Regulator (OSCR).

20.6 The Director of Finance shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trustees as trustees of Endowment Funds and the GNC Fund, including an Investments Register consistent with the current statutory requirements (Law Reform (Miscellaneous Provision) (Scotland) Act 1990).

20.7 All share and stock certificates and property deeds shall be deposited either with the trustee body's Bankers or Investment Advisers, or in a safe, or a compartment within a safe, to which only a designated responsible officer will have access.

20.8 The ownership of all shares and stock certificates, if managed by a commercial concern, shall be periodically verified by the auditors appointed by the Trustees.

20.9 All gifts, donations and proceeds of fund raising activities which are intended for Endowment Funds and the GNC Fund shall be handed immediately to the Director of Finance, or an officer nominated by him/her for the purpose, to be banked directly into the appropriate Endowment Fund or the GNC Fund, subject to the local use of smaller amounts as agreed from time to time.

20.10 All gifts accepted shall be received and held in the name of appropriate Trustees and administered in accordance with the Trustees' policy, subject to the terms of specific Funds. As Trustees may accept gifts for specific and non-specific purposes relating to the health service, officers

shall, in cases of doubt or where there are material revenue expenditure consequences, consult the Director of Finance before accepting any gifts.

20.11 The Director of Finance shall be required to advise the appropriate Trustees on the financial implications of any proposal for fund raising activities which NES may initiate, sponsor or approve under the guidance contained in Circular No MEL (2000)13.

20.12 The Director of Finance shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the Death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the appropriate Trustees by the Director of Finance who alone shall be empowered to give an executor a good discharge.

20.13 Where it becomes necessary for the appropriate Trustees to obtain a grant of probate, or make an application for Confirmation of Executor, in order to obtain a legacy due to the Trustees under the terms of a will, the Director of Finance who alone shall be empowered to give an executor a good discharge.

20.14 Where it becomes necessary for the appropriate Trustees to obtain a grant of probate, or to make an application for Conformation of Executor, in order to obtain a legacy due to the Trustees under the terms of a will, the Director of Finance shall be the Trustee's nominee for the purpose.

20.15 Endowment Funds and the GNC Fund shall be invested subject to the following considerations subject to statutory requirements:

- The policy regarding the treatment of accumulated balances;
- Division of funds between narrow and wide range investments as defined in the Trustees Investment Act 1961 (amended 1995); and
- Agreements of the Trustees after considering any advice received from the Trustees Investment managers.

APPENDIX 1
Scheme of Delegation

Delegated Issue and Scope of Delegation	Responsible Officer	Deputy
Chair all Board meetings and associated responsibilities	Chair	Vice Chair
Risk Management	Chief Executive	Director of Finance
Demonstrate best value for money for all services	Chief Executive	Director of Finance
Disciplinary and Grievance arrangements	Chief Executive	Director of Workforce
Standards of business conduct for staff	Chief Executive	Director of Workforce
Register of Interests - Members - Staff	Chief Executive Chief Executive	Director of Planning and Corporate Resources Director of Workforce
Approve and sign all legal documents which will be necessary in legal proceedings related to staff	Chief Executive	Director of Workforce
Complaints	Chief Executive	Director of Planning and Corporate Resources
Freedom of Information	Chief Executive	Director of Digital
Educational Quality Assurance Systems	Chief Executive	Director of Medicine
Operation of all detailed financial matters including bank accounts and banking procedures.	Director of Finance	Head of Finance
Implementing the Board's financial policies and co-ordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented	Director of Finance	Head of Finance
Delegation of budgets and approval to spend funds within delegated limits	Chief Executive	Director of Finance
Recording and monitoring of payments under the	Director of Finance	Head of Finance

Delegated Issue and Scope of Delegation	Responsible Officer	Deputy
losses and compensation regulations		
Procedures for the procurement, ordering and receipt of goods	Director of Finance	Principal Lead, Procurement
Payment of staff	Director of Finance	Head of Finance
Procedures for the payment of travel, subsistence, study course and other expenses	Director of Finance	Head of Finance
Procedures for the payment of accounts	Director of Finance	Head of Finance
Management of Non-Exchequer funds	Director of Finance	Head of Finance
Liaison with Internal Audit service	Director of Finance	Head of Finance
Issuing Tenders	Director of Finance	Principal Lead Procurement
Receiving and Opening of Tenders	Director of Finance	Authorised personnel
Devise and maintain systems of budgetary control	Director of Finance	Principal Lead, Finance Business Partnering (FBP)
Annual Accounts and reports	Director of Finance	Head of Finance
Banking Arrangements	Director of Finance	Head of Finance
Risk Management Processes	Director of Finance	Head of Planning and Performance
Management and control of computer systems and facilities including data protection	Director of Digital	Principal Lead for Corporate Digital
Investigate any suspected cases of fraud and other irregularity	Director of Finance	Counter Fraud Services

Delegated Issue and Scope of Delegation	Responsible Officer	Deputy
Review, appraise and report in accordance with NHS Internal Audit Manual and best practice	Chief Internal Auditor	
Information Governance	Director of Digital	Principal Lead for Corporate Digital
Caldicott Guardianship	Director of Medicine	Deputy Director of Medicine
HR Management	Director of Workforce	Depute Director of HR
Procedures for employment of staff	Director of Workforce	Depute Director of HR
Leave: annual, compassionate, special leave and leave without pay.	Director of Workforce	Depute Director of HR
Grievance and disciplinary procedures for staff	Director of Workforce	Depute Director of HR
Health and Safety arrangements	Director of Workforce	Depute Director of HR
Responsible for security of the Board's property, avoiding loss, exercising economy and efficiency in using resources and conforming Standing Orders, Financial Instructions and Procedures.	All members and employees of NES.	

APPENDIX 2a:
Records Retention Schedule

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
General				
G001	General	Meeting papers - External	Current year + 1year – Destroy (May be retained longer but for reference needs only. Not to be retained as a NES record.)	Originals available from meeting administrator if required
G002	General	Meeting papers - Administered by the Directorate	Cy + 5 years – Destroy (For NES administered meetings, a master set of the minutes and papers should be retained by the directorate/team who administer the meeting. Where possible these should be stored electronically in a shared space.)	Prescription and Limitation (Scotland) Act 1973.
G003	General	Meeting papers - Internal - not administered by the Directorate	Destroy after meeting or when no longer required for immediate requirements.	Originals available from meeting administrator or Intranet if required
G004	General	General official correspondence files (Only significant business correspondence should be held on file. Circulars, invitations etc. should be destroyed when no longer required)	Current year + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973.
G005	General	NES Policy/procedure documents	Superseded + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973. Business requirement
G006	General	NES Policy development files	Current year + 5 years – Destroy. (Select most significant policy files for possible transfer to The National Archives in co-operation with the Corporate Records Manager.)	Prescription and Limitation (Scotland) Act 1973.
G007	General	Copy financial records.	Current year + 1year - Destroy	Originals with Finance.
G008	General	Copy travel claims	Current year + 1year - Destroy	Originals with Finance.
G009	General	Procurement tenders	Award of contract + 6 years - Destroy	Standing Financial Instructions.

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
G010	General	E-mails forming part of another significant record or file.	As per the retention schedule for that record, activity or file.	
G010	General	E-mails of ephemeral value	Delete as soon as no longer required.	
G012	General	Litigation/tribunal/formal complaint files	10 years after last action - Destroy	Significantly increased risk of follow-up action or litigation. Data Protection Act 1998. Scots Law Society practice.
G013	General	MP/MSP enquiries	10 years - Destroy	Business use. Significantly increased risk of follow-up action.
G014	General	Copies of external (non-NES) reports and publications.	While in current use - Destroy	Can be obtained again from original source. (**NOTE:** Storage on the network of electronic copies of third-party publications without permission may be in breach of copyright.)
Dental Directorate				
D001	Dental Training - Vocational Trainees –	Vocational Trainee files including**:**	Duration of VT + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D002	Dental Training - Vocational Trainees	Copy of contract	Duration of VT + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D003	Dental Training - Vocational Trainees	Copy of practice visit forms	Duration of VT + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D004	Dental Training - Vocational Trainees	Education agreement	Duration of VT + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D005	Dental Training - Vocational Trainees	Monthly absence returns	Duration of VT + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D006	Dental Training - Vocational Trainees	Copies of certificates	Duration of VT + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
D007	Dental Training - Vocational Trainees	Copies of audit	Duration of VT + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D008	Dental Training - Vocational Trainees	Copy of project	Duration of VT + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D009	Dental Training - Vocational Trainees	Claims correspondence	Duration of VT + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D010	Dental training – Vocational Trainees	Vocational Trainee files – Trainees with difficulties/ complaints. (VDP/Hospital)	Last action + 10 years - Destroy	Increased risk of legal action. Data Protection Act 1998. Law Society guidance.
D011	Dental Training - Vocational Trainees	Record of Progress and Achievement (paper file until Aug 2007)	Transfer to trainee at end of programme	Portfolio is 'property' of trainee. Where NES is holding on trainee's behalf, this should be transferred on completion of VDT.
D012	Dental Training - Vocational Trainees	Record of Progress and Achievement (e-portfolio)	Duration of VT + 5 years – Destroy	Trainee may download their own copies at any point. 5-year period covers first GDC CPD cycle.
D020	Dental – HQ	Dental equivalence committee papers	5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D021	Dental- HQ	Dental Dashboard university data	Current + 1 year - Destroy	Cleanse superseded data on annual upload of new data.
D030	Dental training - Dental nurses	Dental nurse portfolio - paper	Transfer to trainee at end of programme	Portfolio is 'property' of trainee
D031	Dental training - Dental nurses	Trainee files	Duration of training + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D040	Dental training – Trainers	Trainer files (including applications, qualifications,	6 years after training role ends – Destroy	HR practice

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
		accreditation, contracts, correspondence)		
D050	Dental training - Administration	Section 63 course files	Current year + 5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D051	Dental training - Administration	Training course files	Current year + 5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D052	Dental training - Administration	Vocational Training practice files	Current year + 5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D053	Dental training – Administration	Determination X Applications	Current year + 3 years - Destroy	Cycle of Dental Practice approval.
D060	General Dental Practitioner - CPD course administration	Request for overnight accommodation	1 year after event - Destroy	In case of queries
D061	General Dental Practitioner - CPD course administration	Approved courses	Current year + 5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D062	General Dental Practitioner - CPD course administration	Signed registers	Delete once data is entered on Pinnacle database.	Pinnacle becomes principal record.
D063	General Dental Practitioner - CPD course administration	Course evaluation form	1 year after event - Destroy	In case of queries. Statistical data captured.
D064	General Dental Practitioner - CPD course administration	Lecturer evaluation forms	1 year after event - Destroy	In case of queries. Statistical data captured.
D065	General Dental Practitioner - CPD course administration	Speakers contracts - annual	Current year + 5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D066	General Dental Practitioner - CPD course administration	Course information	Current year + 5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
D067	General Dental Practitioner - CPD course administration	Speaker correspondence	Current year + 5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D068	General Dental Practitioner - CPD course administration	Course attendee's info	Current year + 5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D069	General Dental Practitioner - CPD course administration	Equal Opps Monitoring forms	Current year + 1 year – Destroy	Data captured for statistical purposes. No requirement for individual forms.
D070	Continuing Education Programmes	As for CPD above.		
D080	Dental clinical audit	SEA form GP216/ audit and SEA	Returned to Practitioners – Not retained by NES	Practitioners are responsible for maintaining their own records.
D081	Dental clinical audit	Audit Reports/SEA report and minutes	Returned to Practitioners – Not retained by NES	Practitioners are responsible for maintaining their own records.
D090	Dental - Hospital Training	Trainee files - SHO	End of training + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D091	Dental - Hospital Training	Trainee files – SPR	End of training + 5 years – Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D092	Dental - Hospital Training	Specialist Training Committees - minutes and papers	Current year + 5 years - Destroy	GDC CPD cycle, Prescription and Limitation (Scotland) Act 1973
D093	Dental - Hospital Training	Recruitment files - SHOs, SPRs	1 year – Destroy	In case of queries. Main record with employing Board
D100	Dental VT recruitment	Unsuccessful applications	End of recruitment + 1 year - Destroy	HR practice. Data Protection Act 1998
D101	Dental VT recruitment	Successful applications	Transfer to Health Board. Retain copy for 1 year – Destroy	HR practice. Data Protection Act 1998

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
D111	Dental Assessment	Assessments – electronic record.	15 years- Destroy	For research and predictive validity. (To be reviewed.)
Finance and Corporate Resources Directorate				
F001	Purchase and payment	Original invoices receivable - Debtors	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28. HM Customs & Excise
F002	Purchase and payment	Original invoices payable - Creditors	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28. HM Customs & Excise
F003	Purchase and payment	Copy invoices	End of Financial Year + 1 year - Destroy	Business use
F004	Purchase and payment	Purchase orders	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28
F005	Purchase and payment	Purchase order database	End of Financial Year + 6 years - Delete time-expired records from database	Business use
F010	Funds receivable	Original invoices receivable - Debtors	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28. HM Customs & Excise
F012	Funds receivable	Income sheets	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28
F020	Financial control	General Ledger	End of Financial Year + 6 years - Delete time-expired records from database	NHS HDL (2006) 28
F021	Financial control	General Ledger - reports	End of Financial Year + 6 years - Destroy	Business use
F022	Financial control	General Ledger prints - initialled	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28
F023	Financial control	Budget monitoring reports	End of Financial Year + 3 years - Destroy	NHS HDL (2006) 28
F024	Financial control	Financial plans, estimates and recovery plans	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28
F025	Financial control	Costings	End of Financial Year + 6 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F030	Financial claims administration	Study Leave Trainee Application Form	End of Financial Year + 6 years - Destroy	Business Use
F031	Financial claims administration	Study Leave Trainee Claim Form	End of Financial Year + 6 years - Destroy	Business Use
F032	Financial claims administration	Study Trainee claim receipts	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
F033	Financial claims administration	Primary Care Claim Forms	End of Financial Year + 3 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F040	Banking	Cheque counterfoils	Completion of audit + 3 years - Destroy	NHS HDL (2006) 28
F041	Banking	Bank statements	Completion of audit + 3 years - Destroy	NHS HDL (2006) 28
F050	Procurement	Signed contracts and arrangements	End of contract + 6 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F051	Procurement	Tenders (accepted and unaccepted)	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28
F052	Procurement	Invitation to Tender	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28
F053	Procurement	Service Level Agreement with supplier	End of Financial Year + 6 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F054	Procurement	Tender evaluation matrix	End of Financial Year + 6 years - Destroy	Standing Financial Instructions
F055	Procurement	Contracts database	Delete life expired records from database	Business use
F056	Procurement	Procurement review - ledger print	Review + 1 year – Destroy	Useful for auditors although not a primary record
F057	Procurement	Procurement review - ledger spreadsheets	Review + 6 years - Destroy	Useful for reference although not a primary record
F060	Audit	Internal Audit Reports	End of Financial Year + 6 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F061	Audit	External Audit Reports	End of Financial Year + 6 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F070	Taxation	VAT returns	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28. HM Customs & Excise
F081	Accountability	SFR returns	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
F082	Accountability	Scottish Government returns	End of Financial Year + 6 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F083	Accountability	Statutory Accounts (Signed copy)	End of Financial Year + 6 years - Destroy	NHS HDL (2006) 28
F084	Accountability	Working papers for audit of Annual Accounts	End of Financial Year + 10 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F090	Payroll	Fiche copy of payroll	End of Financial Year + 10 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F091	Payroll	Manual files	End of Financial Year + 6 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F092	Payroll	Record of unpaid salaries and wages	End of Financial Year End of Financial Year + 6 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F093	Payroll	Staff returns and supporting records	End of Financial Year + 2 years - Destroy	Business Use - NES Standing Financial Instructions (Oct 2006)
F100	Risk Management	Corporate Risk Register	Superseded + 10 years – Destroy	Business value
F101	Risk Management	Departmental Risk Register	Superseded + 6 years - Destroy	Business value
F102	Risk Management	Management of Risk 'Champion' Files	1 year - Destroy	Business need
F103	Risk Management	Risk Register supporting correspondence and minutes	3 years - Destroy	Business need
F110	Communications	Press releases	Permanent	Historical value
F111	Communications	Media enquiries	3 years - destroy	Business use
F112	Communications	NES Publications	Permanent	Historical value
F113	Communications	Events file	18 months	Business use
F114	Communications	Publications files	3 years	Business use
F115	Communications	Publications	Copies of each publication to be sent to the Deposit Libraries and e-Library. Stocks retained while	Legal Deposit Libraries Act 2003

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
			current. Sample kept for 5 years after current - Destroy	
F120	Board administration	Board minutes - signed	Permanent – Transferred to National Archives of Scotland	NHS HDL (2006) 28
F121	Board administration	Board minutes - electronic	Permanent	Business value
F122	Board administration	Board papers - master set	Permanent – Transferred to National Archives of Scotland	NHS HDL (2006) 28
F123	Board administration	Board papers - electronic	Permanent	Business value
F130	Committee Administration	Committee minutes - signed	Permanent	NHS HDL (2006) 28
F131	Committee Administration	Committee minutes - electronic	Permanent	Business value
F132	Committee Administration	Committee Papers - master set	Permanent	NHS HDL (2006) 28
F133	Committee Administration	Committee papers - electronic set	Permanent	Business value
F140	Senior Management administration	SMT/Business Group minutes	Permanent	NHS HDL (2006) 28
F141	Senior Management administration	SMT/Business Group papers	Permanent	NHS HDL (2006) 28
F150	Board/Comm/SM administration	Event/Away-Day files	1 year	Business value
F151	Board/Comm/SM administration	Standing orders	Permanent	Business value
F152	Board/Comm/SM administration	Correspondence	3 years	Business value
F153	Board/Comm/SM administration	Board/Committee membership correspondence	Permanent	NHS HDL (2006) 28
F160	Senior management	Directorate Executive/Management teams' minutes and papers	10 years	Business value

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
F170	Office Services	Property files	Permanent	NHS HDL (2006) 28
F171	Office Services	Fit-out works files	Current + 10 years - Destroy	Business value
F172	Office Services	Accommodation issues files	Current + 10 years - Destroy	Business value
F173	Office Services	Environmental management files	Current + 10 years - Destroy	Business value
F174	Office Services	Health and Safety/Security procedure files	Current + 10 years - Destroy	NHS HDL (2006) 28
F180	Knowledge Services Group/e-library	Awaiting survey		
F190	Information Management and Technology	Systems development records	Lifetime of system + 5 years – Destroy	Joint Information Systems Committee
F191	Information Management and Technology	Systems development records – system not implemented	Last action + 5 years – Destroy	Joint Information Systems Committee
F192	Information Management and Technology	ICT Project Management	End of project + 5 years – Destroy	Joint Information Systems Committee
F193	Information Management and Technology	ICT Strategy	Superseded + 5 years - Destroy	Joint Information Systems Committee
F194	Information Management and Technology	Software licenses	Lifetime of use of software – Destroy	Joint Information Systems Committee
F195	Information Management and Technology	User requests/fault reporting	Last action + 1 Year – Destroy	Joint Information Systems Committee
F196	Information Management and Technology	Routine network management	Current year + 1 year - Destroy	Joint Information Systems Committee
F197	Information Management and Technology	Routine system testing/monitoring	Current year + 1 year - Destroy	Joint Information Systems Committee

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
F198	Information Management and Technology	Security /Acceptable Use breach evidence and actions	Last action + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973.
Human Resources Directorate				
H001	Employee administration	Personnel Files – Central HR file (Contains letters of application and appointment; confirmation of qualifications; contracts; joining forms; references; correspondence; termination form)	End of service + 6 years - Destroy	NHS HDL (2006) 28
H002	Employee administration	Personnel Files - Regional copy. (Contains letters of application and appointment; confirmation of qualifications; contracts; joining forms; references; correspondence; termination form)	End of service – Destroy immediately	Duplicate of central record
H003	Employee administration	Timesheets/Clock cards	2 years - Destroy	NHS HDL (2006) 28
H004	Employee administration	Annual leave records	2 years - Destroy	NHS HDL (2006) 28
H005	Employee administration	Summary information (e.g. name, NI number, dates of service, position) (Core data from Workforce database.)	70th birthday of employee - Destroy	Records Management: NHS Code of Practice. In case of pension disputes. (Review once shared services central database in use.)
H010	Staff governance - Discipline	First written warning	6 months - Destroy	NHS HDL (2006) 28
H011	Staff governance - Discipline	Final written warning	12 months - Destroy	NHS HDL (2006) 28
H012	Staff governance - Discipline	Letter of dismissal	End of service + 10 years - Destroy	NHS HDL (2006) 28

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
H013	Staff governance - Grievance	Grievance records	Conclusion of grievance or end of services + 6 years - Destroy	Limitations Act
H020	Recruitment	Applications - unsuccessful	Completion of recruitment + 1 year - Destroy	NHS HDL (2006) 28
H021	Recruitment	Applications - successful	See Personnel files above	
H022	Recruitment	CVs for non-executive directors - successful applicants	End of service + 5 years - Destroy	NHS HDL (2006) 28
H023	Recruitment	CVs for non-executive directors - unsuccessful applicants	Completion of recruitment + 2 years - Destroy	NHS HDL (2006) 28
	Payroll - see Financial Administration			
Medical Directorate				
M001	Medical training	Trainee portfolios - electronic	5 years after end of training programme- Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M002	Medical training	Trainee portfolios - paper	Transfer to candidate at end of training	
M003	Medical training	Pinnacle database	Retain core events for career - FY2 + 40 years. Strip out other data after 5 years	Core career record. Data Protection Act 1998
M004	Medical training	Doctors Online Teaching System (DOTS)	Delete data after 5 years	Business value. Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period. Data Protection Act 1998
M005	Medical training	Recruitment	Completion of recruitment + 1 year - Destroy	In case of queries. Data Protection Act 1998. MTAS guidance. (Successful applicants details transferred to form part of their record.)
M006	Medical training – All areas	Trainee records – Trainees with difficulties or formal complaints	Destroy 10 years after last action	Significantly increased risk of follow-up action or litigation. Data Protection Act 1998. Scots Law Society practice.

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
				(Overrides normal retention of 5 years after training ends.)
M010	Medical training - Hospital	Training post Start Form	3 years - Destroy	Business value
M011	Medical training - Hospital	Training post Termination Forms	3 years - Destroy	Business value
M012	Medical training - Hospital	Contract Structures	3 years - Destroy	Business value
M013	Medical training - Hospital	SHO files	End of training + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M014	Medical training - Hospital	SPR files	End of training + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M020	Medical training - Foundation	Certificate of Performance	End of FY2 + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M021	Medical training - Foundation	RITA (Record of In-Training Assessment	End of FY2 + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M022	Medical training - Foundation	Significant Event Analysis	End of FY2 + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M023	Medical training - Foundation	Educational Log	End of FY2 + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
M024	Medical training - Foundation	Work based assessment	End of FY2 + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M025	Medical training - Foundation	Multi-source feedback	End of FY2 + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M026	Medical training - Foundation	Certificate of Satisfactory Service	40 years - Destroy	Requested by overseas employers.
M027	Medical training - Foundation	Trainee assessments of post and trainer	End of FY2 + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M028	Medical training - Foundation	Record of Progress	End of FY2 + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M029	Medical training - Foundation	Trainee files - paper based. (Including: Records of discussion form; General correspondence; E-mails; RITA section; Study leave claims; CVs; Application forms; References; Appointment to Unit; Copies of sick lines.	End of FY2 + 5 years – Destroy **OR if trainee continues to specialist training** Transfer to Specialist Trainee file	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M040	Medical Training	Trainer courses/workshops	1 year - Destroy	For local reference.
M041	Medical Training	Trainer/Tutor files (including General correspondence, Approval, Annual reports, Offers of training posts)	End of contract as trainer + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
M042	Medical Training	Rotations files	5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period. Existing practice.
M043	Medical Training	Royal Colleges/PMetB Hospital Visits	5 years - Destroy	5-year visit cycle. Prescription and Limitation (Scotland) Act 1973 (as amended).
M044	Medical Training	PMETB Deanery Visit records	5 years - Destroy	5-year visit cycle. Prescription and Limitation (Scotland) Act 1973 (as amended).
M050	GP Training	GP Training Practice Visits	Retain until accredited - Destroy	Organisational value.
M051	GP Training	GP Training Practice/Trainer file. (Including: Approval; Appointments to training posts; Visits; Reports; General Correspondence.)	End of role as Training Practice + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended), GMC FTP, Revalidation period
M052	GP Training	GP Registrar/Trainee files	End of training + 2 years - Destroy	Organisational value
M053	GP Training	Summative Assessment (successful)	3 years – Destroy	National Office of Summative Assessment protocol
M054	GP Training	Summative Assessment (incomplete or unsuccessful)	5 years – Destroy	National Office of Summative Assessment protocol
M055	GP Training	COGPED audits	3 years – Review	National Office of Summative Assessment protocol.
M056	GP Training	Training practices - problem trainees	Destroy 10 years after last action	Significantly increased risk of follow-up action or litigation.

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
				Data Protection Act 1998. Scots Law Society practice.
M057	GP Training	Poorly performing doctors	Destroy 10 years after last action	Significantly increased risk of follow-up action or litigation. Data Protection Act 1998. Scots Law Society practice.
M058	GP Training	GP CPD database	Delete records 5 years after current	CPD Revalidation period. Prescription and Limitation (Scotland) Act 1973 (as amended). DP Act 1998.
M059	GP Training	GP CPD forms	1 year - Destroy	In case of queries. Data Protection Act 1998.
M060	GP Training	Retainer scheme files	5 years - Destroy	GMC Revalidation period. Prescription and Limitation (Scotland) Act 1973 (as amended). Data Protection Act 1998.
M070	Medical training - Study leave	Study leave applications (yellow copy)	Current year + 1 - Destroy	Can be retrieved from Finance if required.
M071	Medical training - Study leave	Study leave applications (pink copy)	Current year + 6 - Destroy	Financial audit. (Retained by Finance)
M072	Medical training - Study leave	Study leave claims and receipts	Current year + 6 - Destroy	Financial audit
M080	Medical training - CPD course administration	Course database - Details of participants and courses attended.	Delete records after 5 years	CPD Revalidation period. Prescription and Limitation (Scotland) Act 1973 (as amended). DP Act 1998. Payment details (such as credit card numbers) removed after training event
M081	Medical training - CPD course administration	Booking forms	1 year - Destroy	Data Protection Act 1998
M082	Medical training - CPD course administration	Course administration records. (Inc: correspondence, fees, bank	2 years - Destroy	For local reference

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
		details of presenters, presentations/handouts (paper copies of handouts destroyed after course).		
M083	Medical training – CPD course administration	Attendance registers	5 years - Destroy	CPD Revalidation period. May require to provide proof of attendance.
M090	GP appraisal	Appraiser file (including:) Acceptance form, Credibility statements, Shortlisting notes, CVs, Training outcome summary note, Yearly performance management appraisal.	Destroy 5 years after individual cease to be an appraiser.	GMC Revalidation period. Prescription and Limitation (Scotland) Act 1973 (as amended). Data Protection Act 1998.
M091	GP appraisal	Withdrawn and unsuccessful applications to be appraisers	3 years - Destroy.	In case of queries or reapplication. Data Protection Act 1998.
M092	GP appraisal	Applications database	Delete records after 20 years.	Basic information only. Historical statistical and audit.
M093	GP appraisal	Scottish Online Appraisal resource database	Delete records after 20 years	Basic information only. Historical statistical and audit. Appraisal information not held by NES.
M094	GP appraisal	Documents generated for appraisal Process (GP Scot forms)	Held by employing board, appraiser and appraisee Not held by NES.	
M095	GP appraisal	Feedback on appraisals	5 years - Destroy	GMC Revalidation period. Prescription and Limitation (Scotland) Act 1973 (as amended). Data Protection Act 1998.
M100	Medical - HQ	Medical Advisory Group	10 years - Destroy	Organisational value
M101	Medical - HQ	Transitional Boards	5 years - Destroy	Organisational value

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
M102	Medical - HQ	Specialist Committees - minutes and correspondence	10 years - Destroy	Organisational value
Nursing, Midwifery and Allied Health Professionals Directorate				
N001	NMAHP – CATCH	Successful course applications	Pass to HEI if required. If not, destroy after 6 months.	Data Protection Act 1998. HEI has records.
N002	NMAHP – CATCH	Unsuccessful course applications	18 months - Destroy	In case of queries or challenges
N003	NMAHP – CATCH	Database - 2 years after current	Current + 2 years - Delete record	Data Protection Act 1998.
N004	NMAHP – CATCH	Statistical returns	10 years - Destroy	Reference use.
N005	NMAHP – CATCH	Application files – Complaints, disciplinary or fraud cases	Last action + 10 years - Destroy	Significantly increased risk of follow-up action or litigation. Data Protection Act 1998. Scots Law Society practice.
N010	NMAHP - Chaplaincy	Organisation/policy files	Current + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973.
N011	NMAHP - Chaplaincy	Spiritual Care Policies	Until superseded - Destroy	Originals held by Boards.
N012	NMAHP - Chaplaincy	Chaplain Database	Remove non-current records on an annual basis.	Data Protection Act 1998.
N013	NMAHP - Chaplaincy	Subject reference folders	Current - for reference use. Weed	Not records. Reference value only.
N014	NMAHP - Chaplaincy	Events files	2 years - Destroy	In case of queries and to assist future events.
N015	NMAHP - Chaplaincy	Data entry forms	1 year - Destroy	In case of queries
N020	NMAHP - SMMDP	Trainer details - Paper copy	Current + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 (as amended.). Data Protection Act 1998
N021	NMAHP - SMMDP	Candidates details - Paper copy	Current year + 3 years - Destroy	Data Protection Act 1998. 3-year currency of training. 3-

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
				year NMC and Paramedic CPD cycle.
N022	NMAHP – SMMDP	Database - courses and candidates	Remove personal details 4 years after last contact	Data Protection Act 1998.
N023	NMAHP – SMMDP	Contact list - Lead Midwifes	While Current. Weed out superseded entries.	Data Protection Act 1998.
N024	NMAHP – SMMDP	Course files - Course attendance	Current year + 3 years - Destroy	Data Protection Act 1998. 3-year currency of training. 3-year NMC and Paramedic CPD cycle.
N030	NMAHP - Publications	Publications	Copies of each publication to be sent to the Deposit Libraries and e-Library. Stocks retained while current. Sample kept for 5 years after current - Destroy	Legal Deposit Libraries Act 2003
N040	NMAHP - Project Management	Project files	Life of project + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973.
N041	NMAHP - Project Management	Original contracts	Held by Finance	Audit. Standing Financial Instructions.
N042	NMAHP - Project Management	Original tenders.	Award of contract + 6 years	Audit. Standing Financial Instructions.
N043	NMAHP	Data entry forms	Current + 1 year - Destroy	In case of queries
N044	NMAHP	Student records database	Remove personal data 3 years after current. (**To be reviewed.)**	Data Protection Act 1998. Data required for statistical purposes by SGHD. NMC 3-year registration cycle. NMC retain full records for all registered nurses.
N045	NMAHP	Healthcare Associated Infection course records	Current + 3 years - Destroy	Data Protection Act 1998. Data required for statistical purposes by SGHD.
N046	NMAHP	Registration forms	Current + 1 year - Destroy	In case of queries
N047	NMAHP	Healthcare Associated Infection course records	Current + 3 years - Destroy	DP Act 1998. Required for statistical purposes by SGHD.

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
Pharmacy Directorate				
P001	Pharmacy Training administration	Pharmacists database	Delete records 3 years after last contact	Data Protection Act 1998. Business value.
P002	Pharmacy Training administration	Application forms for programmes	End of current year - Destroy	Data is captured to database.
P003	Pharmacy Training administration	Completed register (returned by tutor)	3 years - Destroy	Data Protection Act 1998. Business value.
P004	Pharmacy Training administration	Q&A sheets returned by students	Current year + 6 months - Destroy	In case of queries after annual letter issued.
P005	Pharmacy Training administration	Distance learning - MCQs	Sample set for 5 years	Prescription and Limitation (Scotland) Act 1973.
P006	Pharmacy Training administration	Reminder letters	1 year - Destroy	In case of queries.
P007	Pharmacy Training administration	Completed course appraisals	Destroy after data-entry	Original forms not required after data entry.
P008	Pharmacy Training administration	Procedure documents	Superseded + 5 years	Prescription and Limitation (Scotland) Act 1973.
Psychology Directorate				
S101	Psychology HQ	HEI Course information	Current + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973.
S102	Psychology HQ	Project files	End of Project + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973.
S103	Psychology HQ	Training officer contracts	End of service + 6 years - Destroy	NHS HDL (2006) 28. HR practice.
S201	Training Office	Records of recruitment and selection of trainees	End of recruitment cycle + 1 year - Destroy	NHS HDL (2006) 28. HR practice. In case of query. HEI and employers hold record of successful applicants.
S202	Training Office	Selection process review records.	Review + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973.
S203	Training Office	Feedback forms	1 year - Destroy	For reference.
S204	Training Office	Event files.	Event + 2 years - Destroy	For reference and use of precedent in future events.

Reference	Directorate/Activity	Records Series	Retention/Disposal	Drivers/Notes
Research function				
R001	Research activity	Primary research records	10 years - Destroy	Quality Assurance. JISC Guide to Managing Research Records. Note – Discretion should be used to identify high value records worthy of 10-year retention.
R002	Research activity	Research results and reports	10 years - Destroy	Reference value. Note – Copies of formally published reports must be placed with the statutory deposit libraries. See NES Information Governance Guidance 5.

APPENDIX 2b
Generic Records Retention Schedule

This summary schedule gathers the main functional retention periods which underpin the more detailed corporate schedule. It is intended to give guidance in cases where there are gaps in the fuller corporate schedule.

Function	Examples of records	Retention	Drivers
Project/programme management	Minutes of project meetings; Correspondence;	5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 as amended.
Research management	Correspondence, minutes of programme meetings, questionnaires, literature searches, draft reports	5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 as amended. Publications should be deposited with legal deposit libraries and the NES eLibrary.
Financial management	Invoices, ledgers, accounts	Current financial year + 6 years - Destroy	Taxes Management Act 1970, HMCE guidance, audit
Contract Management	Successful tenders, signed contracts	6 years - Destroy	Taxes Management Act 1970, HMCE guidance, audit
Personnel management	Personal files	Termination of employment + 6 years - Destroy	Taxes Management Act 1970, Data Protection Act 1998
Recruitment	Unsuccessful applications	1 year - Destroy	Data Protection Act 1998
Education governance and quality assurance of education	Correspondence, accreditation visits, course approvals	Current + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 as amended. 5-year CPD/registration cycle for GDC and GMC. 3-year CPD/registration cycle for NMC.
Delivery of education	Course content, records of application and attendance, trainee correspondence, successful applications for training.	Current + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 as amended. 5-year CPD/registration cycle for GDC and GMC. 3-year CPD/registration cycle for NMC.
Administration	General correspondence	Current + 5 years - Destroy	Prescription and Limitation (Scotland) Act 1973 as amended.

	Ephemeral emails	Delete as soon as no longer required	Corporate requirements.
Policy development	Final policy documents, key policy discussion records	Superseded + 10 years	Corporate requirements.
Meetings management	External meetings minutes and papers	Until actions completed - Destroy	Records kept by organiser of meeting
	NES meetings - minutes and papers	Organiser - Retain 5 years - Destroy	Records kept by organiser of meeting
		Other recipients - Until actions completed - Destroy	Records kept by organiser of meeting
	Main set of Board Minutes and papers	Transfer to The National Archives for permanent preservation	Public Records (Scotland) Acts

NES **NES/20/11**
Item 9g
January 2020

NHS Education for Scotland

Board Paper Summary: Finance and Performance Management Committee Minutes

1. Title of Paper

Unconfirmed minutes of the Finance and Performance Management Committee meeting held on 21st November 2019: copy attached.

2. Author(s) of Paper

Jenn Allison, Senior Officer

3. Purpose of Paper

To receive and note the unconfirmed minutes of the meeting of the Finance and Performance Management Committee meeting held on 21st November 2019.

4. Items for Noting

Item 7 – Finance Report

The Committee noted the Finance Report and agreed with the proposal to reallocate the underspend which has developed in the core NES budget before it is used to further reduce the Training Grade deficit.

Item 8 – Performance Management Report

Members noted the report and were satisfied that sufficient controls are in place to manage the performance of NES.

Item 9 – Operational and Financial Planning Update

Members noted progress of Operational and Financial Planning for 2020/21.

Item 10 – Procurement Report

Members noted and were satisfied with the current and planned procurement activity.

Item 11 – OPIP Report

The Committee noted the ongoing performance improvement developments taking place in NES and the new report format.

Item 12 – FPMC Remit

The Committee approved the remit subject to agreed minor amendments.

5. Recommendations

None.

NES
January 2020
JA

NHS Education for Scotland

FINANCE AND PERFORMANCE MANAGEMENT COMMITTEE

Minutes of the Finance and Performance Management Committee meeting held on Thursday 21 November 2019 at Westport, Edinburgh.

Present:	David Garbutt, NES Chair, FPMC Chair Douglas Hutchens, Non-Executive Director Liz Ford, Employee Director
In attendance:	Donald Cameron, Director of Planning & Corporate Resources/Lead Officer Audrey McColl, Director of Finance/Lead Officer Stewart Irvine, Acting Chief Executive Kenny McLean, Head of Procurement Jenn Allison, Senior Officer

1. Chair's welcome and introduction

David Garbutt welcomed everyone to the meeting.

2. Apologies for absence

Apologies were received from Jean Ford, Non- Executive Director and Caroline Lamb, Chief Executive.

3. Minutes of the previous meeting held on 22 Aug 2019 (NES/FPM/19/30)

The minutes of the previous meeting were approved as a correct record. **Action: JA**

4. Action list from previous meeting held on 22 Aug 2019 (NES/FPM/19/31)

Members noted that all the action points had been completed or were in hand.

5. Matters arising from the minutes

A member requested that more consistency is applied to the completion of cover papers to ensure each section is completed and noted not applicable where appropriate.

Action: JA

6. Declarations of Interests

There were no declarations of interests.

Business Matters

7. Finance Report (NES/FPM/19/33)

Audrey McColl introduced a paper presenting the financial results for the seven months to 31st October 2019 and to indicate the anticipated forecast outturn as at 31 March 2020. The following was highlighted:

- NES's original baseline budget for 2019/20 was £439.2m. For NES to produce a balanced budget, the Scottish Government agreed to underwrite £4.9m in relation to the historic recurrent deficit on Medical Training grades. The rest of the NES budget was awarded no uplift and Finance Managers have been monitoring these two elements of funding separately.

- The current underspend on Medical Training Grades is £2.3m which will reduce the amount of funding required from the Scottish Government to £2.6m.

- An underspend of £0.8m is currently forecast across the other elements of the NES budget. Directorates, who contributed £1.1m towards the Training Grade funding Gap when the 2019/20 budget was set, have been asked to submit bids for additional spend which will help to deliver the NES agreed strategic objectives and priorities. Draft submissions for the 2020/21 budget will also be reviewed to identify any planned expenditure which could potentially be brought forward into 2019/20. If at the year-end, there is any surplus remaining this could be used to further reduce the deficit funding required from Scottish Government for medical training grades. The F&PM Committee confirmed their approval of this approach.

- A recruitment lag saving of £1.5m has been allocated to directorates to allow greater control and ownership. To date £1.3m has been realised, although this achievement does not reflect the anticipated split across directorates. It is currently forecast that this target will be met in full, but it is likely that the target will be exceeded.

- Scottish Government have not yet formally agreed future funding for the National Digital Service (NDS).

The following was discussed:

- A member raised a query about the deficit in relation to Training Grades and Audrey McColl assured the Committee that an underwriting agreement is in place with Scottish Government for 2019/20 and will therefore not affect the deficit. Table 4 will be updated to clarify this before submission to the Board.

  Action: AMcC

- Stewart Irvine informed the Committee that there could be an increase of up to 30% in Training Grade applicants from overseas next year, which could have budget

implications in relation to recruitment lag. Members requested that a presentation regarding Training Grade posts is arranged for a Board Planning day. **Action: SI**

- A member queried if the projected underspend of £0.8million would be reported to the Board. Audrey McColl assured members that the underspend and the key components of how it had been utilised would be reported to the Board. Audrey explained that under current agreed governance arrangements any single item of expenditure over £500k would be submitted to the Board for prior approval whilst there is a delegated authority framework in place for authorisation of expenditure under this limit. Audrey McColl agreed to send a copy of the Board report where this would be discussed to Douglas Hutchens, for comment, before its submission to the Board. **Action: AMcC**

- A member asked for clarification regarding the delay to procurement of a Cloud for NDS and the impact on the NDS delivery schedule. Audrey McColl explained that NDS are currently able to use the Azure Cloud already procured by NES Digital.

- A member queried the costs of agency staff and Audrey McColl assured members that NES recruits permanent staff where possible, however due to competitive job markets in the Digital and Financial sectors in Scotland, agency staff are often required to fill posts in these fields.

The Committee noted the Finance Report and were satisfied that sufficient controls are in place to manage the NES financial position. Members agreed with the proposal to reallocate the underspend which has developed in the core NES budget before it is used to further reduce the Training Grade deficit.

8. Performance Management Report (NES/FPM/19/34)

Donald Cameron presented a paper which provided the Committee with an overview of NES's performance against the targets set out in the NES Operational Plan for the second quarter of the reporting year 2019/20. The following was noted/discussed:

- Out of the 111 priority targets, 95 are rated Green, 12 are Amber and 4 are Red. 2 of the red targets are from Medical and 2 from Workforce.

- One of the red Medical targets related to GP Returners and had previously been closed as unachievable due the decrease of applicants. However, this has now been reopened due to recruitment of 2 GP returners in post, 6 confirmed starters with a possible 2 starters in 2019. With an average of 8 participants per year it is now anticipate there will be an increase in the total number of participants by 20%. Stewart Irvine added that the GMC intend to release a survey to former doctors living in the UK who have left post within the last 5 years, to identify reasons why doctors may or may not want to return to post.

- The other red Medical target is in relation to appointment of up to 10 GP SiPS doctors, however currently only one GP remains in the SiPs scheme. This is being closely monitored and publicised widely amongst local networks.

- The two red Workforce targets relates to delivering digital skills to support the Digital Health and Care Strategy, due to delays to funding applications to Scottish Government, and Personal Review & Planning and Essential Learning Completion rates, which are being monitored closely by the Staff Governance Committee.

- In relation to the PCG Amber priority target regarding extension to the property lease for NDS, Donald informed the Committee that NES have followed due processes and delays to the extension have come from Scottish Government, who are yet to approve the business case. Property and Facilities colleagues are commencing the process to search for a longer-term solution from the period of November 2020.

- Out of a total of 562 targets, 503 are rated Green, 51 are Amber and 8 are Red.

- The Committee noted the remaining 4 red targets. One from Digital regarding a delay in recruitment of a developer for the Turas platform, one from Psychology regarding a delay to starting FBT trainees, a medical target which is a duplicate in error and a PCG target relating to arranging Annual Review which is not taking place due to delays from Scottish Government.

- In relation to the PCG target, a member commented that it seems unfair to rate a target red when delays have been out of NES's control and queried as to whether a fourth category RAG status would be suitable. Donald Cameron informed the Committee that introducing a Blue category for work that has been delayed or cancelled out with NES's control has been considered, however PCG colleagues identified this could bring about governance issues and therefore concluded RAG status options should remain as it is.

- A recent audit of performance management recommended that a verification process for the supporting documentation is conducted for a sample of the updates, to provide additional assurance that the inputs are accurate, complete and representative of the current status. Therefore, for the first time, 5% (n=11) of the priority targets were independently verified, which included reviewing meeting agendas/papers, intranet/internet content and screenshots of appropriate documentation. All the information collected verified the updates that had been provided and no changes were made.

Members noted the report and were satisfied that sufficient controls are in place to manage the performance of NES.

9. Operational and Financial Planning Update (verbal update)

Audrey McColl and Donald Cameron provided the committee with an update on Operational and Financial Planning for 2020/21. The following was noted/discussed:

- Operational Planning for 2020/21 is complete. Directorates were asked to link activities against the prioritisation framework, based on the programme for government, Cabinet Secretary priorities and NES core business.

- The draft annual operational plan is currently being drafted and is due to be submitted to Scottish Government on 13th December who will provide comments by February 2020. This will then be submitted to the Board for review and comment in January. The final version will be submitted to the March Board.

- Directorates have not been given a formal indicative budget and have been asked to submit a budget which reflects the most cost-effective way an activity can be delivered, based on the assumption of a flat baseline budget compared to 2019/20. Review meetings with finance have been scheduled for December.

- A member commented that they were pleased to see that there were some initiatives in relation to support for young people in care.

Members noted the progress of Operational and Financial Planning for 2020/21.

10. Procurement Report (NES/FPMC/19/35)

Kenny McLean presented the paper which provided the committee with an update on the procurement activity which has taken place during the second quarter of 2019/20. The following items were noted/discussed:

- The overall commitment which Procurement could directly influence for the second quarter of 2019/20 was just over £10m (of which £7.4m was placed via SLA's to other boards and training grades). Cumulative savings of £601k were identified.

- The National Health Board Procurement senior management team continue to meet monthly. A paper outlining further collaborative opportunities has been submitted to the Internal Support Services Transformation (ISST) steering board and resource funding was approved to support a more detailed investigation into the areas highlighted as opportunities (i.e. IT, educational needs, contractor spend). This resource is expected to be in place by the end of Q3.

- NES has tendered a 3-year Paramedic degree course, providing a standardised degree qualification for the whole of Scotland, provided by five Universities.

- An open tender for Executive Coaching has received 53 submissions, of which 42 have been successfully awarded a place on the new Framework. The Executive Coaching framework will continue to support national leadership priorities and national programmes, as well as providing a unique resource for NHS Scotland Boards and wider Health & Social Care Partnerships.

- The annual Procurement survey was opened to all NES staff on the 30th October. The Procurement survey gives us an opportunity to identify any areas where our stakeholders feel we could make improvements and also highlights any areas where further training and education in our processes may be required.

Following discussion, members noted and were satisfied with the current and planned procurement activity.

11. OPIP Update (NES/FPMC19/36)

Donald Cameron introduced a paper providing an update on the activities undertaken by the OPIP team. The format of the report has recently been updated.

- The main areas of work for the OPIP team continue to focus on cross-organisational projects identified by NES as priorities: SMARTER working; Properties; Unified Communications; Continuing Professional Development; Dental Outreach; and Training Programme Management.

- The OPIP team are working with colleagues in Quality Improvement (QI) to provide training improvement training for staff across NES. A member noted that a member of the QI team has been involved in a Value Management Collaborative, which is a new approach led by Healthcare Improvement Scotland, which brings cost and quality data to the point-of-care to drive sustained improvement.

- A member queried why some sections of the reporting templates were incomplete. Donald Cameron informed the committee that reports will be updated on an ongoing basis and as some of the projects are in their infancy, scoping exercises are not yet complete. He will ensure that these instances are clarified in future reports, to give assurance to the committee that project scoping exercises are underway.

The Committee noted the ongoing performance improvement developments taking place in NES and the new report format.

Items for information

12. Annual Review FPMC Remit (NES/FPMC19/37)

Donald Cameron introduced the FPMC remit for annual review. A member requested that the wording regarding performance management is strengthened.

The Committee approved the remit subject to agreed minor amendments. **Action: DC**

13. FPMC 2020/21 meeting dates (NES/FPMC19/38)

The committee noted the 2019/20 Finance and Performance Management Committee dates that have previously been approved by the Board.

14. Internal Audit Reports

a) Performance Management Reporting

The committee noted the report.

b) Medical Training Grade Management

The committee noted the report.

15. Any Other Business

There was no other business to be discussed.

14. Date of Next Meeting

The date of the next meeting has been scheduled for Wednesday 19th February 2019.

NES
November 2019
JA

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Post Graduate Medical Education & Training (PGMET): 2018-19 Training progression and outturn for doctors in training

2. Author(s) of Paper

Anne Dickson, General Manager Training Management
Prof Moya Kelly, Director of General Practice Education
Prof Clare McKenzie, Postgraduate Dean
Jean Allan, Associate Director of Medicine
Prof Rowan Parks, Acting Medical Director

3. Purpose of Paper

This paper has been prepared to provide Board members with a brief overview of progression and performance management in postgraduate medical education and training (PGMET) and to report on the training year 2018-19 output of doctors following completion of training.

4. Key Issues

1. **Structure of performance management and progression in training within approved programmes.** The Medical Directorate oversees the quality management of postgraduate medical education and training of approx. 6000 doctors in training in Scotland.
2. **Analysis of the outcomes of the Annual Review of Competency and Progression (ARCP).** In Scotland 95% of the outcomes of the ARCPs were positive/neutral, signifying that the doctors receiving these outcomes could satisfactorily progress or be put forward as having completed training.
3. **Analysis of the doctors leaving training through achievement of Certificate of Completion of Training (CCT).** 665 doctors achieved a Certificate of Completion of Training (CCT) for the training year 2018-19, allowing them to seek admission to the GP or specialist GMC register and work as GPs or Consultants.

4. **Other reasons for leaving training.** 110 doctors resigned before completion of their training programme (1.8% of doctors in training) and 12 doctors were released from training due to lack of progression (0.2% of doctors in training).

5. Educational Implications

1 It is the core business of NES and the Medical Directorate to manage and oversee doctors in GMC approved training programmes in Scotland with the objective of contributing to the future trained medical workforce for NHSScotland

2 Progression through training is the responsibility of the Scotland Deanery and is governed by adherence to GMC standards[1] and '*A Reference Guide for Postgraduate Specialty Training in the UK*'[2].

3 Doctors in training are also required to spend a minimum indicative time in training in a programme. This varies between specialties, and is determined partly by statutory provisions, and partly by GMC approved curricula. Completion of all aspects of the required curriculum to an appropriate standard and the required time in training allows the doctor to achieve a Certificate of Completion of Training (CCT) and thereby to seek admission to the relevant parts of the GMC register as a GP or Consultant.

4 The Annual Review of Competence and Progression (ARCP) is a review of how the doctor has progressed against their GMC approved training curriculum and how they have demonstrated this through completion of required assessments and examinations, as well as other professional requirements.

5 Some doctors will have more than one ARCP due to dual specialty training so the number of ARCP outcomes will be greater than the number of doctors in training. There is variation between specialty groups and level in the proportion of positive/neutral outcomes, due to the number of doctors taking time out of programme and who are on parental/sick leave.

6. Financial Implications

It is not the aim of this paper to detail the (substantial) costs of the training grade medical workforce as this has been covered in previous papers to the Board. It is to provide a view of the performance management of the training grade medical

[1] https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/promoting-excellence
[2] https://www.copmed.org.uk/gold-guide-7th-edition/the-gold-guide-7th-edition

workforce which consumes a significant proportion of the NES budget and the delivery of a trained medical resource to NHS Scotland.

7. Which of the 5 Key Areas of Focus in the NES Strategy for 2019-24 does this align to?

Theme 1 – A high quality learning and employment environment
Theme 2 – National Infrastructure to improve attraction, recruitment, training and retention
Theme 3 – Education and training for a skilled, adaptable and compassionate workforce.

8. Impact on the Quality Ambitions

Monitoring of the range of outcomes of the ARCP is one of the activities that contribute to the overall quality management of training programmes.

Adherence to the required standards and guidelines in reviewing doctors in training and their progression through their programme ensures the doctor is appropriately trained and competent and meets the requirements of the regulator in seeking admission to specialist registers allowing them to work as trained GPs and Consultants in NHSScotland.

9. Key Risks and Proposals to Mitigate the Risks

Monitoring of outcome trends and areas of concern mean that NES can focus efforts to support Scottish Government policy in delivering an effective trained workforce and work with partners/stakeholders such as the BMA, Scottish Academy of Medical Royal Colleges and Health Boards to improve quality of training and experience of doctors in approved training programmes.

This is very closely aligned to our work on recruitment and retention of doctors in training.

10. Equality and Diversity

Further work will be undertaken to look at ARCP outcomes aligned to E&D information held on Turas TPM, however as this information is voluntary the picture may be incomplete. Additional sources of information including the GMC Dashboard will be used. The Fairness in Training for All Group (FITFA) will be considering what is the best format for differential attainment information to be shared and will have oversight of any action plans emerging.

11. Health Inequalities

This report does not have any direct linkage with altering health inequalities.

12. Communications Plan

Information regarding trainees with unsatisfactory ARCP outcomes (2, 3 and 4) has already been shared with the appropriate Health Board Directors of Medical Education as per the Gold Guide. This ensures that employers are aware of those trainees who may need additional support or are being removed from training programmes.

The ARCP outcomes are submitted to the GMC who report on trends in early spring of each year.

Additionally, this report will be shared with Specialty Training Boards to consider if any actions are needed.

13. Recommendation(s) for Decision

The Board is asked to **note** and **comment** upon the attached report.

NES
January 2020

Post Graduate Medical Education & Training (PGMET): 2018-19 Training progression and outturn for doctors in training

Summary

1. It is the core business of NES and the Medical Directorate to manage and oversee doctors in GMC approved training programmes in Scotland with the objective of contributing to the future trained medical workforce for NHSScotland. The Medical Directorate oversees the quality management of postgraduate medical education and training of approx. 6000 doctors in training in Scotland.

2. Progression through training is the responsibility of the Scotland Deanery and is governed by adherence to GMC standards[1] and '*A Reference Guide for Postgraduate Specialty Training in the UK*'[2].

3. Doctors in training are also required to spend a minimum indicative time in training in a programme. This varies between specialties, and is determined partly by statutory provisions, and partly by GMC approved curricula. Completion of all aspects of the required curriculum to an appropriate standard and the required time in training allows the doctor to achieve a Certificate of Completion of Training (CCT) and thereby to seek admission to the relevant parts of the GMC register as a GP or Consultant.

4. The Annual Review of Competence and Progression (ARCP) is a review of how the doctor has progressed against their GMC approved training curriculum and how they have demonstrated this through completion of required assessments and examinations, as well as other professional requirements.

5. Some doctors will have more than one ARCP due to dual specialty training so the number of ARCP outcomes will be greater than the number of doctors in training. There is variation between specialty groups and level in the proportion of positive/neutral outcomes, due to the number of doctors taking time out of programme and who are on parental/sick leave.

6. In Scotland, 95% of the outcomes of the ARCPs were positive/neutral, signifying that the doctors receiving these outcomes could satisfactorily progress or be put forward as having completed training.

7. 665 doctors achieved a Certificate of Completion of Training (CCT) for the training year 2018-19, allowing them to seek admission to the GP or specialist GMC register and work as GPs or Consultants.

[1] https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/promoting-excellence

[2] https://www.copmed.org.uk/gold-guide-7th-edition/the-gold-guide-7th-edition

8. 110 doctors resigned before completion of their training programme (1.8% of 6000 doctors in training) and 12 doctors were released from training due to lack of progression (0.2%).

Post Graduate Medical Education & Training (PGMET): 2018-19 Training progression and outturn for doctors in training

1. Purpose

1.1 This paper has been prepared to provide Board members with a brief overview of progression and performance management in postgraduate medical education and training (PGMET) and to report on the training year 2018-19 output of doctors following completion of training.

2. Background

2.1 The Medical Directorate oversees the quality management of postgraduate medical education and the training of approx. 6000 doctors in training in Scotland.

2.2 After successfully obtaining a medical degree from an approved medical school, graduates of UK universities and overseas applicants who meet the General Medical Council (GMC) requirements for English language and qualifications can apply for postgraduate training. UK graduates obtain provisional GMC registration on successfully completing their undergraduate qualification.

2.3 The current training journey is outlined below:

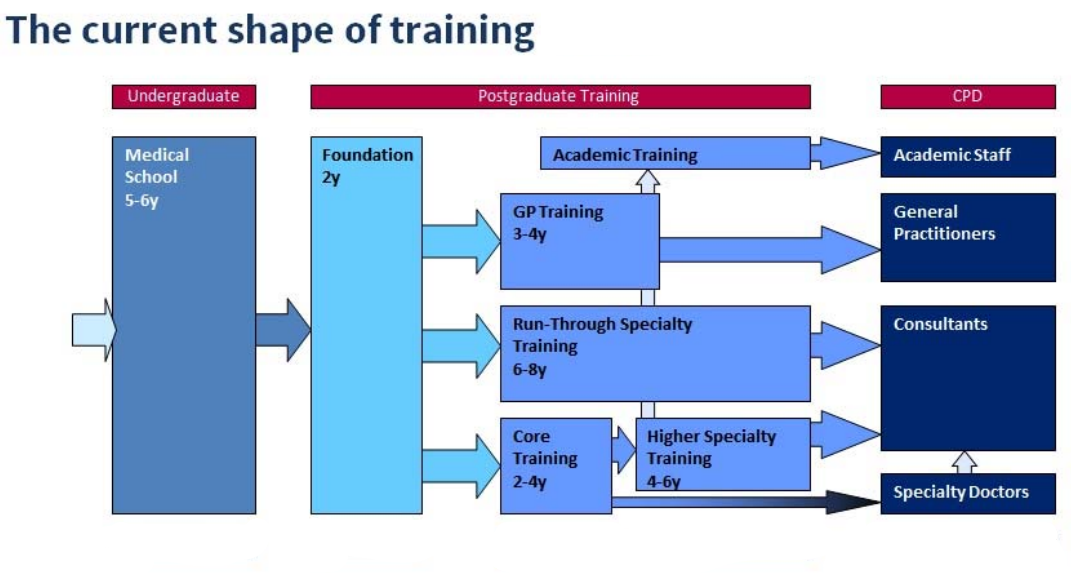


Fig 1 – current model of Postgraduate Medical Education

2.3 All UK graduates must complete the first year of foundation training to obtain full GMC registration. In Scotland, 850 graduates enter foundation training each year. Both years of foundation training are required to progress into specialty training.

2.4 Following successful completion of foundation training, a doctor applies for a core programme, which provides a general introduction to their chosen speciality group e.g. medical or mental health, or goes into a run through specialty which means they choose a specific specialty. This includes General Practice.

2.5 The "Shape of Training" review[3] published in 2013 recommended that postgraduate training be amended to increase flexibility and meet the needs of future patients. Curricula are being redeveloped and currently core trainees in surgery and medicine are part of the pilot projects. All of Scotland's core surgery and medicine posts are included in the pilots.

3. Performance Management of Training

3.1 At each stage of training, at least annually, doctors undergo a review to ensure they are achieving the outcomes required by the curriculum for their programme. This is described in detail below.

3.2 Postgraduate curricula are written by the Medical Royal Colleges and must be approved by the GMC. As part of the implementation of the UK Shape of Training Report, the high-level purpose of all revised curricula must be approved by the GMC Curriculum Oversight Group (COG) which includes representation from the 4 Departments of Health, and the 4 Statutory Education Bodies, to ensure consistency across the UK and that curricula align with the needs of the populations in the four home nations.

3.3 Doctors in training are required to record their achievements and completion of curricular requirements during their training. These achievements are normally recorded in an electronic portfolio, normally overseen by the relevant Royal College(s) or Foundation School.

4. Annual Review of Competency and Progression (ARCP)

4.1 Background

4.1.1 Towards the end of the training year (August to July), an Annual Review of Competency and Progression (ARCP) panel will be convened for the programme, in accordance with NES policy[4].

[3] Securing the future of excellent patient care: Final report of the independent review led by Professor David Greenaway (GMC 2013) https://www.gmc-uk.org/-/media/documents/shape-of-training-final-report_pdf-53977887.pdf

[4] https://www.scotlanddeanery.nhs.scot/trainee-information/annual-review-of-competence-progression-arcp/

4.1.2 This is a desktop exercise which reviews evidence of the doctor in training's activities over the year, including completion of the required assessments and experience. The ARCP panel also reviews the doctor's completion of GMC required declarations to maintain their licence to practice and to contribute towards revalidation requirements. Doctors in training who progress satisfactorily/no review (green or orange in Table 1 below) do not normally attend the review. Those who receive an outcome which indicates a concern with performance against curricular requirements (noted in blue in Table 1 below) are invited to attend a second panel in person to receive the outcome and any actions agreed. There is a right to review or appeal an outcome. An outcome 5 or 7.4 is regarded as a holding outcome pending more information from the trainee.

4.1.3 The composition of the panel and the outcomes they can give to a doctor in training are set out in the 'Gold Guide' - the 'Reference Guide for Postgraduate Specialty Training in the UK' (Conference of Postgraduate Medical Deans, 7th edition, Jan 2018)[5]. Panels must include some form of external oversight, including lay representation. Outcomes vary according to the circumstances of the doctor in training, for example a doctor working as a Locum Appointment for Training (LAT) will be given outcome 7s.

4.1.4 In relation to the outcome figures, doctors in training can have more than one outcome:

- Doctors in receipt of an outcome 5 will also receive a follow-up outcome once the required evidence has been provided or otherwise. Outcomes 5 and 7.4, the LAT equivalent, are regarded as holding outcomes as the trainee will go on to have a further final outcome.
- Doctors in 'dual training' will receive two outcomes, one for each specialty. The national training number (NTN) has been recently reviewed in order to show dual specialty and subspecialty more clearly for reporting.
- Doctors may receive more than one ARCP within a 12-month training period.

4.1.5 This data is collected and published by the GMC to compare outcome distribution across the UK. It is also useful from the Scotland Deanery perspective in considering outcome distribution across specialty groups/regional programmes and provides vital information for the quality management of programmes.

[5] https://www.copmed.org.uk/gold-guide-7th-edition/the-gold-guide-7th-edition

No Review	No outcome is issued: doctor is on maternity leave / long-term sick leave; doctor has resigned etc. The doctor is temporarily not able to work and unavailable for review.
Outcome 1	**Satisfactory** progress - achieving progress and the development of competences at the expected rate.
Outcome 2	Development of specific competences required – additional training time not required. Not applicable for Foundation doctors.
Outcome 3	Inadequate progress by the doctor – additional training time required.
Outcome 4	Released from training programme - with or without specified competences.
Outcome 5	Neutral outcome / holding response - panel cannot issue an outcome because evidence is incomplete.
Outcome 6	**Recommendation for completion** of training - gained all required competences.
Outcome 7.1	(LAT) Satisfactory progress in or completion of the post.
Outcome 7.2	(LAT) Development of specific competences required – additional training time not required.
Outcome 7.3	(LAT) Inadequate progress by the doctor.
Outcome 7.4	(LAT) Neutral outcome / holding response - panel cannot issue an outcome because evidence is incomplete.
Outcome 8	Out of programme for clinical experience, research or a career break (OOPR/OOPE/OOPC).

Table 1: ARCP outcomes (from Gold Guide 7th edition)

4.1.6 The data in Table 2 below shows the total number of ARCP outcomes recorded in TURAS TPM (NES training management system) for the training year 2018-19. The ARCPs are grouped by specialty grouping (e.g. Medical contains results for all medical core and specialty programmes).

4.1.7 These data were also sent to the GMC in November 2019. The GMC publish their own analysis of progression data in comparison to UK deaneries/LETBs on their website[6]. The 2018-19 data will be published in Spring 2020.

[6] https://www.gmc-uk.org/education/reports-and-reviews/progression-reports

4.2. ARCP Analysis

Specialty Group	No Review	1	2	3	4	5	6	7.1	7.2	7.3	7.4	8	Total Outcomes
Foundation	37	815	0	7	3	292	779	0	0	0	0	0	1933
Obstetrics & Gynaecology and Paediatrics	45	315	17	10	0	106	50	28	0	0	0	25	596
Mental Health	40	143	7	11	7	37	73	9	1	1	0	5	334
GP, Public Health and Occupational Medicine	94	677	31	22	4	210	295	0	0	0	0	6	1339
Diagnostics	19	165	12	3	0	53	41	4	1	0	0	7	305
Anaesthetics, Emergency Medicine and Intensive Care Medicine	54	366	13	13	3	111	124	39	7	2	2	11	745
Surgery	33	364	29	18	4	123	130	38	2	2	3	40	786
Medicine	166	580	15	42	7	268	247	43	2	3	0	115	1488
TOTAL	**488**	**3425**	**124**	**126**	**28**	**1200**	**1739**	**161**	**13**	**8**	**5**	**209**	**7526**

Table 2: ACRP outcomes by specialty grouping for training year 18/19

4.2.1 Of the 7526 ARCP outcomes recorded, 7227 (96%) were positive or neutral outcomes. 299 (4%) were outcomes that indicated further activity was needed to reach the required standard. Of these, 28 were outcome 4 which meant the doctor was released from training. (This does not translate to 28 doctors but 28 outcomes which may include dual training). If the 1693 neutral outcomes (no outcome, 5 and 7.4) are removed, 5534 (95%) were positive outcomes.

4.2.2 This is the third year that the Deanery has reviewed this data from a 'Scotland' perspective. A key focus for the Deanery in 2018-19 was to see if the number of outcome 5 & 7.4 was reduced following introduction of clearer and more consistent rules for submission and nature of evidence. Outcome 5s have decreased slightly from 1222 to 1200 and shows a slight trend downwards over three years. Further work on improving the information on evidence submission will be done during 2019-20 to further support trainees in submitting their evidence for review as this is an acknowledged area of stress for them. As can be seen in Fig 2 there is variation within specialty groups which needs further investigation.

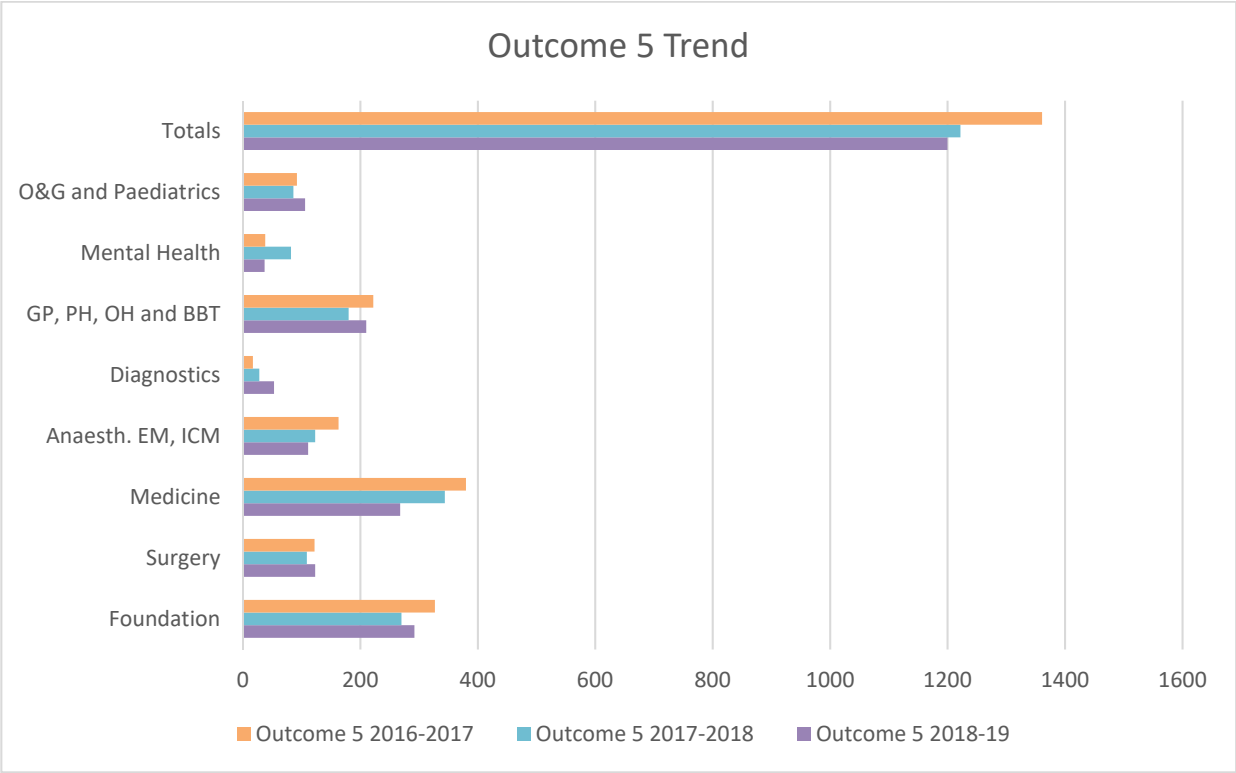


Fig 2: Trend data by specialty and year for Outcome 5

4.2.3 In comparing data from 2016-17, 2017-18 and 2018-19, a full trend analysis is not possible as data from 2016-17 did not record the 'no outcome' figures. However, the trend data from 2018-19 shows a slight increase in positive / neutral outcomes from 94% to 95% in comparison with 2017-18.

4.2.4 Within the specialty groupings, the proportion of positive outcomes (Outcome 1, 6, 7.1 and 8) against the total outcomes (with holding outcomes removed) varies between 89% in mental health specialties to 99% in foundation as shown in Table 3.. There is a higher proportion of no outcomes for doctors on parental and other leave in the later stages of training compared to foundation.

Speciality Grouping	Neutral/ holding (i.e. no review, outcome 5 & 7.4)	Positive Outcomes (1, 6, 7.1 & 8)	Concerns Outcomes (2, 3, 4, 7.2 & 7.3)	Total including all outcomes	Total excluding neutral outcomes	% positive outcomes against total excluding neutral outcomes
Foundation	329	1594	10	1933	1604	99
Surgery	159	572	55	786	627	91
Medicine	434	985	69	1488	1054	93
Anaesth. EM, ICM	167	540	38	745	578	93
Diagnostics	72	217	16	305	233	93
GP, PH, OH & BBT	304	978	57	1339	1035	94
Mental Health	77	230	27	334	257	89
O&G & Paediatrics	151	418	27	596	445	94
Totals	**1693**	**5534**	**299**	**7526**	**5833**	**95%**

Table 3: **Positive outcomes by specialty grouping**

5. Outturn Data for Doctors completing training

5.1 Background

5.1.1 Once doctors have completed their specialty programme of training, they are awarded an outcome 6 at their final ARCP. The formal date of the end of their training is determined by the duration of the programme. As above, the number of outcome 6s will not compare directly to the number of doctors, due to dual training and the fact that a doctor may have two ARCPs within the survey dates.

5.2 Outturn Analysis

5.2.1 For the training year 2018-19, 665 doctors obtained their Certificate of Completion of Training (CCT). 247 doctors completed training to CCT in General Practice and 418 doctors completed training to CCT in other specialties. This included 6 doctors on an academic track. This was an increase on 2017-18, when 612 doctors completed training.

Type	2018-19 Count of Trainee	2017-18 Count of Trainee
GP	247	249
Specialty	418	363
Grand Total	**665**	**612**

Table 4: Number of CCTs achieved during year 2018-19 and 2017-18

5.2.2 For foundation training, 813 FY1 completed the year and were put forward for full GMC registration. 844 completed FY2 and were then able to progress to specialty training. In addition, 334 doctors completed core training in uncoupled specialties, and were able to apply to higher specialty training.

Type	2018-19 Count of Trainee	2017-18 Count of Trainee
FY1	813	794
FY2	844	778
Core Training	334	269
LAT	69	65
Grand Total	**2060**	**1906**

Table 5: number who completed training elements in 2018-19 and in 2017-18

5.2.3 In addition to those completing their programme of training, a number of doctors left before completion of training in 2018/19:

- 110 (1.8% of 6000 doctors in training) (88 in 17/18) resigned from training.
    - 43 gave no reason
    - 16 relocated elsewhere
    - 15 for other education and development
    - 13 career change
    - 13 for health or family reasons
    - 10 in order to change specialty

- 12 (25 in 17/18) were released from training due to lack of progression. This is approx. 0.2% of 6000 doctors in training.
- 12 (12 in 17/18) doctors transferred out of Scotland to Deaneries elsewhere in the UK to continue training. (0.2% of doctors in training).

6. Conclusion

6.1 The Medical Directorate oversees the quality management of postgraduate medical education and training of approx. 6000 doctors in training in Scotland.

6.2 A key responsibility is managing the progression of doctors in training. The Annual Review (ARCP) ensures that every doctor in training has a review and assessment of their ability to move into the next year of training or to complete training. 95% of the outcomes of the ARCPs were positive/neutral, signifying that the doctors receiving these outcomes could satisfactorily progress or be put forward as having completed training.

6.3 Some doctors will have more than one ARCP due to dual specialty training so the number of ARCP outcomes will be greater than the number of doctors in training.

6.4 There is variation in the proportion of positive outcomes across specialty groupings, reflecting the number of doctors who take a period of time out of programme, or who are on parental/sick leave. This is higher in specialty compared to core and foundation, and the proportion of doctors in training taking time out of programme varies across specialties.

6.5 665 doctors achieved a Certificate of Completion of Training (CCT) for the training year 2018-19, allowing them to seek admission to the GP or specialist GMC register and work as GPs or Consultants.

6.6 110 doctors resigned before completion of their training programme (1.8%) and 12 doctors were released from training due to lack of progression (0.2%).

Anne Dickson, General Manager Training Management
Prof Moya Kelly, Director of General Practice Education
Prof Clare McKenzie, Postgraduate Dean
Jean Allan, Associate Director of Medicine
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NES **NES/20/13**
Item 8
January 2020

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Medical Revalidation

2. Author(s) of Paper

Amjad Khan, Director of Postgraduate GP Education, NES Revalidation Lead
Christiane Shrimpton, Associate Postgraduate Dean (Appraisal & Revalidation),
William Liu, Training Manager (Medical Appraisal)

3. Purpose of Paper

This paper serves to update the board on matters relating to revalidation and the recently published Medical appraisal and revalidation quality assurance (MARQA) report.

4. Key Issues

1 Revalidation was introduced in December 2012 to support doctors to develop their practice, drive improvements in clinical governance and give patients confidence that their doctor is up to date. Every doctor, whether in or out of training must revalidate every 5 years in order to retain a licence to practise in the UK.

2 NES is the 'Designated Body' for all doctors in training in Scotland and as a result the Medical Director is the Responsible Officer. However, as is made clear in the GMC guidance document '*Effective governance to support medical revalidation: A handbook for boards and governing bodies',* 'responsibility for the quality and safety of services (clinical governance) sits first and foremost with healthcare provider organisations and the individual professionals working within them'.

3 The key challenge for NES as a Designated Body is therefore to have functional arrangements in place to deal with any clinical governance concern(s) that arise about a doctor in training, and that these concern(s) are considered in any revalidation recommendation.

4 In November 2019, NES published the annual audit of revalidation in Scotland, *Medical Appraisal and Revalidation Quality Assurance (MARQA) Review 2018/19.* The report is published on behalf of Scottish Government.

5 The report provides a wealth of detail on the 13,355 doctors in Scotland with a 'prescribed connection', 12,640 who were eligible for an annual appraisal and 12,068 of whom (95%) had an appraisal. This is an increase of three percentage points over the previous year and the range among territorial Health Boards was 90% to 100%. A total of 2811 doctors across Scotland were identified for revalidation.

6 This published report contains the following 2 recommendations on page 1 and NES, through the Medical Appraisal team, will work with NHS Boards towards implementation of these recommendations:

a. Designated bodies have been required to achieve an overall appraisal rate of 90% (including both primary and secondary care doctors). In some designated bodies, the high appraisal rates in primary care have offset poorer appraisal rates in secondary care. The panel recommends that the RDBS consider making it a requirement that the 90% threshold for appraisal rates should apply separately to primary and secondary care

b. Designated bodies should be mindful that there are an increasing number of doctors who are designated as 'clinical fellows' and are employed outwith recognised junior doctor training pathways. DBs should ensure that there are systems in place to identify and support these doctors and to provide them with an appraisal.

c. All appraisers in Scotland must undergo core training to equip them with skills to undertake appraisal. This training also ensures consistency of the appraisal process and is provided by NES.

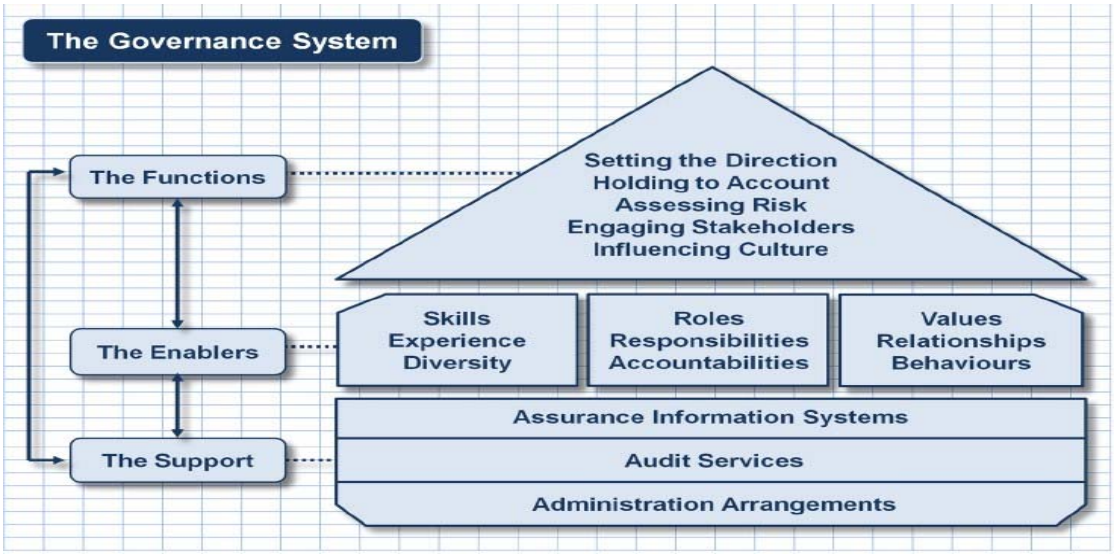
5. Educational Implications

1 NES supports appraisal and revalidation across Scotland by offering appraiser training, running an annual Scottish Medical Appraisers Conference, supporting the network of lead appraisers, health board admin teams as well as training course tutors; as well as the continued provision of Scottish Online Appraisal Resource (SOAR). We also support the Appraisers by attending local Appraiser meetings to provide updates on the work we do; as well as organising annual development days for Responsible Officers in Scotland.

2 There have been changes in key personnel in the appraisal and revalidation team at NES since the last report to the board. Dr Amjad Khan has taken over from Professor Ronald MacVicar as Revalidation lead for NES with huge support from Dr Christiane Shrimpton (Associate Postgraduate Dean for Appraisal and Revalidation) and William Liu as Training Manager for Medical Appraisal. We have started the process of updating our appraiser courses for both new and established appraisers. This will ensure the courses meet the needs of doctors working within Scotland and are also fit for purpose. In addition, we are working closely with Scottish Government colleagues in reviewing and updating the current guidance we provide for doctors and appraisers to help with the appraisal process.

3 A review of governance across NHS Scotland has recently been undertaken, commissioned by Scottish Government. John Brown, Chair of NHS Greater Glasgow and Clyde, led this review and has asked NES to propose areas for inclusion in the "Governance Blueprint" in relation to Educational Governance. This provides an opportunity to recommend that NHS Boards have sight of their performance regarding appraisal and are implementing the recommendations contained in the NES Medical Appraisal and Revalidation Quality Assurance Report 2018/19.

4 The review team developed the **corporate governance blueprint** which 'describes a three-tiered model that defines the functions of a governance system, the enablers and the support required to effectively deliver those functions'.



6. Financial Implications

No new financial implications.

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

- A high-quality learning and employment environment, national infrastructure to improve attraction, recruitment, training and retention
- Education and training for a skilled, adaptable and compassionate workforce
- A higher performing organisation (NES)

8. Impact on the Quality Ambitions

Revalidation in the healthcare professions is a key element of ensuring safe, effective and person-centred care with a focus on the individual practitioner reflecting on her/ his performance and supported by a portfolio of evidence that is shared at annual appraisal.

9. Key Risks and Proposals to Mitigate the Risks

NES has a role in training appraisers and in supporting Boards and their Appraisal Leads in delivering on their Appraisal and Revalidation responsibilities. Pressures in the service have had some impact in some Boards on their ability to recruit appraisers and this has impacted on appraisal rates in secondary care as demonstrated in the MARQA review of 2018/19.

10. Equality and Diversity

As explained in the paper, NES has recently taken on the process of auditing revalidation from Healthcare Improvement Scotland. We will consider the requirement for a revised equality and diversity impact assessment as we take forward any changes to the process.

11. Health Inequalities

It is unlikely that Medical Revalidation will impact on health inequalities, other than through reflection by individual doctors on their practice and how inequalities contribute.

12. Recommendation(s) for Decision

The Board is invited to note the attached paper.

NES
November 2019
AK/CS/WL

Medical Revalidation

1. Background

1.1 Every licensed doctor who practises medicine must revalidate. Medical revalidation, which was introduced in December 2012, sets out to support doctors to develop their practice, drive improvements in clinical governance and give patients confidence that their doctor is up to date.[1] The governance arrangements for medical revalidation are set out in guidance from the General Medical Council (GMC),[2] and describe key responsibilities for:

a. The organisations in which doctors work ('Designated Bodies'). Medical revalidation is designed to provide a powerful lever for organisations to drive improvements in the quality of patient care and treatment, and is reliant upon robust systems for clinical governance, including appraisal and local quality assurance

b. 'Responsible Officers (ROs)': a senior doctor, usually the Medical Director of the organisation, who oversees systems for governance and appraisal for doctors, for dealing with practice concerns about doctors and for advising the GMC about doctors' fitness to practise

c. Individual doctors, who must demonstrate that they continue to meet the values and principles expected of the profession set out in the GMC's core guidance *Good Medical Practice*. This is achieved by doctors reflecting on a portfolio of information and evidence at annual appraisal of the doctor's whole practice.

1.2 Medical revalidation is based upon a five-yearly recommendation by a doctor's RO to the regulator and towards the end of the first cycle of revalidation, in March 2016, Sir Keith Pearson was requested by the GMC to review the impact of revalidation. In his report *Taking revalidation forward: Improving the process of relicensing for doctors,*[3] he concluded that 'revalidation has settled well and is progressing as expected' and described significant resulting benefits including; annual appraisal of whole practice; regular, supported reflection on practice; and strengthened clinical governance, all leading to improved practice. He did acknowledge concerns from within the profession that revalidation is unnecessarily bureaucratic and burdensome, and put forward a series of recommendations for revalidation to achieve its goal of increasing assurance,

[1] https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation

[2] https://www.gmc-uk.org/-/media/documents/governance-handbook_pdf-73078021.pdf

[3] https://www.gmc-uk.org/-/media/documents/Taking_revalidation_forward___Improving_the_process_of_relicensing_for_doctors.pdf_68683704.pdf

and to secure confidence across the medical profession. These recommendations were made to the GMC itself, to healthcare organisations and their Boards and to government health departments.

1.3 The GMC has described in its November 2018 report 'Taking revalidation forward: Working with others to improve revalidation' how it has addressed the recommendations from the Pearson report, and frames this in terms of improvements for doctors (including doctors in training), improvements for patients and improvements for responsible officers, suitable persons and healthcare providers.

1.4 Improvements for doctors relate mainly to clarity of guidance and information provision. In providing assurance to patients that all licenced doctors are up to date and fit to practise, the regulator has focused on ways to help patients to understand revalidation, ways of increasing lay and patient involvement in revalidation and reviewing patient feedback requirements for revalidation. The Pearson report described a need to engage Boards more in how governance processes that support revalidation work within their organisations. In response, the regulator set out to improve governance and oversight and as a result published, also in November 2018, *Effective clinical governance for the medical profession: A handbook for organisations employing, contracting or overseeing the practice of doctors*.[4]

1.5 This guidance aims to provide Boards with a description of the core principles underpinning effective clinical governance for doctors, focusing particularly on responsibilities outlined in the Responsible Officer regulations.

2. The NES role in medical revalidation

2.1 NES has three major roles in medical revalidation in Scotland:

2.2 **Firstly**, NES is the 'Designated Body' for all doctors in training in Scotland and as a result, the Medical Director is the RO for a number of doctors that approaches 6000. This is by far the largest number of doctors for any Designated Body in Scotland and one of the largest in the United Kingdom. In this task the Medical Director is supported by the four regional Postgraduate Deans and the two GP Directors who act with delegated authority as ROs.

The revalidation requirement for annual appraisal are met for doctors in training by the Annual Review of Competency Progression (ARCP) arrangements.[5] The ARCP panel considers evidence of progression in training against the competencies described in the relevant curriculum, and reflection on this portfolio of evidence is a key feature. As

[4] https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf

[5] http://www.scotlanddeanery.nhs.scot/trainee-information/annual-review-of-competence-progression-arcp/

[6] https://www.gmc-uk.org/-/media/documents/governance-handbook_pdf-73078021.pdf

is made clear in the GMC guidance document *Effective governance to support medical revalidation: A handbook for boards and governing bodies responsibility for the quality and safety of services,*[6] '[clinical governance] rests first and foremost with healthcare provider organisations and the individual professionals working within them'. The key challenge for NES as a Designated Body is therefore to have functional arrangements where any clinical governance concerns that arise about a doctor in training are taken into account in any revalidation recommendation.

To address this, doctors in training are required to detail the whole scope of their practice and declare, prior to each ARCP panel meeting any issues with their health, probity or critical incidents/ complaints.[6] These declarations, without which an ARCP Outcome cannot be awarded, require to be signed off by the trainee's supervisor. Revalidation recommendations, which are also in a five-yearly cycle for doctors in training are informed by ARCP outcomes, trainee declarations, and regular meetings between regional deanery teams and territorial Health Board senior teams that focus on trainee performance or clinical governance issues.

NES is also the Designated Body for a very small number of senior doctors for whom NES is the major or only employer. The Medical Director is the RO for these doctors and reciprocal annual appraisal arrangements are in place with one of the other special Health Boards (NSS).

2.3 **Secondly**, NES has taken on the responsibility to produce the annual audit of revalidation in Scotland, this previously having been a responsibility of Healthcare Improvement Scotland. The 2018/19 report, which is included with this paper, provides a wealth of detail on the 13,171 doctors in Scotland with a 'prescribed connection', 12,485 who were eligible for an annual appraisal and 11,508 of whom (92%) had an appraisal. This proportion of doctors that had an annual appraisal represents a fall of two percentage points over the previous year, and the range among territorial Health Boards was 72% to 100%. A total of 515 doctors across Scotland were identified for revalidation.

The report drew together three recommendations detailed above.

2.4 **Thirdly**, NES supports appraisal and revalidation across Scotland by (i) offering appraisal training, (ii) supporting the network of lead appraisers and (iii) hosting the Scottish Online Appraisal Resource (SOAR).[9] A recent change in key personnel provides an opportunity to review our current systems and processes, and to consider how best we as an education and training organisation can support the development of revalidation in Scotland to meet its original aspirations and to deliver on the recommendations of the Pearson report (as well as supporting the service in Scotland to address the three recommendations listed above). These recent changes in

[6] http://www.scotlanddeanery.nhs.scot/trainee-information/revalidation-during-training/

personnel include Dr Christiane Shrimpton's appointment as APGD (Appraisal & Revalidation), replacing Dr Niall Cameron, and William Liu as Appraisal Training Manager, replacing Harry Peat.

3. Conclusion

3.1 The regulator's guidance for medical revalidation requires that:[7]

a. organisations appoint a senior doctor (a responsible officer – RO) to oversee systems for governance and appraisal for doctors, for dealing with practice concerns about doctors and for advising the GMC about doctors' fitness to practise;

b. organisations are also responsible for providing resources to support ROs in their role. Their local governance arrangements should incorporate constructive challenge around the way services are delivered and monitored;

c. ROs must assure themselves that the quality of their systems supports the evaluation of doctors' fitness to practise in a fair and consistent way

3.2 NES has robust processes in place to support these requirements in relation to the doctors for which it is their Designated Body. It is also in a strong position to support NHS Scotland, and individual Boards in the delivery and continuous improvement of medical revalidation

Amjad Khan/Christiane Shrimpton/William Liu

[7] https://www.gmc-uk.org/-/media/documents/governance-handbook_pdf-73078021.pdf

NHS Education for Scotland

MEDICAL APPRAISAL & REVALIDATION QUALITY ASSURANCE

(MARQA) REVIEW 2018/2019

CONTENTS

KEY FINDINGS

1 Overall Appraisal rate in Scotland for all designated bodies during 2018/2019 is 96%, up 4% from 2017/2018.

2

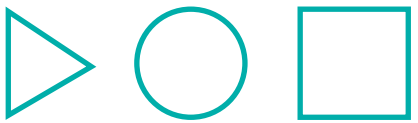
Sector	Appraisal completion
Primary Care	99%
Secondary Care	93%
Total	96%

3 Of the 2811 doctors identified for revalidation in 2018/2019, a positive recommendation was made for 2631 (94%). The comparable figure for 2017/2018 was 84%.

4 The revalidation decision was deferred for 198 doctors (7%). The comparable figure for 2017/2018 was 16%.

5 This year further sub-analysis of the data was undertaken for both primary and secondary care doctors, to better understand whether there are any challenges for specific sub-groups of doctors. In particular, Clinical Fellows were considered as a separate group for the first time. The appraisal rate for this group was 76%.

6 Last year's report identified a small number of designated bodies where performance could be improved. The review panel particularly wishes to commend the work that has been undertaken by these designated bodies to ensure that these organisations now meet their requirements for appraisal and revalidation.



KEY DATA FOR 2018/2019

Key Data Comparison	2018/2019		2017/2018		Variance
Number of doctors with a prescribed connection	13355		13171		1%
Number of doctors not eligible for an appraisal	715	5%	686	5%	0%
Number of doctors eligible for an appraisal	12640	95%	12485	95%	0%
Number of doctors who completed an appraisal	12068	96%	11508	92%	4%
Number of doctors due for revalidation	2811		515		
Number of doctors who were recommended for revalidation	2631	94%	432	84%	10%
Number of doctors whose revalidation was deferred	198	7%	82	16%	-9%
Number of non-engagement notifications	1		1		0

More doctors were revalidated in 2018/2019 than in the previous year. This is because the structure is such that the majority of the doctors are revalidated within the first three years of the 5-year cycle. The final two years are used predominantly to deal with outstanding issues and doctors who have complex circumstances.

This explains why only 515 were eligible for revalidation in 2017/2018, of whom 84% were revalidated. In comparison in 2018/2019, 2811 doctors were eligible for revalidation, and 2631 (93%) were revalidated.

INTRODUCTION

MEDICAL REVALIDATION

Doctors practising in the UK are required to hold a licence to practise issued by the General Medical Council (GMC) and subject to renewal every 5 years. This is known as medical revalidation and is the process by which medical doctors are legally required to demonstrate that they are up-to-date and fit-to-practise.

Revalidation was introduced as a legal requirement across the UK from December 2012, with the GMC providing the oversight, including advice and support to stakeholders:

https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation

Revalidation is based on annual appraisals undertaken in the workplace by trained appraisers. The appraisal must include all aspects of a doctor's work and is based on the GMC's core guidance for doctors, Good Medical Practice:

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

INTRODUCTION

For the purpose of revalidation a doctor requires to be registered (affiliated) with a designated body as per The Medical Profession (Responsible Officers) Regulations 2010 and 2013. The designated body is required to appoint a responsible officer (RO). The RO has a number of legal responsibilities including a requirement to make a recommendation to the GMC as to whether a doctor should be revalidated based on the outcome of appraisal and any other information that is available. Based on this information the GMC determine whether a doctor's "Licence" should be renewed. In Scotland all the Health Boards are Designated Bodies; with the medical director having the role of RO. The vast majority of doctors are affiliated to their Health Boards for revalidation purposes. A small number of doctors are affiliated to non-NHS bodies who meet the criteria to declare themselves a designated body.

MEDICAL APPRAISAL

Medical Appraisal in Scotland, undertaken by trained appraisers, is not designed to be a pass or fail process, but one that helps a doctor to reflect on their practice and achievements in the past year, and assists them to identify areas for improvement. It does however, include and consider important aspects of a doctor's practice including continuing education, complaints and significant incidents.

"When well delivered I have yet to hear anyone suggest Appraisal is not a worthwhile use of their time. In a stressed world, the benefit of having a protected session to look in on yourself and your professional practice is essential."

Dr Mike Winter *(former chair of MARQA Review Panel)*

Doctors are assisted in preparing for appraisal by having access to SOAR (Scottish Online Appraisal Resource) which has been developed and hosted by NES. This is available to all doctors in Scotland. It allows doctors to complete their appraisal forms, upload the necessary supporting information and submit them for sharing with their Appraiser. It also allows Responsible Officers (ROs) to make revalidation recommendations directly from SOAR to GMC.

INTRODUCTION

REVALIDATION RECOMMENDATIONS

The RO can make one of the following three recommendations regarding a doctor to the GMC:

- Positive Recommendation
- Deferral
- Non-Engagement

Deferral of revalidation is a neutral act and can arise for a number of reasons, including ill health or when a doctor has a prolonged period of leave. Most doctors are recommended for revalidation at the end of the period of deferment. Doctors who do not engage with appraisal and revalidation may have their licence to practise revoked by the GMC.

REVALIDATION DELIVERY BOARD SCOTLAND (RDBS)

The Revalidation Delivery Board was convened by Scottish Government (SG) to oversee the development and implementation of revalidation in Scotland and to ensure consistency of the process. The Board issues guidance as required. The Board is chaired by Professor Ian Finlay and includes key partners and stakeholders. An important function of the Board is to commission and then consider an independent annual review of appraisal and revalidation across Scotland.

INTRODUCTION

THE MARQA REVIEW

A review of appraisal and revalidation has been commissioned by RDBS on behalf of SG since 2010. This was initially undertaken by Health Improvement Scotland (HIS) but since 2017/2018 it has been produced by NES, when it was re-named "Medical Appraisal & Revalidation Quality Assurance (MARQA) Review".

REVIEW METHODOLOGY

In the first instance, a self-assessment pack (consisting of a data sheet of appraisal and revalidation completion rates; and a declaration of appraisal and revalidation governance arrangements) is sent to all designated bodies in Scotland for their completion.

This year the self-assessment pack was sent to 47 Designated Bodies, one more than last year.

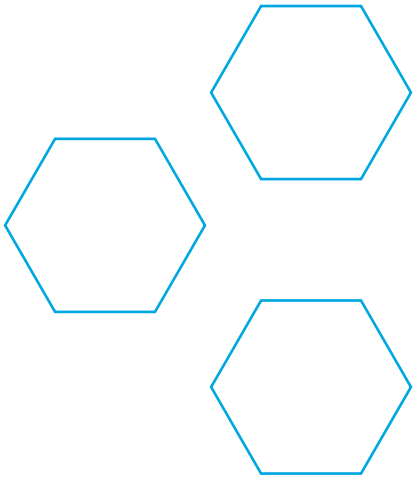
At the conclusion of the first 5-year Revalidation cycle, NES undertook a review of the existing questionnaire pack and consulted with NHS Scotland Health Boards' Appraisal Leads and Administration teams. As a result, a number of changes were made to the data questionnaire this year.

These included the following:

- The data for primary and secondary care were separated,
- Clinical fellows were identified separately as a sub group and,
- Questions relating to the support of Appraisers were added.

Designated Bodies were also asked to provide a detailed description of their Governance Arrangements.

A panel is convened to review the submitted returns. The Panel can seek further information and where necessary there is an escalation procedure carried out by Healthcare Improvement Scotland.



OUR FINDINGS

REVALIDATION RATES

This year, there were 2811 doctors due for Revalidation; of whom 2631 were Revalidated (94%). This is an increase of 10% from last year.

DEFERRALS

There was a substantial decrease in deferrals this year. In Scotland 7% of doctors were deferred (down from 16% in 2017/2018).

Whilst this was a welcome trend, the nature of the data collection does not include an analysis of the reasons for deferral. The GMC has recently introduced new and more detailed deferral categories, which have been added to SOAR. This will allow the review panel, in the future, to better understand why doctors are deferred.

APPRAISAL COMPLETION RATES: PRIMARY AND SECONDARY CARE FINDINGS

There is a consistently higher appraisal rate in primary care than secondary care.

The overall appraisal rates for all designated bodies and the comparable figures for last year are shown in full in appendix 3.1.

APPRAISER TRAINING & SUPPORT

The submissions indicated that all Appraisers in Scotland are NES-trained, but show that the support provided for Medical Appraisers varied between designated bodies.

The panel agreed that providing continuing support for Appraisers is as important as supporting their initial training in maintaining a high quality and consistent appraisal process. Examples of continuing support include:

- Attendance at NES Appraiser Refresher training (once every 5 years)
- Attendance at local Appraisers' meetings and development days
- Attendance at the NES run annual Scottish Medical Appraisers Conference

APPRAISAL OF CLINICAL FELLOWS

The panel has identified that Clinical Fellows comprise a growing sub-group of doctors who require an appraisal. Health boards are encouraged to ensure that this group of doctors are identified and supported to undergo appraisal.

OUR FINDINGS

DOCTORS WITH A MISSED APPRAISAL IN 2018/2019

Most designated bodies reported that a percentage of the doctors with a prescribed connection to them had not been appraised, having been exempted on specific grounds. Having reviewed those instances where there were significantly higher rates of non-appraisal, the panel was satisfied overall with the additional information and reasons given.

ACKNOWLEDGEMENTS

NES would like to thank all designated bodies for completing and submitting the questionnaires.

The review panel wishes to recognise the efforts made by the following health boards who have shown improvements this year:

- NHS Dumfries & Galloway
- NHS Fife
- NHS Highland
- NHS Tayside

CONCLUSION AND NEXT STEPS

1. It has been a successful year for Medical Appraisal and Revalidation in Scotland with the highest appraisal completion rate to date at 96%.

2. Appraisal rates are generally higher in primary care than in secondary care.

3. The data suggests that the appraisal and revalidation process is firmly embedded in Scotland.

4. In 2018/2019 all appraisals in Scotland were undertaken by a NES trained appraiser.

5. Deferral rates in Scotland are falling; the rate for 2018/2019 is 7%. The new GMC deferral categories (replicated in SOAR) will allow more detailed analysis of the reasons for deferral next year.

6. Clinical fellows are included as a separate category this year for the first time. The appraisal rates for this group are lower than those for other groups of doctors. Designated bodies are encouraged to ensure that they have processes in place to identify and support this group of doctors who are not in formal training.

RECOMMENDATIONS

1 Designated bodies have been required to achieve an overall appraisal rate of 90% (including both primary and secondary care doctors). In some designated bodies, the high appraisal rates in primary care have offset poorer appraisal rates in secondary care. The panel recommended that the 90% threshold for appraisal completion rates should be applied separately to primary and secondary care.

2 Designated Bodies should be mindful that there are an increasing number of doctors who are designated as "clinical fellows" and are employed outwith recognised junior doctor training pathways. DBs should ensure that there are systems in place to identify and support these doctors and to provide them with an appraisal.

3 All appraisers in Scotland must undergo core training to equip them with skills to undertake appraisal. This training also ensures consistency of the appraisal process and is provided by NES.

In addition to core training, continuing support should be given to appraisers to ensure that they maintain their appraisal skills. Examples of this continuing support include:

- Attendance at appraiser Refresher Training Courses
- Organising local appraisers meetings
- Attendance at annual Scottish Medical Appraisers Conference

Details of the Medical Appraiser training programme is available on the Medical Appraisal Scotland website: **www.appraisal.nes.scot.nhs.uk**

APPENDICES

APPENDIX 1:
Panel and Observers

Names	Role/Organisation
Frances Dow (Chair)	Lay Member
Sharon Baillie	Programme Manager, Healthcare Improvement Scotland
Niall Cameron	GP, NHS Greater Glasgow & Clyde
Rosie Dixon	Primary Care Appraisal Lead, NHS Borders and NHS Lothian
Alison Graham	Medical Director, NHS Ayrshire & Arran
William Liu	Training Manager (Medical Appraisal), NES
Elizabeth Muir	Clinical Effectiveness Co-Ordinator, NHS Fife
Sue Robertson	Specialty and Associate Specialist (SAS) Doctor, NHS Dumfries and Galloway
Christiane Shrimpton	Associate Postgraduate Dean for Appraisal and Revalidation, NES
Robyn Smith	Anaesthetist, Golden Jubilee Centre
Elizabeth Tait	Professional Lead for Clinical Governance, NHS Grampian
Jim Walker	Lay Member
Ian Finlay (Observer)	Scottish Government
Sally White (Observer)	Scottish Government

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APPENDIX 2:
Organisations involved in 2018-2019 review

NHSScotland

- Ayrshire & Arran
- Borders
- Dumfries & Galloway
- Fife
- Forth Valley
- Grampian
- Greater Glasgow & Clyde
- Highland
- Lanarkshire
- Lothian
- Orkney
- Shetland
- Tayside
- Western Isles
- National Waiting Times Centre
- The State Hospitals Board for Scotland
- NHS 24
- NHS Education for Scotland
- Healthcare Improvement Scotland
- NHS Health Scotland
- Scottish Ambulance Service
- NHS National Services Scotland

Hospices

- ACCORD Hospice
- Ardgowan Hospice
- The Ayrshire Hospice
- Bethesda Hospice
- Children's Hospices Across Scotland (CHAS)
- Highland Hospice (part of NHS Highland's submission)
- Marie Curie Edinburgh
- Marie Curie Glasgow
- The Prince & Princess of Wales Hospice
- St Andrew's Hospice (part of NHS Lanarkshire's submission)
- St Columba's Hospice
- St Margaret of Scotland Hospice
- St Vincent's Hospice
- Strathcarron Hospice
- Surehaven Glasgow Hospital (part of NHS Dumfires & Galloway's submission)

APPENDICES

APPENDIX 2:
Organisations involved in 2018-2019 review

Non-NHS Organisations

- Assured Occupational Health Ltd (New Designated Body)
- Castle Craig Hospital
- DHI Scotland
- Glasgow Memory Clinic
- Loudon Surgical Consulting Ltd
- MP Locums Healthcare Ltd
- Mental Welfare Commission for Scotland
- Scottish Government
- TauRx Pharmaceuticals

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APPENDIX 3: Data submission breakdown

Less than 85% | Between 85% and 90%

APPENDIX 3.1:
Overview of Appraisal completion rates for Primary and Secondary Care doctors across Scotland

Sector	NHSScotland Boards		Hospices		Non-NHS Organisations		TOTAL (2018/2019)				Variance	
	Prescribed Connection	Eligible	Prescribed Connection	Eligible	Prescribed Connection	Eligible	Prescribed Connection	Eligible	Appraised	%	2017/18	+/-
Primary Care	5555	5233	3	3	1	1	5559	5237	5190	99%	97%	2%
Secondary Care	7667	7280	52	48	77	75	7796	7403	6878	93%	89%	4%
TOTAL	**13222**	**12513**	**55**	**51**	**78**	**76**	**13355**	**12640**	**12068**	**96%**	**92%**	**4%**

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APPENDIX 3.1.1:
Primary Care Staff Groupings across Scotland

Eligible GPs (i.e. on Performers List) and Completed Appraisals	NHSScotland Boards		Hospices		Non-NHS Organisations		TOTAL (2018/2019)			Variance	
	Eligible	Appraised	Eligible	Appraised	Eligible	Appraised	Eligible	Appraised	%	2017/18	+/-
Principal GP	3302	3280	0	0	0	0	3302	3280	99%	-	-
Employed GP	111	111	0	0	0	0	111	111	100%	-	-
Retainee	50	50	0	0	0	0	50	50	100%	-	-
Sessional (Locum)	985	970	2	2	0	0	987	972	99%	-	-
Associate	4	4	0	0	0	0	4	4	100%	-	-
Retired	2	1	0	0	1	1	3	2	67%	-	-
Salaried	729	722	1	1	0	0	730	723	99%	-	-
Other	50	48	0	0	0	0	50	48	96%	-	-
TOTAL	**5233**	**5186**	**3**	**3**	**1**	**1**	**5237**	**5190**	**99%**	**97%**	**2%**

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APPENDIX 3.1.2:
Secondary Care Staff Groupings across Scotland

Eligible Doctors and Completed Appraisals	NHSScotland Boards		Hospices		Non-NHS Organisations		TOTAL (2018/2019)			Variance	
	Eligible	Appraised	Eligible	Appraised	Eligible	Appraised	Eligible	Appraised	%	2017/18	+/-
Consultants (including honorary contract holders)	5508	5204	19	19	5	5	5532	5228	95%	89%	6%
Staff, Associate Specialists, and Specialty Doctors	981	896	26	25	13	13	1020	934	92%	87%	5%
University employed staff with a licence to practice	21	20	0	0	0	0	21	20	95%	85%	10%
Secondary Care Locums (employed for 2 months or more in the 12 months up to 31 March)	321	284	1	1	25	25	347	310	89%	88%	1%

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APPENDIX 3.1.2:
Secondary Care Staff Groupings across Scotland (continued)

Eligible Doctors and Completed Appraisals	NHSScotland Boards		Hospices		Non-NHS Organisations		TOTAL (2018/2019)			Variance	
	Eligible	Appraised	Eligible	Appraised	Eligible	Appraised	Eligible	Appraised	%	2017/18	+/-
Independent healthcare providers only (doctors with practising privileges who have a prescribed connection to the organisation)	3	2	2	2	5	5	10	9	90%	100%	-10%
Clinical Fellows	388	295	0	0	0	0	388	295	76%	-	-
Others (doctors in leadership roles, civil service, in wholly independent practice, and doctors not directly employed)	58	55	0	0	27	27	85	82	97%	91%	6%
TOTAL	7280	6756	48	47	75	75	7403	6878	92%	97%	-5%

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APPENDIX 3.1.3:
Appraisal completion rates for Primary Care (PC) and Secondary Care (SC) staff per Designated Body

NHSScotland Health Boards	Eligible doctors		Completed appraisals				Total		Variance	
	PC	SC	PC	%	SC	%	PC + SC	%	2017/18	+/-
Ayrshire & Arran	340	440	340	100%	400	91%	740	95%	94%	1%
Borders	116	157	114	98%	150	96%	264	97%	95%	2%
Dumfries & Galloway	151	176	151	100%	171	97%	322	99%	86%	13%
Fife	314	328	310	99%	301	92%	611	95%	87%	8%
Forth Valley	275	273	275	100%	261	96%	536	98%	98%	0%
Grampian	550	701	550	100%	653	93%	1203	96%	98%	-2%
Gt Glasgow & Clyde	1105	2082	1095	99%	1941	93%	3036	95%	94%	1%
Highland	435	303	426	98%	278	92%	704	95%	87%	8%
Lanarkshire	477	667	470	99%	559	84%	1029	90%	92%	-2%
Lothian	951	1311	941	99%	1252	96%	2193	97%	95%	2%
Orkney	34	20	33	97%	16	80%	49	91%	89%	2%
Shetland	28	21	28	100%	21	100%	49	100%	95%	5%
Tayside	418	594	415	99%	557	94%	972	96%	74%	22%
Western Isles	33	25	32	97%	20	80%	52	90%	96%	-6%

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APPENDIX 3.1.3:
Appraisal completion rates for Primary Care (PC) and Secondary Care (SC) staff per Designated Body (cont.)

NHSScotland Health Boards	Eligible doctors		Completed appraisals				Total		Variance	
	PC	SC	PC	%	SC	%	PC + SC	%	2017/18	+/-
National Waiting Times Centre	0	101	0	0%	95	94%	95	94%	100%	-6%
The State Hospitals Board for Scotland	0	14	0	0%	14	100%	14	100%	77%	23%
NHS 24	0	0	0	0%	0	0%	0	0%	100%	0%
NHS Education for Scotland	4	7	4	100%	7	100%	11	100%	67%	33%
Healthcare Improvement Scotland	2	8	2	100%	8	100%	10	100%	100%	0%
NHS Health Scotland	0	4	0	0%	4	100%	4	100%	67%	33%
Scottish Ambulance Service	0	0	0	0%	0	0%	0	0%	0%	0%
NHS National Services Scotland	0	48	0	0%	48	100%	48	100%	100%	0%
TOTAL	**5233**	**7280**	**5186**	**99%**	**6756**	**93%**	**11942**	**95%**	**92%**	**3%**

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APPENDIX 3.1.3:
Appraisal completion rates for Primary Care (PC) and Secondary Care (SC) staff per Designated Body (cont.)

Hospices	Eligible doctors		Completed appraisals				Total		Variance	
	PC	SC	PC	%	SC	%	PC + SC	%	2017/18	+/-
ACCORD Hospice	0	2	0	0%	2	100%	2	100%	100%	0%
Ardgowan Hospice	0	2	0	0%	2	100%	2	100%	100%	0%
The Ayrshire Hospice	0	4	0	0%	4	100%	4	100%	100%	0%
Bethesda Hospice	0	2	0	0%	2	100%	2	100%	100%	0%
Children's Hospices Across Scotland (CHAS)	0	3	0	0%	3	100%	3	100%	0%	100%
Highland Hospice	*Submitted as part of NHS Highland's returns*									
Marie Curie Edinburgh	0	7	0	0%	7	100%	7	100%	100%	0%
Marie Curie Glasgow	2	2	2	100%	2	100%	4	100%	100%	0%
The Prince & Princess of Wales Hospice	0	4	0	0%	4	100%	4	100%	100%	0%
St Andrew's Hospice	*Submitted as part of NHS Highland's returns*									
St Columba's Hospice	0	8	0	0%	8	100%	8	100%	100%	0%

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APPENDIX 3.1.3:
Appraisal completion rates for Primary Care (PC) and Secondary Care (SC) staff per Designated Body (cont.)

Hospices	Eligible doctors		Completed appraisals				Total		Variance	
	PC	SC	PC	%	SC	%	PC + SC	%	2017/18	+/-
St Margaret of Scotland Hospice	1	4	1	100%	4	100%	5	100%	100%	0%
St Vincent's Hospice	0	3	0	0%	3	100%	3	100%	67%	33%
Strathcarron Hospice	0	7	0	0%	6	86%	6	86%	100%	-14%
Surehaven Glasgow Hospital	*Submitted as part of NHS Dumfries & Galloway's returns*									
TOTAL	3	48	3	100%	47	98%	50	98%	97%	1%

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APPENDIX 3.1.3:
Appraisal completion rates for Primary Care (PC) and Secondary Care (SC) staff per Designated Body (cont.)

Non-NHS Organisations	Eligible doctors		Completed appraisals				Total		Variance	
	PC	SC	PC	%	SC	%	PC + SC	%	2017/18	+/-
Assured Occupational Health Ltd	0	0	0	0%	0	0%	0	0%	n/a	n/a
Castle Craig Hospital	0	4	0	0%	4	100%	4	100%	100%	0%
DHI Medical Group Scotland	0	6	0	0%	6	100%	6	100%	n/a	n/a
Glasgow Memory Clinic	0	4	0	0%	4	100%	4	100%	100%	100%
Loudon Surgical Consulting Ltd	0	1	0	0%	1	100%	1	100%	100%	0%
MP Locums Healthcare Ltd	0	25	0	0%	25	100%	25	100%	100%	100%
Mental Welfare Commission for Scotland	0	3	0	0%	3	100%	3	100%	100%	0%
Scottish Government	0	31	0	0%	31	100%	31	100%	97%	3%
TauRx Pharmaceuticals	1	1	1	100%	1	100%	2	100%	100%	0%
TOTAL	**1**	**75**	**1**	**100%**	**75**	**100%**	**76**	**100%**	**99%**	**1%**

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APPENDIX 3.2:
Overview of Doctors Identified for Revalidation across Scotland

Designated Body Type	Due Revalidation in 2018/19	Positive Recommendations	%	Deferrals	%	Non-Engagement
NHS Scotland Health Boards	2785	2607	94%	196	7%	1
Hospices	10	10	100%	0	0%	0
Non-NHS Organisations	16	14	88%	2	13%	0
TOTAL	**2811**	**2631**	**94%**	**198**	**7%**	**1**

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APPENDIX 3.2.1
Breakdown of Doctors Identified for Revalidation per Designated Body

NHSScotland Health Boards	Due Revalidation in 2018/19	Positive Recommendations	%	Deferrals	%	Non-Engagement
Ayrshire & Arran	145	140	97%	8	6%	0
Borders	57	50	88%	7	12%	0
Dumfries & Galloway	85	76	89%	9	11%	0
Fife	125	117	94%	17	14%	0
Forth Valley	111	107	96%	5	5%	0
Grampian	280	264	94%	16	6%	0
Gt Glasgow & Clyde	656	622	95%	37	6%	0
Highland	203	191	94%	12	6%	0
Lanarkshire	254	228	90%	27	11%	0
Lothian	476	451	95%	26	6%	1
Orkney	8	7	88%	1	13%	0
Shetland	9	8	89%	1	11%	0
Tayside	323	300	93%	23	7%	0
Western Isles	13	11	85%	2	15%	0

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APPENDIX 3.2.1
Breakdown of Doctors Identified for Revalidation per Designated Body (cont.)

NHSScotland Health Boards	Due Revalidation in 2018/19	Positive Recommendations	%	Deferrals	%	Non-Engagement
National Waiting Times Centre	28	24	86%	4	14%	0
The State Hospitals Board for Scotland	2	2	100%	0	0%	0
NHS 24	0	0	0%	0	0%	0
NHS Education for Scotland	3	3	100%	0	0%	0
Healthcare Improvement Scotland	1	1	100%	0	0%	0
NHS Health Scotland	1	0	0%	1	100%	0
Scottish Ambulance Service	0	0	0%	0	0%	0
NHS National Services Scotland	5	5	100%	0	0%	0
TOTAL	**2785**	**2607**	**94%**	**196**	**7%**	**1**

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APPENDIX 3.2.1
Breakdown of Doctors Identified for Revalidation per Designated Body (cont.)

Hospices	Due Revalidation in 2018/19	Positive Recommendations	%	Deferrals	%	Non-Engagement
ACCORD Hospice	1	1	100%	0	0%	0
Ardgowan Hospice	0	0	0%	0	0%	0
The Ayrshire Hospice	1	1	100%	0	0%	0
Bethesda Hospice	2	2	100%	0	0%	0
Children's Hospices Across Scotland (CHAS)	0	0	0%	0	0%	0
Highland Hospice	*Submitted as part of NHS Highland's returns*					
Marie Curie Edinburgh	3	3	100%	0	0%	0
Marie Curie Glasgow	3	3	100%	0	0%	0
The Prince & Princess of Wales Hospice	0	0	0%	0	0%	0
St Andrews Hospice	*Submitted as part of NHS Lanarkshire's returns*					
St Columba's Hospice	0	0	0%	0	0%	0

APPENDICES

APPENDIX 3.2.1
Breakdown of Doctors Identified for Revalidation per Designated Body (cont.)

Hospices	Due Revalidation in 2018/19	Positive Recommendations	%	Deferrals	%	Non-Engagement
St Margaret of Scotland Hospice	0	0	0%	0	0%	0
St Vincent's Hospice	0	0	0%	0	0%	0
Strathcarron Hospice	0	0	0%	0	0%	0
Surehaven Glasgow Hospital	Submitted as part of NHS Dumfries & Galloway's returns					
TOTAL	**10**	**10**	**100%**	**0**	**0%**	**0**

APPENDICES

APPENDIX 3.2.1
Breakdown of Doctors Identified for Revalidation per Designated Body (cont.)

Non-NHS Organisations	Due Revalidation in 2018/19	Positive Recommendations	%	Deferrals	%	Non-Engagement
Assured Occupational Health Ltd	0	0	0%	0	0%	0
Castle Craig Hospital	0	0	0%	0	0%	0
DHI Medical Group Scotland	0	0	0%	0	0%	0
Glasgow Memory Clinic	1	1	100%	0	0%	0
Loudon Surgical Consulting Ltd	0	0	0%	0	0%	0
MP Locums Healthcare Ltd	1	0	0%	1	100%	0
Mental Welfare Commission for Scotland	0	0	0%	0	0%	0
Scottish Government	14	13	93%	1	7%	0
TauRx Pharmaceuticals	0	0	0%	0	0%	0
TOTAL	**16**	**14**	**88%**	**2**	**13%**	**0**

APPENDICES

APPENDIX 3.3

Overview of 5-year Appraisal Completion trends *Number (and percentage) of completed appraisals from 2014/15 to 2018-2019*

NHSScotland Health Boards	2014/15	%	2015/16	%	2016/17	%	2017/18	%	2018/19	%
NHSScotland Health Boards	10972	93%	11029	92%	11158	94%	11380	92%	11942	95%
Hospices	39	83%	47	96%	52	96%	54	97%	50	98%
Non-NHS Organisations	55	81%	69	88%	76	96%	71	99%	76	100%
TOTAL	**11066**	**93%**	**11145**	**92%**	**11286**	**94%**	**11505**	**92%**	**12068**	**96%**

APPENDICES

APPENDIX 3.3.1

Breakdown of 5-year Appraisal Completion trends per Designated Body

NHSScotland Health Boards	2014/15	%	2015/16	%	2016/17	%	2017/18	%	2018/19	%
Ayrshire & Arran	699	96%	727	99%	712	96%	729	94%	740	95%
Borders	244	87%	235	89%	271	95%	273	95%	264	97%
Dumfries & Galloway	300	92%	258	80%	296	89%	256	86%	322	99%
Fife	562	92%	551	84%	557	94%	547	87%	611	95%
Forth Valley	492	95%	516	92%	537	99%	562	98%	536	98%
Grampian	1114	98%	1175	98%	1207	98%	1236	98%	1203	96%
Gt Glasgow & Clyde	2735	92%	2778	94%	2854	95%	2908	94%	3036	95%
Highland	699	91%	670	90%	687	94%	633	87%	704	95%
Lanarkshire	916	89%	934	93%	893	92%	956	92%	1029	90%
Lothian	1992	92%	2021	92%	2099	95%	2203	95%	2193	97%
Orkney	59	98%	51	94%	47	100%	49	89%	49	91%
Shetland	38	84%	42	95%	43	96%	37	95%	49	100%
Tayside	925	94%	852	89%	732	81%	761	74%	972	96%
Western Isles	53	95%	49	82%	49	98%	51	96%	52	90%

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APPENDIX 3.3.1
Breakdown of 5-year Appraisal Completion trends per Designated Body (cont.)

NHSScotland Health Boards	2014/15	%	2015/16	%	2016/17	%	2017/18	%	2018/19	%
National Waiting Times Centre	77	85%	95	95%	97	93%	108	100%	95	94%
The State Hospitals Board for Scotland	14	100%	14	82%	13	93%	10	77%	14	100%
NHS 24	2	100%	2	100%	2	100%	1	100%	0	0%
NHS Education for Scotland	7	70%	8	100%	7	100%	4	67%	11	100%
Healthcare Improvement Scotland	3	100%	8	100%	8	100%	8	100%	10	100%
NHS Health Scotland	4	100%	4	100%	3	75%	2	67%	4	100%
Scottish Ambulance Service	0	0%	0	0%	0	0%	0	0%	0	0%
NHS National Services Scotland	37	100%	39	100%	44	100%	46	100%	48	100%
TOTAL	**10972**	**93%**	**11029**	**92%**	**11158**	**94%**	**11380**	**92%**	**11942**	**95%**

APPENDICES

APPENDIX 3.3.1
Breakdown of 5-year Appraisal Completion trends per Designated Body (cont.)

Hospices	2014/15	%	2015/16	%	2016/17	%	2017/18	%	2018/19	%
ACCORD Hospice	2	100%	2	100%	2	100%	2	100%	2	100%
Ardgowan Hospice	0	0%	1	100%	2	100%	1	100%	2	100%
The Ayrshire Hospice	4	100%	4	100%	5	100%	6	100%	4	100%
Bethesda Hospice	2	100%	2	100%	2	100%	2	100%	2	100%
Children's Hospices Across Scotland (CHAS)	0	0%	2	100%	2	100%	0	0%	3	100%
Highland Hospice	*Submitted as part of NHS Highland's returns*									
Marie Curie Edinburgh	5	71%	7	100%	7	100%	8	100%	7	100%
Marie Curie Glasgow	NA		7	88%	6	100%	4	100%	4	100%
The Prince & Princess of Wales Hospice	7	78%	3	100%	4	80%	6	100%	4	100%
St Andrew's Hospice	*Submitted as part of NHS Lanarkshire's returns*									
St Columba's Hospice	5	100%	4	100%	8	100%	9	100%	8	100%

APPENDICES

APPENDIX 3.3.1
Breakdown of 5-year Appraisal Completion trends per Designated Body (cont.)

Hospices	2014/15	%	2015/16	%	2016/17	%	2017/18	%	2018/19	%
St Margaret of Scotland Hospice	5	100%	4	100%	3	100%	4	100%	5	100%
St Vincent's Hospice	2	100%	1	100%	2	67%	2	67%	3	100%
Strathcarron Hospice	7	78%	10	91%	9	100%	10	100%	6	86%
Surehaven Glasgow Hospital	*Submitted as part of NHS Dumfries & Galloway's returns*									
TOTAL	**39**	**83%**	**47**	**96%**	**52**	**96%**	**54**	**97%**	**50**	**98%**

APPENDICES

APPENDIX 3.3.1
Breakdown of 5-year Appraisal Completion trends per Designated Body (cont.)

Non-NHS Organisations	2014/15	%	2015/16	%	2016/17	%	2017/18	%	2018/19	%
Assured Occupational Health Ltd									0	0%
Castle Craig Hospital	7	100%	7	100%	3	60%	2	100%	4	100%
DHI Medical Group Scotland					5	100%			6	100%
Glasgow Memory Clinic	0	0%	1	100%	1	100%	2	100%	4	100%
Loudon Surgical Consulting Ltd							1	100%	1	100%
MP Locums Healthcare Ltd	5	42%	15	65%	26	96%	25	100%	25	100%
Mental Welfare Commission for Scotland	4	80%	4	100%	3	100%	5	100%	3	100%
Scottish Government	32	97%	32	97%	33	100%	32	97%	31	100%
TauRx Pharmaceuticals					3	100%	2	100%	2	100%
TOTAL	**55**	**81%**	**69**	**88%**	**76**	**96%**	**71**	**99%**	**76**	**100%**

APPENDICES

APPENDIX 3.4
Revalidation of Doctors in Training

Year	Doctors in Training	Due Revalidation	%	Revalidated	%
2014/2015	5920	552	9%	511	93%
2015/2016	5673	643	11%	643	100%
2016/2017	5723	570	10%	570	100%
2017/2018	5783	691	12%	691	100%
2018/2019	**5683**	**560**	**10%**	**560**	**100%**

APPENDICES

APPENDIX 4 - GLOSSARY

Terminology	Description
Annual Appraisal	The formative process of preparing, collating and reflecting on information relating to the doctor's whole practice; followed by a discussion with an appraiser at a formal, confidential meeting. The appraisal meeting between the appraisee (the doctor) and appraiser should take place every year. The appraisal year for both primary and secondary care has been aligned to the financial year (1 April–31 March). An appraisal is considered to be completed when the summary of the appraisal discussion and Personal Development Plan have been recorded and signed off by the appraiser and appraisee (Appraisal Form 4), within 28 days of the appraisal meeting. Where an appraisal is not signed off or did not take place, a Form 5 should be used in lieu of a Form 4. Form 5A is used where there is a legitimate reason for not being appraised (e.g. maternity leave, long term sick, sabbatical etc); and Form 5B is used for non-engagement.
Clinical Fellows	This group of doctors are employed on contracts that are neither recognised training positions nor career grade posts. They have a range of experience and responsibility for direct patient care. For example, some may be taking time out of their training programme to acquire teaching or research experience and others may be employed directly for service purposes. Some of the latter group can be at a relatively early stage in their medical careers and some may be international medical graduates; both groups would be unfamiliar with the UK appraisal process.

APPENDICES

APPENDIX 4 - GLOSSARY

Terminology	Description
Designated Body	An organisation that employs or contracts with doctors and is designated in The Medical Profession (Responsible Officer) Regulations 2010, as amended by The Medical Profession (Responsible Officer) (Amendment) Regulations 2013.
General Medical Council (GMC)	The public body that maintains the official register of medical practitioners within the UK. Its chief responsibility is 'to protect, promote and maintain the health and safety of the public' by controlling entry to the register and suspending or removing members when necessary.
Good Medical Practice (GMP)	Good Medical Practice, published by the GMC, sets out the principles and values on which good practice is founded; these principles together describe medical professionalism in action. The guidance is addressed to doctors, but it is also intended to let the public know what they can expect from doctors: **www.gmc-uk.org/guidance/good_medical_practice.asp**
Independent Healthcare Provider	An NHS term for a healthcare services provider (a term which, as used in the UK, refers to an organisation, not an individual healthcare professional) that operates independently of the NHS.

APPENDICES

APPENDIX 4 - GLOSSARY

Terminology	Description
Licence to Practise	To practise medicine in the UK, all doctors are required by law to be both registered and hold a licence to practise. This applies to practising full time, part time, as a locum, privately or in the NHS, or employed or self-employed. Licences are issued, renewed and withdrawn by the GMC.
Prescribed Connection	The formal link between a doctor and their Designated Body. It is the route by which doctors are able to find their Responsible Officer. Regulation 10 and 12 in The Medical Profession (Responsible Officer) Regulations 2010 set out the 'prescribed connection' between designated bodies and doctors and these are explained in more detail in the Responsible Officer guidance.
Remediation	The overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carrying out some re-skilling, to more formal supervised programmes of remediation or rehabilitation.
Responsible Officer (RO)	A licensed doctor with a least five years' experience who has been nominated or appointed by a Designated Body. In Scotland, Medical Directors have been appointed as Responsible Officers and they have a key role in developing more effective liaison between organisations and the GMC as the regulatory body for all doctors. They also oversee the arrangements for medical revalidation, including all methods of evaluating fitness to practise. The GMC will make the final decision on revalidation of any doctor.

APPENDICES

APPENDIX 4 - GLOSSARY

Terminology	Description
Revalidation	Medical Revalidation is the 5-yearly process to renew a doctor's licence to practise. Recommendations are made by the doctor's Responsible Officer to the GMC.
Revalidation Recommendation: Positive	A "positive" recommendation to revalidate is a formal declaration from a Responsible Officer to the GMC that a licensed doctor remains up-to-date and fit to practise. The Responsible Officer has to be assured that doctors have: • met the GMC's requirements for revalidation • participated in systems and processes to support revalidation • collected the required supporting information for revalidation
Revalidation Recommendation: Deferral	If the RO is not satisfied with the information provided to make a positive recommendation, the doctor's Revalidation can be deferred, usually up to 6 months.
Scottish Online Appraisal Resource (SOAR)	The national online system used to record appraisal for trainees and doctors in primary and secondary care.

Medical Appraisal & Revalidation Quality Assurance (MARQA) Review 2018/2019

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 656 3200** or email **altformats@nes.scot.nhs.uk**.

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www.nes.scot.nhs.uk

NESD1051 | Medical Appraisal & Revalidation Quality Assurance (MARQA) Review 2018/2019 | Designed by the NES Design Team

NES **NES/20/14**
Item 10c
January 2020

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

NHS Education for Scotland draft Annual Operational Plan (AOP) 2020-21.

2. Author(s) of Paper

Donald Cameron - Director of Planning and Corporate Resources

3. Purpose of Paper

To present the draft Annual Operational Plan (AOP) for 2020-21.

4. Key Issues

The AOP guidance was received at the end of November 2019 and NES was required to submit a draft 2020-21 AOP to the Scottish Government (SG) by 13th December 2019. The guidance highlighted that SG did not expect these drafts to have been through Boards by the first submission date of 13 December and that SG would provide feedback in January 2020 – key dates are as follows;

SG feedback on draft - 24th January 2020
NES Board feedback on draft - 30th January 2020
Final draft to SG – 14th February 2020
Final draft to F&PM committee – 19th February 2020
Final draft to NES Board – 26th March 2020

NOTE: In addition, we received a letter from Caroline Lamb, Director of Digital Reform & Service Engagement, Scottish Government **(See appendix 1&2).** This letter has asked that we submit a more detailed Digital Health and Care Plan in draft by the end of January 2020. This will be presented to the NES Board in March alongside the final version of the AOP.

This draft AOP has yet to be designed and represents the second year of our strategy for 2019-24 which was finalised by the Board on 28th February 2019. It also considers the feedback we received from SG on the 2019-20 AOP and broadly follows the SG guidance received, describing our priorities over the three-year planning timescale set out in the SG financial framework with a focus on workforce and digital. After feedback has been received from SG

and the Board the final version will be brought to the NES Board meeting in March.

For NES's specific national NHS Board remit, this AOP supports Scotland's National Performance Framework and focuses on our priority performance targets, key actions for health and care within Protecting Scotland's Future: The Government's Programme for Scotland (PfG) 2019-20 and the Cabinet Secretary's priorities including waiting times improvement, investment in mental health, and health and social care integration. It works on a three-year forward look does and not cover all our work. This is contained within our more detailed operational plan covering the full range of our activities, desired outcomes and SMART performance targets for next year.

5. Educational Implications

This draft AOP positions NES to develop a national workforce and digital leadership role in line with our strategy for 2019-24.

6. Financial Implications

The AOP will be delivered in accordance with the financial plan agreed by the Board.

7. Which NES Strategic 'Key Area of Focus' does this align to?

The AOP is supported by a detailed operational plan which is aligned with the five key areas of strategic focus and outcomes within the NES strategy for 2019-24.

8. Key Risks and Proposals to Mitigate the Risks

Some of the key challenges for delivery of the 2020-21 AOP activities include:

- financial resourcing
- versatility of our workforce
- changing policy and political environment

Policy analysis is an on-going feature of the planning process along with the development of collaborative approaches. We aim to mitigate risk by developing a workforce with the flexibility to work across traditional boundaries and developing a lead role as the national workforce and digital organisation. In addition, we will continue to develop our approach to operational planning by focussing on the longer-term *Desired Outcomes,* and the *SMART Targets* which act as steppingstones to achieving that outcome. The process is integrated with long-term financial planning and individual and corporate performance management.

9. Equality and Diversity Impact Assessment

The NES response to the equality and diversity agenda is set out in the detailed operational plan.

10. Communications Plan

The final AOP will be supported by corporate communications, following approval by the Board and sign-off by the Scottish Government.

11. Recommendation(s) for Decision

To comment on and approve the 2020-21 draft AOP for submission to the Scottish Government.

Annual Operational Plan (AOP) 2020/21

V1 Draft – DC 27/11/19
V2 Draft – DC 02/12/19 with DSI comments
V3 Draft – SW/DC 13/12/19 with ET and wider comments

1. Introduction from our Chair and Chief Executive

NHS Education for Scotland (NES) is the national NHS Board with responsibility for education, training and workforce development. We work with key partners in the Scottish Government, NHS Boards, regions, social care, the academic sector and UK professional bodies and regulators across Scotland's diverse geography.

The NES *Annual Operational Plan (AOP) 2020/21* describes our priorities over the three-year planning timescale set out in the Scottish Government's financial framework. This AOP supports *Scotland's National Performance Framework* and focuses on our priority performance targets, key actions for health and care within *Protecting Scotland's Future: The Government's Programme for Scotland (PfG) 2019-20* and the Cabinet Secretary's priorities including waiting times improvement, investment in mental health, and health and social care integration.

In taking forward this AOP we will place the emphasis on a whole system approach, working with our key partners across health and care to improve workforce recruitment, retention, planning and careers in order to provide the right numbers of trained staff in the right place at the right time. This AOP is also aligned with the *NES Strategy 2019-24* which describes our ambition to develop a skilled and sustainable workforce supported by digital innovation and high-quality data.

This AOP provides the basis on which the Scottish Government will hold NES to account for our contribution towards on-going improvements in safe, effective and person-centred care. Subject to resourcing, it will be delivered within the financial plan submitted alongside this AOP which sets out an indicative breakeven position in each year of the three-year planning cycle to 2022-23.

David Garbutt	**Stewart Irvine**
Chair	Acting Chief Executive

2. National Boards Collaborative

We are part of a collaborative of eight national NHS Scotland boards providing services where improved quality, value and efficiency is best achieved through a national approach. We share a common purpose and by working closely together, and with our partners in the Scottish Government, regions, territorial boards and integration joint boards, we will support the changes required to improve services, reduce unnecessary demand, improve workforce sustainability and strengthen leadership to protect and improve Scotland's health.

The National Boards Collaborative Programme focuses on three areas - (1) improvement, transformation and evaluation; (2) digitally enabled service redesign; and (3) a sustainable workforce:

These are the areas where we believe we can help our partners redesign services to meet technological, demographic and societal changes. We will take on difficult issues in partnership to identify where national support can help deliver real sustainable change to address priority areas such as waiting times, integration, mental health, primary care and healthcare associated infection.

3. Our Vision and Mission

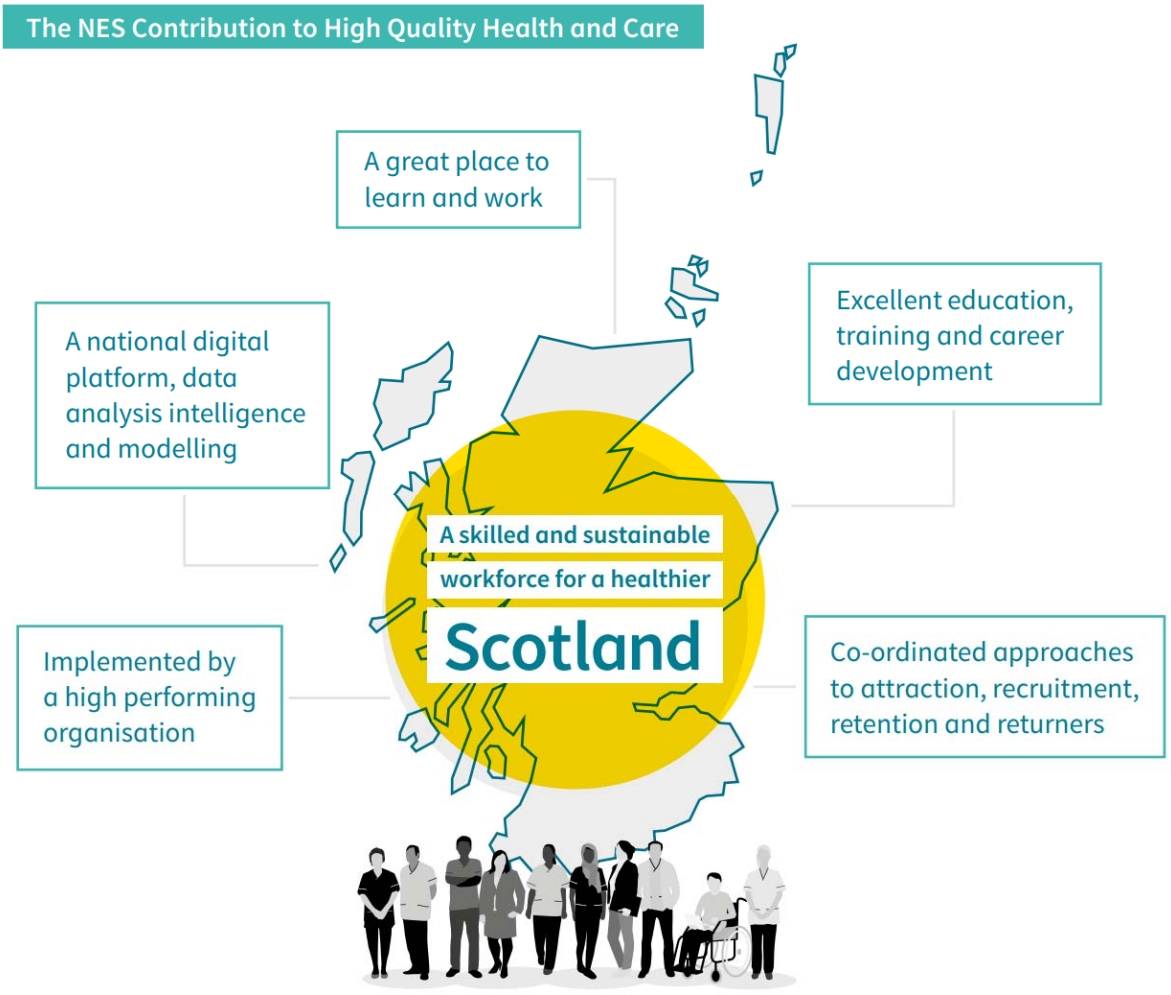
OUR VISION: ‘A skilled and sustainable workforce for a healthier Scotland’
OUR MISSION: ‘Enabling excellence in health and care through education, workforce development and support’

This AOP supports *Protecting Scotland's Future: The Government's Programme for Scotland 2019-20 (PfG)* and contributes to *Scotland’s National Performance Framework*. The national performance framework places a strong focus on public service reform and NES has an important role in shaping a skilled and sustainable workforce to deliver the services we will need for the future. Many actions relevant to NES have featured in the PfG over recent years with an increasing emphasis on workforce sustainability and digital innovation. Of note this year are the announcements of additional foundation places for medical graduates and proposals for a new medical school.

The PfG has helped to guide our operational and financial planning for 2020-21 alongside the *NES Strategy 2019-24*, the *Health and Social Care Delivery Plan*, the *National Clinical Strategy* and the *Digital Health and Care Strategy*. In addition, the Cabinet Secretary’s priorities on waiting times, integration, mental health, primary care and healthcare associated infection, as well as the Scottish Government’s workforce plans, help to establish our planning priorities and are reflected in the strategic outcomes set out within the *NES Strategy 2019-24*.

Through our detailed operational and financial planning process we have placed a strong emphasis on evaluating the impact of our activities in terms of driving change, innovation and quality improvement. Developing and retaining a skilled and sustainable workforce will involve supporting the wellbeing of our staff and providing more flexible careers for the health and social care workforce. In addition, a proper understanding of the supply routes into health and social care, allied to improved career entry and progression, awareness of career opportunities and role development will be key to ensuring we have the right numbers of trained staff, in the right place at the right time.

Alongside workforce, digital innovation will continue to play a key role in supporting the workforce and in developing safer services which enable people to manage their own health. In Scotland, health and social care providers will need to work together to build the digital infrastructure required to meet increasing demand, improve safety and create more time for care. Key to meeting these challenges will be digitally enabled models of care which use data and intelligence for service and workforce planning and currently there are a range of emerging initiatives which support the principle that people want to live at home as long as possible, with easier access to services and less need to travel. The *Digital Health and Care Strategy* provides a framework for the development of new digitally enabled models of care which the health and care workforce and the public are confident using.



2020/21 represents the second year of the *NES Strategy 2019-24* which identifies five key areas of focus as follows;

- ***a high-quality learning and employment environment***
- ***national infrastructure to improve attraction, recruitment, training and retention***
- ***education and training for a skilled, adaptable and compassionate workforce***
- ***a national digital platform, analysis, intelligence and modelling***
- ***a high performing organisation (NES)***

This AOP and the *NES Strategy 2019-24* are ambitious and will require sufficient funding to support their full delivery. We will work with Scottish Government to ensure that the financial plan which underpins the delivery of this AOP will enable us to fully realise the benefits of a skilled and sustainable workforce. Although the financial plan is balanced as noted within the risks and assumptions, it assumes that the training grade deficit will be fully funded, and that all anticipated allocations are received.

4. A Skilled and Sustainable Workforce

A skilled and sustainable workforce lies at the heart of our health and care system, and recent data shows a continuing upward trend in the numbers of staff working in healthcare. Alongside this however, there is clear evidence of increasing demand, driven in part by changes in the demography of the population, evidence that staff turnover and vacancy rates are increasing, and evidence that the workforce is getting closer to retirement. Geography also has an impact with higher vacancy rates in remote and rural areas. Taking account of current vacancy levels, there is a risk that further workforce gaps will appear without action to increase the supply routes into health and social care.

In medicine and dentistry, while numbers in post continue to increase, long term vacancies account for over half of all vacancies and there are challenges filling training posts in some specialties and in some locations, and in retaining doctors and dentists once qualified. Nursing and midwifery turnover and vacancy rates are also rising with long term vacancies a feature of this trend. In the allied health professions (AHPs), although turnover remains steady, there has been an increase

in vacancies with the highest rate and numbers in physiotherapy. In healthcare science (HCS) there are also high vacancy rates and increasing number of staff nearing retirement leading to gaps in the early career grades.

Improving workforce supply is therefore essential to addressing the Cabinet Secretary's priorities as people seek more flexible careers and working patterns. This AOP provides a high-level summary of the priority work that NES will deliver over the next three years, subject to capacity and funding, to improve the training and employment experience and attract and retain the right people.

The *Waiting Times Improvement Plan* identifies workforce skills and supply as key elements of improving access to services. Over the next three years, NHS Scotland is embarked on an ambitious programme to improve waiting times through new elective and major trauma centres. These developments and other new models of care will need skilled staff and the service will need to consider whether there are enough trainees coming through the system and what additional training and education, or recruitment activity needs to be commissioned.

NES has been working to identify a range of roles to add workforce capacity through enhancement or increased numbers, such as operating department practitioners (ODP), nurse endoscopists, reporting radiographers and sonographers, healthcare support workers, physician associates, surgical first assistants and anaesthesia associates. Over the next three years we will work with officials and service partners to take a strategic approach to how these roles are developed, providing consistency and transferability in terms of standards and development programmes.

This AOP is underpinned by a more detailed operational plan covering our core work to develop a well-trained workforce and prepare professionals for practice. This AOP is based on our priority performance targets, key actions for health and care within the programme for government and the Cabinet Secretary's priorities. In addition, we will continue to deliver a range of other activity in areas such as mental health, primary care, healthcare associated infection, quality improvement, person centred care, patient safety, advanced practice, leadership and

management, children and young people, maternal health, role development and remote and rural healthcare. The full range of these activities and their associated outcomes, SMART performance targets and budgets are included in the more detailed operational and financial plan which supports this AOP.

4.1 High Quality Learning and Employment

Strategic Outcomes

- *More consistent, modern and flexible employment experiences*
- *High quality training programmes and placement learning*
- *Meaningful career conversations, appraisal and educational portfolios*
- *Excellent support for workplace learning and development*
- *Improved opportunities to access learning*
- *More accessible and flexible resources for remote and rural learners*
- *Improved employee and trainee feedback, engagement, and health and well-being*
- *Best value national administrative systems which enable flexible working and release time*
- *More accessible employment and training services, resources and information*

An important aspect of NES's role is educational governance, quality management and educational infrastructure to ensure a high-quality learning and employment environment which exceeds regulatory standards. This involves commissioning and quality management for the trainee medical, dental, psychology, pharmacy and healthcare science workforce and performance management of pre-registration nursing and midwifery programmes.

In medicine NES will continue to provide a quality management framework and we will publish an annual quality report on our work with Scotland's medical schools and NHS Boards to address areas needing improvement and promote good practice. This includes work with the General Medical Council on 'enhanced monitoring' and a continuing contribution to the *Sharing Intelligence for Health and Social Care Group*.

Over the next three years NES will continue to deliver training for staff providing educational supervision and practice education to improve the quality of the learning and employment environment where we recruit, manage and quality assure education and training. Subject to funding, we will develop a digital solution to triage which education providers, training programmes, and trainers require quality management support, and which captures the planning, delivery and outcomes of quality management activities. We will also deliver a range of activities designed to quality assure training placements such as site visits, end of placement reviews, annual reviews with employers and education providers and feedback mechanisms from both trainees and service users. For the newly developed paramedic education programme we will establish a quality assurance and performance monitoring process.

NES will continue to implement flexible employment models to enhance the attractiveness of Scotland as a place to work and train. Subject to progress with *e:EES*, we will develop *TURAS People* and *TURAS Learn* to support the lead employer model for doctors and dentists in training and to ensure statutory and mandatory training compliance. Subject to funding, we will continue to implement the lead employer programme by extending the single employer model to dental trainees, further improving the employment experience through streamlined pre-employment checks and links to payroll. To support equality and diversity we will implement reasonable adjustment 'passporting' arrangements for doctors and dentists in training. We will also provide a workforce policies national digital solution and develop *TURAS* to enable trainees to apply for less than full time training, out of programme experience and study leave.

Effective educational commissioning is crucial to ensuring high-quality education and training. To support this, we will work with higher and further education to consolidate a new education commissioning model which was recently used for operating department practitioner (ODP), integrated community nursing and paramedic programmes. This approach will ensure good educational governance, quality control and improvement with the essential first step of data collation, to enable a better understanding of workforce supply.

NES will continue to take the ‘statutory responsible officer’ role for all doctors in training and in auditing medical appraisal across Scotland. We will provide revalidation, career conversations and appraisal resources to help clinicians develop their practice, drive improvements in clinical governance and give patients confidence that their treatment is up to date. For medical appraisal we will improve accessibility to training by introducing remote learning and online applications within the *Scottish Online Appraisal Resource* (SOAR).

Subject to funding, over the next three years we will develop digital solutions for the wider workforce which make it easier to link personal development plans (PDPs) with learning resources and ePortfolios. This will involve developing links between *TURAS Learn* and *TURAS Appraisa*l so that learning records can be viewed and created as part of PDPs. In addition, we will develop links between *TURAS ePortfolio* and *TURAS Learn* so that learning records and resources are accessible from an individual's ePortfolio.

Gathering feedback provides valuable information on which to base improvements in the training and employment experience. NES will support national (UK) surveys where these exist, undertake local trainee surveys across a range of professions and extend the mechanisms for gathering feedback to join up with employment experience tools. We will also develop system sign on to *iMatter* from *TURAS*.

Over the next three years NES will continue to support the implementation of key recommendations from the UK *Shape of Training Review* to reform the structure of postgraduate medical training across the UK. This will involve full participation in Scottish and UK-level meetings on curricula redesign and credentialing of medical skills, supporting priorities for Scotland such as surgical training and internal medical training, and developing a credential in remote and rural practice. We will also continue to work with key partners to improve junior doctors’ working lives by contributing to expert working groups supporting the wellbeing of staff, and the redesign of rotas.

NES continues to promote fairness for all trainees, and we will work with regulators to tackle differential attainment rates between different demographic groups. We will continue to evaluate information about learners' performance, progression and outcomes so we can monitor the impact of the action plan we have in place.

4.2 Attraction, Recruitment, Training and Retention

Strategic Outcomes

- *Improved promotion of career opportunities in health and care and easy access to information*
- *Greater awareness of career opportunities in health and care for young people and school leavers*
- *Higher education outcome agreements that meet the needs of health and care*
- *Widened access to higher education and improved recruitment in key areas*
- *Sufficient education and training capacity to meet future workforce needs*
- *High take up and fill rates in post-graduate training programmes*
- *Effective support for staff returning to work or retraining*
- *Initiatives to support succession planning*

In terms of attraction, recruitment, training and retention, NES is well placed to promote careers in healthcare, help equip young people for jobs and improve access to learning for healthcare support workers. We will continue to improve the attractiveness of NHS Scotland as an employer, with a focus on widening access and developing careers and, subject to funding, there are a range of potential opportunities for the future. These include taking responsibility for *JobTrain,* the new digital recruitment system aligned to the *NHS Scotland Careers* portal. *JobTrain* enables people to set up job alerts, target vacancies, save and view previous applications and book interviews. Bringing *JobTrain* into NES would enable future integration with other *TURAS* workforce applications to improve the user experience and reduce 'drop offs' which can occur when working across different systems.

Subject to funding, we are also well positioned to provide enhanced support for international recruitment and for staff experience tools such as *iMatter* and *Dignity at Work*. Taking a national approach to these areas has the potential to better align workforce initiatives and further integrate cloud-based workforce applications.

NES will provide recruitment services for the healthcare professions, working to target numbers for postgraduate and pre-registration training to ensure there is a supply of well-trained staff to meet demand. In medicine we will recruit, train and support doctors in training to agreed targets, including expansion of the general practice workforce, supply to remote and rural areas and increasing the numbers of foundation trainees, particularly in mental health and general practice. In dentistry we will provide national vocational training, core, specialty and post 'Certificate of Completion of Specialist Training' and therapist vocational training (TVT) to agreed target numbers. We will also commission and recruit to agreed target numbers for healthcare science and applied psychology and psychotherapy training programmes and provide a national pre-registration pharmacist scheme. To support the administration of these programmes we will review the training programme management (*TURAS TPM*) application to enable more professional groups to use it.

We will also manage Additional Cost of Teaching (ACT) funding in undergraduate medicine, dentistry and pharmacy, working with NHS Boards and universities to ensure the needs of the NHS are fully met. In medicine we will support the recommendations made by the *Increasing Undergraduate Education in Primary Care Review Group* to ensure GP practices are properly supported for teaching medical students. In dentistry, we work with the Student Awards Agency Scotland (SAAS) to review the impact of the dental undergraduate bursary scheme and we will monitor the use of funding for dental outreach centres providing clinical placements for final year students.

Over the next three years NES will continue to meet the challenges of workforce supply and sustainability by promoting career opportunities and supporting youth employment. Subject to funding, we will take a lead role in developing new foundation, modern and graduate apprenticeships, and we will increase use of the

modern apprenticeship levy through the flexible workforce development fund. In addition, we will lead the development of national resources to improve workforce planning skills across health and social care.

We will continue to deliver a joint action plan with the Scottish Funding Council (SFC) which includes outcome agreements with universities. In medicine this includes widening access and increasing the pool of applicants who stay and work in Scotland and enabling students to gain more experience in primary care. We will collect and analyse recruitment and retention data to inform commissioning and we will work with Scotland's colleges to strengthen access to pre-registration programmes. We will also commission and performance manage higher education providers to deliver school nursing education and we will continue to support nurses through postgraduate diplomas as part of the Scottish Government's commitment to an additional 500 advanced nurse practitioners.

Over the next three years NES will oversee the provision of paramedic education in universities at ordinary degree level. We will also work with the Scottish Government to develop career pathways and resources for consultant, advanced and senior allied health professionals (AHPs). The AHP careers fellowship scheme will continue to support work-based change and improvement projects which contribute to local and national priorities and which provide career development. We will also deliver a three-year action plan to implement clinical skills across the nursing, midwifery and AHP workforce.

Over the next three years, we will embed the recently developed *Perioperative Career and Development Framework.* Supported by a *TURAS Learn* site and educational events, this will provide consistency across Scotland and improve perioperative recruitment, career planning and role development. This will help reduce the plethora of roles and titles within the perioperative workforce and improve workforce data quality. We will also provide a refreshed *Anaesthetic Assistant Competency Framework* to support vocational development of staff groups beyond anaesthetic assistants.

NES is committed to improving retention through return to work programmes accompanied by careers advice and enhanced induction for practitioners. In medicine we will provide GP returner and enhanced induction programmes and we will provide mentoring and coaching and a staying in practice scheme (SIPS). In dentistry we will aim to increase the numbers returning to practice and the number of staff accessing support for returning to work. We will also deliver a programme of remediation and bespoke support for dental registrants, including mandatory training. In addition, we will implement national guidelines for the AHP practice education network to support returners to practice and provide nursing and midwifery return to practice programmes.

4.3 A Skilled, Adaptable and Compassionate Workforce

Strategic Outcomes

- *Learner-centred continuing professional development which ensures practitioners keep up to date*
- *Enhanced roles to support an improved skill mix and service redesign*
- *Well-developed multi-disciplinary teams*
- *Improved development for support workers and allied health professionals*
- *Clear career progression routes for all roles*
- *A caring and compassionate workforce*
- *People developed with the right values and behaviours to operate across boundaries*
- *Access to leadership and management development at all levels*
- *A culture of continuous improvement embedded in everyday practice*
- *Excellence in clinical practice based on evidence and safe models of care*
- *Coherent approach to developing and sharing learning resources*

NES will continue to support the Scottish Government's drive to embed *Realistic Medicine* so that people and their families are involved in decisions about their care and fully aware of its implications. We will support service reform, harmonised workforce practices, and positive workplaces through learning resources, continuing professional development (CPD) and role development. Crucial to developing the workforce, improving waiting times and driving integration will be

new models of community-based care. This area of our work is supported by our *TURAS Learn* platform giving health and social care staff access to learning, knowledge, evidence and subscription content. Over the next three years we will continue to migrate NHS Boards and local authorities to *TURAS Learn.*

NES will provide CPD for primary care practitioners and teams. Supported by the *CPD Connect* and *TURAS Learn* platforms, this will involve programmes for general medical and dental practice, general practice nursing, GP practice pharmacists and pharmacy technicians, community pharmacists and optometry. In primary care we will support GP practices to provide clinical leadership and supervision to multi-disciplinary teams. We will deliver vocational training for practice managers and provide accredited training, clinical career fellowships, short courses and pre-registration placements with GP nurses. We will also continue to manage attainment of the Scottish Government target for an additional 500 advanced nurse practitioners to be trained and to commission education for district nurses, community children's nurses and looked after children's nurses.

For pharmacists NES will deliver a learning pathway and competence framework for advanced practitioners working in general practice and we will provide independent prescribing development. We will also scope the educational needs of pharmacy support workers and deliver a foundation learning pathway for pharmacy technicians in GP practices. In dental practice we will provide vocational qualifications (SVQs), professional development awards (PDAs) and higher units (HN), to enhance the roles of dental care professionals. We will also reduce inequalities and access to oral care for priority groups through a range of programmes for vulnerable people where consent is an issue. In optometry we will provide ‘teach and treat’ centres and role development to support independent prescribing and optical assistants. We will also focus on ocular therapeutics, ocular hypertension and glaucoma.

Over the next three years NES will aim to support Scottish Government mental health priorities such as mental health improvement, suicide prevention, perinatal and infant mental health, the adult mental health collaborative, primary care and community mental health support, comorbidities, prison health, drug and alcohol

misuse and psychological trauma. Mental health will remain a priority for NES in these areas:

- pre and post registration education of mental health disciplines (mental health nursing, psychiatry, clinical psychology)
- mental health education for pre and post registration healthcare disciplines including those in primary care settings (general medical practitioners, practice nurses, allied health professionals, health visitors, school nurses)
- mental health education for multidisciplinary staff, social care and third sector staff (care home, residential care and care at home staff)

Recruitment to psychiatry remains a challenge and we will aim to improve the experience of mental health placements in undergraduate and early-years training while providing a full range of regional and national educational opportunities. In psychology we will deliver pre-registration education covering clinical psychology, psychological therapies in primary care and applied psychology for children and young people to develop the skills to support people with complex psychological needs. We will deliver a range of resources for the wider multi-disciplinary workforce in areas such as infant mental health, parenting and the early years. In addition, we will maintain our commitment to child and adolescent mental health services (CAMHS) education for multi-disciplinary and multi-agency staff. These initiatives will develop enhanced capacity to improve waiting times for mental health services and psychological therapies.

To improve early years mental health the Scottish Government is committed to developing new community perinatal mental health services and infant mental health hubs. These services will require multi-professional and multi-agency training for staff in cognitive behavioural therapy and psychological therapies where we have significant expertise and experience. Over the next three years we will help build workforce capacity and capability in paediatric psychosocial care and through parenting programmes. Additional school nurses are also being recruited and we will provide training in early psychological care and implement the findings of a learning needs analysis to support CPD and digital resources.

For AHPs we will use the *Mental Health Improvement and Suicide Prevention Knowledge and Skills Framework* to support mental health practice at informed, skilled, enhanced and specialist levels. In general practice, mental health will remain a major component of training through training placements in psychiatry, approved medical practitioner training, CPD for the primary care workforce and a specialist and associate specialist development programme.

Over the next three years NES will continue to deliver in areas such as learning disabilities, autism and dementia and will provide an educational framework for psychological wellbeing in adults with learning disabilities. To continue to support implementation of the dementia promoting excellence framework we will continue to provide a range of learning events and masterclasses, deliver a range of training for trainers' programmes, including palliative and end of life care, and deliver a fourth cohort of the dementia specialist improvement leads programme for staff from health and social care.

The Scottish Government is working with COSLA to increase the pace and effectiveness of health and social care integration. NES will continue to provide role development in areas such as independent prescribing, dementia, forensics, end of life and bereavement care and mental health, not only on a multi-professional basis, but also across health and social care. Adverse childhood experiences and women's health have been identified as priorities and we will continue to support the family nurse partnership (FNP) through supervisor learning and mentoring, evaluation to ensure license compliance and research on transitioning from theory to practice. The Scottish multi-professional maternity development programme (SMMDP) will link with our work on maternal health by providing educational resources, clinical skills courses and continuity of care support for multi-professional maternity teams and pre-hospital care practitioners. Oral health improvement has also been identified as a public health priority and we will continue to provide an enhanced practitioner training programme for general dental practitioners to provide domiciliary care in social care settings.

NES will embed person-centred care in our activities, placing people at the heart of services and increasing the number of volunteers involved in our work. This will

include training for health and social care staff in death, dying and bereavement as well as spiritual care and chaplaincy education. Our spiritual care and chaplaincy team will continue to deliver *Values Based Reflective Practice* (VBRP®), support for the *Patient Reported Outcome Measure* (PROM) and *Community Chaplaincy Listening* to create more time for care and reducing anxiolytic and antidepressant prescribing. We will work with the Scottish Social Services Council (SSSC) to support the carers strategy and spread *Project Lift* and we will further develop the duty of candour eLearning resources. In addition, we will provide patient safety and clinical skills training as well as education and research in human factors and ergonomics. Our multi-professional maternity skills programme (SMMDP) will provide resuscitation and obstetric emergency courses, core mandatory training, and skills training to support the new maternity programme *Best Start*. We will also deliver education in health protection and infection prevention and control and provide development and improved career pathways which widen access to education for support workers, administrators and managers.

NES quality improvement (QI) activities will continue to support the *Waiting Times Improvement Plan*, through the *Access QI* programme, supporting NHS Boards with QI expertise to reduce waiting times, increase capacity, improve clinical effectiveness and design new models of care. We will also provide a broad range of QI programmes and curricula supported by a national network of leads and practitioners and we will provide a development package in leadership, governance and quality improvement for non-executive board members and board chairs.

NES will continue to work with the Scottish Government to implement *Project Lift* leadership development, talent management and appraisal. Over the next three years we will provide early careers programmes and we will support the growth of leadership communities in integration settings, including delivery of the *Leadership Cubed* programme and *Career Conversations* for high potential individuals. During 2019 we launched *NHS Connect* on the *TURAS* platform to provide a human resource, organisational development and learning portal for the national boards. We will continue to develop *NHS Connect* to provide resources, supported by a restructured team to co-ordinate leadership activity, work to shared goals and develop a ‘joined up’ approach. This will help assess the viability of a single system

approach to organisational, leadership and workforce development across health and care. Subject to funding, we will also provide national learning resources for statutory and mandatory training to support agenda for change pay reform.

4.4 Digital Platform, Analysis, Intelligence and Modelling

Strategic Outcomes

- *A national digital platform with a coherent architecture*
- *The ability to rapidly introduce and scale up new technologies based on consistent standards*
- *Products developed on the national platform that improve patient care and experience.*
- *Business, administrative and workforce systems that create time for care and improve the employment experience.*
- *Improved access to information, data analytics and intelligence*
- *Improved capability and capacity in our specialist digital workforce*
- *A workforce with up to date skills to deliver digitally enabled services*
- *Accessible, accurate and linked workforce data for planners and decision-makers*

Over the next three years NES will continue to deliver key elements of the *Digital Health and Care Strategy* to help reduce waiting times, improve safety, create more time for care and develop the workforce to use data for service and workforce planning. We acknowledge the crucial role we have as digital leaders through development of the single national digital platform and through *TURAS*, our workforce platform. Better use of digital and data will help the health and care system achieve the best possible outcomes for people by providing;

- knowledge and information where and when it's needed
- workforce resources and services for all health and care staff
- leadership to ensure digital is an enabler of service redesign
- digitally enabled homes to support self-management
- video clinics for outpatient attendances
- easy access to health records, test results and outpatient booking
- real-time support to staff at people's homes or working in care homes

We will continue to support the *Digital Health and Care Strategy* through the NES Digital Service (NDS). We will host new community health index (CHI) services on the national digital platform with agreed policies on information governance, safety and security and the technology for access. We will also manage the transition from interim *Azure Active Directory* (AAD) to access through Office 365.

Over the next three years NDS will develop clinical modelling expertise and clinical risk management processes. We will develop a research strategy and our approach to local government engagement, and we will agree work plans for connecting NHS Boards to the national digital platform through a test environment. We will also take responsibility for the national integration hub with an agreed approach to integration with local legacy systems and we will develop a shared data store with access control and analytic resources.

Over the next three years NDS will develop a policy for commissioning services such as: community monitoring through devices and sensors; use of patient reported outcomes to monitor health; digital communication with citizens and carers; virtual, telephone and video appointments and; digital scheduling and appointments. In addition, the *Recommended Summary Plan for Emergency Care and Treatment (*ReSPECT) will be available in all NHS Boards and we will establish a new public cloud service, support the development of a major trauma application, develop digital messaging services and provide a clinical data repository (CDR). We will also deploy authentication for national digital platform products, engage citizens in their development and enable them to create a digital identity to access and update their own health information.

The Scottish Government has placed a strong emphasis on improving workforce planning over the next three years and NES will continue to develop the *TURAS Data Intelligence* platform and data analytics services. Subject to funding, we are also well positioned to address the variation in workforce data and analytics related to the staff governance standard by providing NHS Boards with improved access to their own data and the ability to adapt it to their own needs.

This work coincides with the transfer of responsibility for national workforce statistics to NES and includes migrating historic workforce data into *TURAS Data Intelligence.* We will form a new workforce data team to fulfil our newly acquired responsibilities for national workforce statistical analysis, reporting and publication. We will also source new data to enhance *TURAS Data Intelligence* covering numbers of staff across disciplines, the number/types of healthcare professionals in the training/supply pipeline and trends in workforce flow. A framework for modelling this activity has been produced to better predict the impact of changes in policy, training capacity and supply on workforce availability.

Over the next year, we will continue to engage with workforce planners and social care partners to finalise the *TURAS Data Intelligence* dataset and we will achieve accreditation as a national statistics provider. We will provide quarterly publications for the core NHS workforce and the psychology and CAMHS workforce, along with analysis of the medical and dental workforce and for newly qualified nurses and midwives to support intake planning. For AHPs, we will develop data sharing agreements and add data to *TURAS Data Intelligence*.

Throughout the various sections of this AOP there is a range of work identified to develop workforce resources, tools and systems within the *TURAS* platform. In addition to these, we will develop an employee data model to help provide better employment support and advice and improve the quality of information on people joining, leaving or moving jobs. Over the next year we will also continue to integrate legacy *Knowledge Network* services into the *TURAS* platform.

Another priority for NES is supporting the modernisation of national business and workforce systems. A key element of this work is procurement of national *eRostering* to improve the deployment of staff, reduce reliance on agency and locum staff, give employees more flexibility, improve the quality of workforce data and create more time for care. Subject to funding, over the next year we will complete the integration of *eRostering* data with the *Scottish Single Timesheet System* (SSTS), to eliminate manual data entry duplication. We will also continue to support the national roll-out of Office 365 across NHS Scotland.

Working with cross sector partners, NES will support the workforce and information governance domains of the *Digital Health and Care Strategy* with a focus on leadership and a digitally enabled workforce that is confident using digitally enabled services. Over the next three years we will provide digital information and health literacy resources through *TURAS Learn.* In addition, subject to funding, we will establish a nationally managed and locally oriented network of digital champions supported by digital skills resources for the health and social care workforce. We will also provide national resources and guidance on information governance.

4.5 A High Performing Organisation

Strategic Outcomes

- *A positive and flexible employment experience for NES staff*
- *Improved training, organisational development and quality improvement capacity and capability*
- *A culture of innovation, improvement and shared responsibility*
- *A digitally enabled NES*
- *Effective accountability and governance and a sustainable NES*

NES acknowledges that every member of our staff has a role to play in creating a modern, happy and healthy workplace supported by excellent governance and business support to ensure we are equipped to deliver in a changing world. Delivering this AOP will require resources and a healthy organisational culture. We will also need to maintain a focus on the risks associated with cost and system pressures which, if not managed, could lead to under-investment in the health and care workforce and difficulties delivering the national digital platform. We will mitigate these risks through strong stakeholder engagement, partnership working with Scottish Government to address resourcing challenges and being clear on expectations and deliverables for the national digital platform.

Over the next three years NES will maintain a strong focus on staff governance, development and wellbeing to ensure our employees have a positive employment experience. We will aim to achieve full compliance with personal review and

planning and essential learning for eligible staff and we will continue to develop our organisational culture and collective leadership through specialist interventions, staff training and the application of *Our Way*. We will also support directorates to adopt a workforce planning model that focuses on the early identification of key role requirements, skills gaps and solutions to improve supply. We will maintain our excellent *iMatter* performance and we will implement *Trickle,* a digital tool for real-time staff engagement. In addition, we will promote compassionate leadership, update our internal leadership and management programmes and provide support focused on digital skills, *Smarter* working and career transitions.

Over the next three years NES will place a strong emphasis on organisational performance improvement which will enable us to work in new ways, supporting great work and working lives. We will continue to embed *Smarter* working practices through flexible working policies, digital technology and workplace design which enable our staff to work in a way which suits their personal circumstances and improves efficiency and effectiveness. We will also standardise processes for our continuing professional development (CPD) programmes to avoid unnecessary variation and duplication and make the best use of the *TURAS* platform.

NES has a mainly rented office and training space estates infrastructure which we monitor through regular condition and planned maintenance reviews. Over the next three years, we will contribute to developing a strategic joint approach to property and asset management across the national boards and maintain our focus on climate change by creating *Smarter* workplaces which provide a better staff experience and a more efficient and sustainable use of space. Over the next year we will also scope the options for the end of our lease at the Centre for Health Sciences in Inverness in 2021 and we will establish a long-term property option for the NES Digital Service (NDS) in Edinburgh. Due to the nature of our estate infrastructure, we have identified no high and significant backlog maintenance or equipment replacement risks.

Over the next three years we will continue to develop corporate services which deliver effective accountability and governance and meet our responsibilities to

become a more sustainable and energy-efficient organisation. We will continue to provide cloud-based digital services which support *Smarter* working. In addition, over the next year we will implement a communications solution, integrated with Office 365, to replace our telephone systems and we will put in place a cloud-based backup service to ensure critical data and services are recoverable within a single business day.

5. Our Annual Operational Plan (AOP) for 2020/21

This AOP focuses on a range of workforce and digital priorities which will require funding and partnership working to deliver. It is aligned to the *NES Strategy 2019-24* and describes our priority activities plus support for key actions within the programme for government and the Cabinet Secretary's priorities on waiting times, integration, mental health, primary care and healthcare associated infection.

This AOP does not cover all our planned work and is underpinned by a more detailed operational and financial plan, also aligned to the *NES Strategy 2019-24*, which includes the full range of our activities, their desired outcomes, SMART performance targets and budgets.

Both this *Annual Operational Plan* and the *NES Strategy 2019-24* can be found at: www.nes.scot.nhs.uk/about-us/corporate-plans-and-annual-reports.aspx. The more detailed information contained in our 2020/21 operational plan can be obtained by e-mail from nes.planning@nes.scot.nhs.uk

Appendix 1

NHS Chief Executives
NHS Directors of Finance
Integration Authority Chief Officers
Integration Authority Chief
Finance Officers

cc NHS Board Chairs
IJB Chairs

11 December 2019

Dear Colleague

DIGITAL HEALTH & CARE – ANNUAL OPERATIONAL PLAN 2020/21

Further to John Connaghan and Christine McLaughlin's letter of 06 November 2019 providing guidance in relation to Annual Operational Plans, I am now writing to you with further details on the digital health & care component.

For the first time, the AOP guidance included digital health & care as one of the core requirements for inclusion. That included an expectation that NHS Boards set out the critical contribution of digital to the successful delivery of their AOPs and related plans within their AOP, along with an articulation of the national and local dimension.

Attached to this letter is additional guidance to Health Boards and Integration Authorities providing more detail on our expectations, which includes the development of a dedicated plan for digital health & care. I would ask you to note that this is significantly wider in scope and intent to what would traditionally be captured in any eHealth or technology enabled care plans, capturing as it does the breadth of the Digital Health & Care Strategy – particularly in relation to workforce development, leadership, skills and citizen engagement.

The guidance sets digital within the same context as the AOP – namely, asking for Boards to demonstrate how digital will contribute to how Boards and their partners are addressing the Cabinet Secretary's priorities on waiting times improvement; investment in mental health; service transformation and the delivery of greater progress and pace in the integration of Health and Social Care.

The guidance provides clarity on our Programme for Government commitments, and sets out a number of national initiatives that require local leadership to drive implementation. The guidance also articulates a number of principles that we expect all organisations involved in the delivery of care to have either adopted, or demonstrate how they are working towards adopting them.

I recognise that this a new a process for Boards and Integration Authorities that will take time to properly bed in. We are asking for initial draft digital health & care plans by the end of January 2020, along with completion of a short template which is contained within the guidance.

It would then be my intention that my team and I make ourselves available to you to discuss your Plans in more detail as we align their further development and ultimate sign-off with the AOP process.

At the same time, we will be further developing our new Financial Framework for Digital Health & Care, and I would welcome the support of NHS Directors of Finance and Integration Authority Chief Finance Officers as part of this process. I would anticipate both the planning process, and the accompanying financial framework, to be developed further over the course of 2020/21. If you have any questions about this process, please direct them to alistair.hodgson@gov.scot.

Finally, I am delighted to have taken up this new post in the Scottish Government and I look forward to engaging with you all as collectively we move towards a digital future in support of our shared ambitions for health & social care.

Caroline Lamb
Director of Digital Reform & Service Engagement

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Digital Health & Care Scotland

Appendix 2

Digital Health & Care – Local Implementation Guidance for 2020/21

1. Background

1.1 On 06 November 2019, guidance was issued to Health Boards and Integration Authorities covering the completion of Health Boards Annual Operational Plans (AOPs). These Operational Plans had to be set in the context of the Scottish Government's National Performance Framework, the Scottish Government's Programme for Scotland, the Medium Term Financial Framework and Integration Authorities strategic commissioning plans.

1.2 For the first time, the AOPs included guidance on digital health & care. This set out minimum expectations whilst also indicating that further, more detailed, guidance on digital would follow. This guidance note provides further detail on what is required from territorial Health Boards and their Integration Authority partners, and National Health Boards.

2. Introduction

2.1 In addition to the above context, *Scotland's Digital Health & Care Strategy: enabling, connecting and empowering* sets outs the overarching ambitions for digital health & care in Scotland. What our Strategy aims to do is become, over time, one of the first successful adopters globally of a truly integrated digital approach that supports and enables greater health and social care integration whilst opening up access and self-management approaches for our citizens.

2.2 The focus of this strategy is two-fold, both of which will support our principal aim of fundamentally improving outcomes through better coordination and delivery of care:

1. We wish to empower citizens to better manage their health and wellbeing, support independent living and gain access to services through digital means. We know this is leading to a shift in the balance of care by using the tools and technologies that we are already increasingly using for all other aspects of our lives, and
2. In order to achieve this at scale, we need to put in place the underpinning architectural and information governance building blocks for the effective flow of information across the whole care system that will enable the transformational ambitions of the Health and Social Care Delivery Plan, including public health and social care reform priorities.

2.3 In setting out how we take this forward, the Strategy set out a number of principles and expectations that all future developments, whether nationally, regionally or locally developed and delivered, are required to follow:

- Our citizens and front-line staff need to be involved from the very beginning for any service redesign. An essential component of making digital health and care successful is in involving citizens and front line staff in the design of tools and technologies to support them, as set out in the Scottish Approach to Service Design;
- All digital services need to adhere to the Digital Scotland Service Standard;

- Equality and accessibility needs to be built in and we reuse where possible, utilising familiar and inclusive technology for staff and citizens that is as flexible and personalised as it can be. This extends to using 'low tech' options than can be better utilised by our services and how they communicate and engage with citizens, such as text messaging, email and telephone to ensure an equitable approach.
- All organisations involved in the delivery of care should sign up to the Digital Participation Charter to ensure that they are working towards everyone – staff and those they support/care for – having the essential digital skills required.
- National by default, local by exception – wherever possible, we should be moving to single instances of the same version of systems rather than multiple variations. This is a continuation of long standing Scottish Government policy.
- Ensure that all current and future services are secure, resilient and adhere to the specifications and standards set at a national level.

2.4 As the AOP guidance sets out, Scottish Government release of funding for Digital Health & Care will be predicated against the receipt of, and agreement on, NHS Board plans to meet national expectations. This means that all future national funding will be dependent on adherence to these principles and expectations – Boards must be in a position to evidence how they are applying them in practice, or working towards applying them.

2.5 For National Health Boards, in line with the AOP guidance it is acknowledged that not all elements of this guidance, or indeed all Ministerial priorities, may apply to the National NHS Boards. There may also be alternative or additional priority areas that specific National Boards may wish to include in their AOP. A number will, however, have a role in supporting the territorial Boards and their Integration Authority partners deliver aspects of this guidance and we would expect those Boards to articulate their role in supporting local delivery. NSS and NES, in particular, have responsibility for delivering the bulk of national initiatives, including on workforce development and support for local implementation, and their plans should be clear on their enabling role.

2.6 In line with the AOPs, the digital health & care plans should be developed as a three year planning cycle, updated annually. For 2020/21, we expect to see planned actions and programmes of activity which will be absolutely firm and aligned to budgets while accepting that, for future years, specific programmes of work may still be developing. However, like the AOPs, Plans are expected to make clear links between all actions or activities and the outcomes and benefits they are expected to deliver, and be clearly set in the context outlined above.

3. Priorities

3.1 The AOP guidance sets out that we are clear that both staff and citizens should have the digital capability to access, update and meaningfully use relevant health *and* social care information from wherever they are, regardless of organisational boundaries. This includes having access to the necessary tools, products and smart devices to effectively manage their care responsibilities, access services and have the necessary skills and training to do so. This means that Health Boards must work with their Local Authority and Integration Authority partners, other Health Boards, along with national partners such as National Services Scotland (NSS), National Education for Scotland (NES), including the NES Digital Service (NDS), Healthcare Improvement Scotland (HIS), NHS24 and the Local Government Digital Office (LGDO), to realise this ambition.

3.2 Within that context, our priorities are largely those set out in the Programme for Government and the major national investment programmes. Ultimately, we are looking to see a

focus on improved outcomes for individuals through the application of technology as an integral part of quality cost-effective care and support, particularly in relation to the delivery of health & social care integration (including the ability of staff to be able to access relevant information).

Programme for Government

3.3 There are three specific initiatives highlighted in the PfG:

- **Scale up of Attend Anywhere**. This is a direct response to the commitment in the Strategy to *"Spread the use of video consultations direct from people's homes (including care homes) and mobile devices to allow greater and more convenient access to both routine care and specialist support from anywhere in the country"*. All territorial Health Boards and some national boards have received funding to progress this, with an initial focus on outpatients. Our PfG commitment is to extend its use further into primary care and social care. All plans are expected to set out their plans for mainstreaming its use.
- **Scale up BP (remote management of hypertension in primary care)**. This covers part of the commitment in the Strategy to *"Deliver remote monitoring of long term conditions by scaling-up our work on home and mobile health and care monitoring nationally to support prevention and supported self-care within priority care pathways."* Approximately half of the integration authorities have received funding to date, with the remainder expected to engage over the next 12 months. All plans are therefore expected to set out their plans for the extension and embedding of remote management of hypertension in primary care as part of routine service delivery.
- **Transforming Local Systems**. Principally about developing our collective approach to supporting the adoption of the Scottish Approach to Service Design within local service change. Currently focusing on frailty, breathlessness and survivors of abuse in four 'pathfinder' Integration Authorities, with a further five 'named partners'. Those areas with Integration Authorities involved in this are expected to articulate their work, although we would expect all Boards to consider their general approach to adopting the Scottish Approach to Service Design.

3.4 In addition, the PfG highlights work on a shared national ophthalmology patient record (which will be taken forward at a national level), continued development of cCBT (which is now fully embedded and expected to be run as a business as usual service by all Boards), online autism support, online learning modules and the further development of a Trauma app in the West of Scotland. Where appropriate, plans should articulate the local application of each of these commitments.

Significant National Initiatives

3.5 There are a number of major programmes of investment which require local implementation for success. We are principally interested in Board's approach to implementation, how they will realise the anticipated benefits of these investments and the extent to which they will support the delivery of health & social care integration.

- **HEPMA**. Whilst a Hospital Electronic Prescribing and Medicines Administration (HEPMA) system is live in 4 territorial Boards, we anticipate full implementation across the remaining Boards in the next 3-5 years. For those still implementing, Plans should set out their approach, with a particular emphasis on benefits realisation.

- **GP IT**. Whilst work continues at a national level on the framework, Plans should set out the intended approach to implementation and benefits realisation, particularly in relation to local multi-disciplinary teams. This includes work on existing systems.
- **Windows 10/Office 365.** We are currently considering the operating model that will be used nationally, the licencing profile and the wider workforce access, e.g. opticians and dentistry. The funding model is being finalised for full roll out and national implementation, but we would expect Plans to be able to articulate the workforce engagement plans of Boards, the anticipated local benefits including enhanced collaborative working across care sectors and organisational boundaries, the ability for greater multi-disciplinary team interaction, and the options for greater remote working (for example). This includes consideration of Local Authorities implementation of Office 365 and the positive impact on staff working within integrated health & social care services.
- **CHI/Child Health.** Whilst CHI is largely a national programme, the Child Health component offers significant opportunities for enhanced local services, and Plans should set out Boards approach to maximising the benefits of the new Child Health system. Boards may also wish to consider whether there are any local implications of the CHI replacement which need to be factored into their planning.
- **Social Work Systems**. Replacement procurement for a number of councils being led by Scotland Excel and the Local Government Digital Office. We would expect Boards to be able to articulate how they are engaging with their Integration Authorities to maximise the opportunities to support the delivery of integrated care.
- **Electronic [Medical] Record Systems**. There are a wide variety of instances and versions of systems in place, and Boards should articulate their plans for convergence and alignment – noting in particular the general expectation that staff are given the digital capability to access, update and meaningfully use relevant health *and* social care information from wherever they are, regardless of organisational boundaries.
- **NT**

3.6 This includes the other aspects of the PfG and AOP guidance where we would expect to see consideration of the digital contribution included, such as in mental health, waiting times, integration, social care, primary care, cancer care etc.

3.7 We would therefore expect the digital aspects of all of these to be included in the relevant parts of the AOP.

Enabling Environment

3.8 In developing our Strategy with local government, we recognised the opportunity for co-designed person centred approaches, the need for a national 'once for Scotland' approach, the requirement to support adoption of evidence-based technologies and rapid national scale-up, and a need to address cultural barriers to encourage widespread acceptance and uptake of technology and innovation. This, in turn, requires health and care organisations that put digital at the heart of their ways of working. We recognise that significant effort will also be required here: too often, digital initiatives fail to be adopted at scale due to insufficient focus on designing and implementing new 'ways of working' and the culture change that accompanies it.

3.9 Therefore we would expect plans to articulate their approach to implementation and service design more broadly, along with their approach to embedding digital at the heart of their organisation, including on ensuring the necessary leadership is in place. As part of this, we would expect Boards to take into account findings from their digital maturity self assessments.

3.10 We also set out in the AOP guidance our expectation that staff have access to the necessary tools, products and smart devices to effectively manage their care responsibilities, access services and have the necessary skills and training to do so. This includes all community-based staff. Plans should set out their approach to enabling this, including any work required on upgrading core infrastructure and peripherals, in conjunction with Integration Authorities and partners.

Innovation

3.11 We recognise that digital health is a significant growth area, with new initiatives and opportunities arising all the time – both from within services and through engagement with industry, as well as major sources of funding at a Scottish, UK and European level. This is to be welcomed. Whilst there are likely to be far too many such initiatives to capture within individual plans, nevertheless we would like to see articulation of Boards approach to innovation in digital health & care (e.g. in areas such as connected health, IoT, AI, machine learning, automation, robotics, 5G etc.). This includes how they engage staff and citizens in the development of new innovations, how the targeting of innovation activity relates to local and national strategic priorities and known service pressures, how Boards engage with industry, the approach taken to working with partners/building consortiums, procurement methodologies and how any learning will be shared with other Boards and organisations.

4. National Support

4.1 Delivering on our collective ambitions is a shared endeavour – we recognise that no one organisation can deliver all that is required on their own. Modernising and deploying fluid, real time healthcare interoperability is complicated and requires us to build a complex often novel capability. This is invariably against a backdrop of ongoing legacy refresh, existing modernisation programmes and tight fiscal conditions. Adding in an expectation of greater access and control for our citizens adds in an additional (but wholly necessary) layer of complexity.

Implementation

4.2 To therefore ensure clarity exists across the system, a robust priority setting process will be developed by Scottish Government and COSLA, and work is now underway on this. This includes identifying the digital needs of major programmes of reform and other priority areas across the health & care system as a whole. We will use this to set out the priorities of national delivery partners such as NSS and NES, and will share this with the wider system to help provide clarity on what is being worked on at a national level and by whom. This will ultimately include the national expectation on standards.

Governance

4.3 We will also establish a new governance model for 2020 onwards. The Digital Health & Care Strategic Portfolio Board will remain as the principle governance board for digital health & social care, co-chaired by Scottish Government and local government. It will be complemented by two ‘sub’ governance groups in line with the two-fold focus of our Strategy – one with a focus on empowering citizens and one with a focus on enabling infrastructure. We will set out this new governance model in the new year along with consideration around the role of other governance groups and mechanisms, particularly as digital becomes an increasingly core part of almost all change/improvement developments and initiatives at both a local and a national level.

Leadership

4.4 Our Strategy notes that countries, regions and organisations which have made major progress generally have dedicated senior leadership such as Chief Digital Officers, Chief Technology Officers, Chief Clinical Information Officers, Chief Data Officers etc. Within the Scottish Government, we now have in place Jonathan Cameron as Deputy Director for Digital Health & Care and Caroline Lamb as the first dedicated Director for Digital Health & Care (as Director for Digital Reform and Service Engagement).

4.5 The recent digital maturity exercise revealed significant variation in the levels of strategic leadership across Boards. We committed in our Strategy to establish the leadership roles, skills and experience required to drive the agenda for Digital Health and Care in Scotland. We will accelerate this work and write out separately to Boards and Integration Authorities on the recommended leadership roles and skills required at a local level. In the interim, we would ask Boards to consider how they are best placed to drive this agenda forward at a strategic/executive level and a clinical/service level.

Funding

4.6 For the purposes of planning, Boards should assume a continuation of the existing national resource levels for ongoing development. This is with the caveat that a new financial framework is being developed which will change how funds are distributed and what for, with a greater emphasis on nationally-driven funding. We will work with Directors of Finance on the development of the framework, with 2020/21 likely to be a transitional year. This work will be continue after the Scottish Government sets its overall budget in the New Year, and will be designed to complement local resource allocation – it will remain the responsibility of Boards to fund ongoing costs.

4.7 Boards should not assume, however, that only 'digital' money should be spent on 'digital' developments – with digital now a core part of all services, there is an expectation that core funding of services, and funding of service (re)design, includes consideration of the digital aspect within the relevant budget setting exercise – including that of Integration Authorities. This is an essential component of becoming a digital organisation.

Shared learning & knowledge exchange

4.8 We will continue to run an annual "digifest" and an annual learning network event, as well as support a number of other conferences and events. We will also run a series of webinars, establish an online resource and share practice, including on approaches to implementation. We would encourage Boards and Integration Authorities to participate in these and enable their staff to participate accordingly. We will also establish an overall measurement framework and support for benefits realisation and evaluation.

5. Next Steps

5.1 There are now two things required from Health Boards and their Integration Authority partners:

- As part of the initial AOP guidance, Boards should already be working on ensuring that digital is appropriately highlighted within their initial draft AOPs, due for submission to the Scottish Government **by 13 December**. This includes the Programme for Government commitments and alignment with Integration Authorities strategic commissioning plans. As the AOP guidance indicates, we will then work with Boards to provide feedback and support over January and February.

- Completion of a more detailed Digital Health & Care delivery plan, in direct response to this guidance, **by 31 January 2019** (at the latest). Annex A provides a short template for submission alongside your plan. Please complete Annex A and submit along with your initial draft Digital Health & Care Plan to digihealthcare@gov.scot.

5.2 We will then align the more detailed digital health & care plans with the AOP process, with revised drafts of both expected to be submitted by the end of February with final feedback by the end of March. At that point, arrangements should be put in place to ensure this final draft is taken through the appropriate governance processes prior to formal sign off by the Chief Executive and formal submission to the Scottish Government for due consideration to release of any additional funding to compliment Boards own funding.

5.3 Funding will only be available where it is clear that Plans will improve personal outcomes, deliver at scale, are sustainable and efficient and represent good value for money. These are the core National criteria we will use to assess Plans.

5.4 Please direct any questions related to this guidance to digihealthcare@gov.scot.

ANNEX A – Template for Completion

Leadership
Please provide names, designations and contact details for each. If there is more than one (e.g. for clinical leads) please set out their areas of focus

Executive/Strategic Lead for Digital Health & Care (SRO)	
Operational Lead for Digital Health & Care	
Clinical/Professional Lead(s) for Digital Health & Care	
Integration Authority Lead for Digital Health & Care	
Other notable leads	
Contact for Digital Health & Care Plan	
Contact for knowledge exchange/dissemination of practice	

Principles
Please provide details of how you are approaching embedding the principles set out in the Digital Health & Care Strategy

Adopting the Scottish Approach to Service Design	
Adherence to the Digital Scotland Service Standard	
Equality & Accessibility	
Reuse and utilising of 'low tech' options	
Digital Participation • for staff • for citizens	
'Once for Scotland' system implementation	
Security, resilience and adherence to national standards	

Implementation & Benefits Realisation
Please provide details of how you will measure success

Is your plan clear on what you expect to achieve through this period? What are the clear, realisable and measurable benefits?	
How will citizens benefit? How many will benefit? How will this be benchmarked and how will citizen experience and feedback be incorporated?	
How are you engaging/working with staff locally on making Digital improvements and promoting a Digital is for everyone culture?	

How will you measure progress, attribute outcomes to activities/inputs, learn, and develop from operational experience?	
What are the likely key milestones, key actions and interim targets/achievements?	
How will your proposal(s) contribute to the national health & wellbeing outcomes, National Performance Framework, local single outcome agreements, etc.?	
For local initiatives, what consideration has been given to whether they could be national initiatives (or regional)?	
How will you share learning/celebrate success/acknowledge and highlight failure?	

Governance and Management

Please show how your governance, leadership and management will be achieved to keep a focus and drive on digital health & care across the Board and the Integration Authority/ies.	
Please give any details of any existing Strategies/Plans that are of direct relevance, including links to any publically-available documents.	

National Support

Please set out what national support you would welcome. This can be from the Scottish Government, National Boards or others. Please be as specific as possible, including on why such support is required.	

Finance

More detailed financial planning will be conducted via the forthcoming financial framework for digital health & care, which will set out how the Scottish Government will provide funding to Health Boards, Integration Authorities, Local Authorities and other partners. This will be an iterative process that will be developed over 2020, in conjunction with NHS Directors of Finance and Integration Authority Chief Finance Officers. Part of this will require more regular reporting on Scottish Government funding as part of demonstrating delivery of outcomes related to the Digital Health & Care Strategy.

Please complete this template and submit along with your initial draft Digital Health & Care Plan to digihealthcare@gov.scot by Friday 31 January 2020. The initial draft does not need to have been cleared by any internal governance prior to initial submission, but due consideration should be given as to what internal governance sign-off will ultimately be required, including at Health Board and Integrated Joint Board level.

NES **NES/20/15**
Item 10d
January 2020

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Development of the draft NES Financial Plan for 2020/21

2. Author(s) of Paper

Lizzie Turner, Head of Finance Business Partnering
Audrey McColl, Director of Finance

3. Purpose of Paper

To provide the Board with a progress update on the development of the NES Financial Plan for 2020/21 and to outline the steps which will be required over the next 2 months to finalise this position. The figures in this report are not yet final and may change before the final submission to the Board in March. Material movements will be noted at that time.

4. Key Items

1 The Scottish Government have confirmed that the 2020/21 Budget announcement will take place on 6th February, in advance of The UK Budget announcement for 2020/21, which is currently expected on 11th March.

2 In the interim we have been advised to continue with our current planning assumptions;

- no baseline uplift
- no uplift for pay progression
- pay inflation fully funded

3 We have also assumed that, as in 2019/20, the underlying recurrent deficit on medical training grades will be underwritten by the Scottish Government.

4 In addition, we have been carrying out scenario planning in the event that our baseline funding is reduced, or we require to fund growth within the organisation. We are reviewing options which would reduce our non-pay spend by up to 10%. This would inevitably restrict some activity.

5 Board members will be aware that NES contributed an agreed £2.5m, on a recurring basis, in 2018/19 to the National Boards savings target of £15m. The national target had not been achieved in full on a recurring basis and as a consequence, the Scottish Government removed a further £1.5m from NES in 2019/20. Given the underlying recurrent deficit on training grades we had requested that this be returned to the NES baseline and included the funding in our anticipated allocations. However, we have now been informed that a slightly reduced contribution of £1.33m is required. We are meeting with the Scottish Government on the 29th January to discuss the implications of this proposal for the 2019/20 financial year and beyond. *Members should note that the proposed additional contribution to the National Board collaborative savings target has not been built into the figures contained within this report.*

6 As shown in Table 1 we are currently anticipating baseline recurrent funding of £463m but have a budget requirement of £486m, creating an initial overall budget gap of £22m (inc that relating to Medical Training Grades).

Table 1 : Summary of draft NES baseline position

	Medical Training Grades		**Rest of NES**		
	Recurring £000s	**Non recurring £000s**	**Recurring £000s**	**Non recurring £000s**	**Total £000s**
Anticipated budget available	**263,365**	**0**	**200,133**	**0**	**463,498**
Directorate budget submissions 20/21	275,235	0	199,822	(54)	475,003
Additional Funding requests	0	0	790	153	943
Medical Training Grade cost pressures (detailed in section 4.4)	0	9,597			9,597
Budget required	**275,235**	**9,597**	**200,612**	**99**	**485,543**
		284,832		**200,711**	
Initial Budget Gap	**(11,870)**	**(9,597)**	**(479)**	**(99)**	**(22,044)**
Proposed actions to reduce gap					
Recruitment Lag				1,500	1,500
Recycle Training Grade funding		17,917		0	17,917
Other Income				330	330
Procurement savings				300	300
Total gap reductions		**17,917**		**2,130**	**20,047**
Remaining Gap	**(11,870)**	**8,320**	**(479)**	**2,031**	**(1,997)**
		(3,550)		**1,553**	(1,997)

7 Within Medical Training grades, the initial recurrent funding gap for 2020/20 of £11.8m and the non-recurrent pressure of £9.6m can be reduced on a non-recurrent basis by recycling £18m of funding available from Less than Full time posts and from vacant posts where the amount of funding provided to Boards has been frozen at 2016/17 rates, to £3.55m.

8 As part of the agreement with SG to underwrite the deficit on medical training grades in 2019/20, until a more sustainable funding model had been put in place, it was agreed that NES would make every effort to release savings on the balance of the NES budget to reduce the amount of additional funding required for Medical training grades. In creating the draft budget for 2020/21 we have currently assumed the same approach and £1.5m has been identified which could contribute to reducing the training grade deficit to £2m, which would be underwritten by Scottish Government.

9 However, if we are now required to make an additional contribution to the National Boards collaborative savings target of £1.3m then these savings would no longer be available and the deficit on training grades would remain at £3.5m.

10 A final high-level draft of the Annual Financial Plan has to be submitted to the Scottish Government in February, this will primarily be based on the figures in this paper, extended to cover a 3 year planning period. A further update will be provided to the Board as part of the planned Board development day in February. Any changes will then be incorporated into the paper for consideration at the March Board meeting.

5. Educational Implications

The draft budget will underpin the activities that we will include in our Annual Operational plan. This has been drafted based on Directorate submissions to the planning system however this work cannot be fully completed until we have an agreed funding position and a balanced 3year financial plan.

6. Financial Implications

A robust operational planning process (including developing a draft budget) is essential to ensure that we do not breach any of our delegated financial limits. The pressures on NES to achieve the savings required to break even will be managed during the year.

7. Which of the 5 key Outcome(s) does this align to?

A robust operational planning process contributes to the achievement of all our strategic objectives.

8. Impact on the Quality Ambitions

The education and training that NES provides/commissions is designed to impact on all the quality ambitions.

9. Key Risks and Proposals to Mitigate the Risks

There is a risk that the planning assumptions we use at this stage are not sufficient to identify the amount of savings we are ultimately required to make. It is recognised, both internally and at Scottish Government that, given the current level of uncertainty, operational planning for 2020/21 will be an iterative process.

10. Equality and Diversity

At a later stage in the process the equality and diversity impact of any agreed efficiency savings will have to be assessed.

11. Communications Plan

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

Yes		No	X

Operational Planning guidance has been produced and a detailed timetable made available on the intranet for all planners. If significant efficiencies are required which impact service delivery, then a formal external communications plan will be developed.

12. Recommendation(s) for Decision

The Board is asked to note;

- the approach to operational planning for 2020/21 and beyond
- the impact of the proposed additional contribution of £1.3m to the National Boards collaborative savings target has not yet been included in any of the tables in this report.

NES
January 2020
LT& AMcC

1.0 Background

1.1 The NES strategic framework 2019-2024, published last year, will guide our operational planning over the next three years and we will align our annual programmes of work, desired strategic outcomes and performance targets to the strategic themes and their operational headings.

1.2 The Cabinet Secretary for Health and Sport last year confirmed a new planning and performance cycle for all NHS Boards. This requires Boards to deliver a break-even position over a three-year period, with flexibility to underspend or overspend up to one per cent of their annual budget on pre-agreed projects. This is not intended as a general carry forward allowance but rather is aimed at enabling a longer-term focus in financial planning cycles.

1.3 The Annual Operational Plans (AOP) process this year has been developed to have an increased focus on outcomes which will be reflected over this longer planning period with a first draft submitted to SG in December. Boards are also required to provide more detail around required savings to deliver breakeven and identify the steps the board is taking to reduce the reliance on non-recurring savings over the planning period.

1.4 Within the draft AOP we made a clear statement that activity will only be able to be carried out where adequate funding is provided (both baseline and non-recurrent). During the Operational Planning process we have noted that we are increasing our reliance on non-recurrent Scottish Government funding to deliver our outcomes. Scottish Government have indicated they will be meeting with all boards to discuss the AOP position during January, but we do not yet know what format this meeting is likely to take.

1.5 A final high-level draft submission of the AOP is required to be made to Scottish Government in February, this will be based on the figures in this report, any material changes will be brought to the Board Development day in February. Until our funding position is confirmed the budget will be based on no baseline uplift and pay inflation being funded however we are also working on scenario planning for options to reduce our non-pay spend by up to 10%. These savings may be required should we face an efficiency saving in 2020/21 following the budget announcement, or we require unfunded growth within the organisation.

1.6 The Scottish Budget will be published on 6th February, ahead of the UK budget on 11th March. Scottish Government have confirmed that unless figures are significantly different no adjustments will be made to the figures announced on 6th February. In developing funding figures the Scottish Government will have considered the expected implications for Scotland arising from the UK Budget, the impact of Scottish Government decisions on tax raising powers, their internal spending review as well as the implications from the emerging Brexit arrangements. The consequence of this timing is that the NES budget setting process will almost be at final draft stage before the board's baseline recurring funding is known. This means that assumptions being made about the level of funding available may need to be revised and subsequent changes made to the budgets allocated to directorates.

1.7 The Scottish Government has completed the Spending review to agree their funding priorities over the next three years as previously reported to board. The impact for individual Boards of the spending review will not be known until the publication of the Scottish Budget although we know that the Scottish Governments budget is under considerable pressure.

1.8 In 2019/20 we began discussions with Scottish Government to separate the NES budget into two elements: Medical Training Grades and Non-Training Grades. This is to reflect the specific nature of Training Grade cost drivers and the impact on the overall NES recurring budget. Last year, we set a budget which had a residual funding gap of £6m relating to the historical underfunding of Medical Training Grades; £1.1m of which was offset by non-recurring savings made across the rest of NES. Scottish Government agreed to fund this on a non-recurring basis in 2019/20 and to look to identify recurring funding for future years. We have continued this approach of splitting out the Medical training grade element of the NES budget in this planning cycle.

1.9 Although NES contributed £2.5m on a recurring basis in 2018/19 to the National Boards savings target of £15m, the national target had not been achieved in full on a recurring basis. As a consequence, the Scottish Government removed a further £1.5m from NES in 2019/20 and have now informed us that a slightly lower contribution of £1.33m is required. We have requested an urgent meeting with Scottish Government to discuss this and no allowance has been built into the figures contained within this report. Should this be required the contribution that NES can make towards the underlying Medical Training grade deficit will be reduced.

2.0 Operational Planning Process

2.1 The collaborative and integrated operational planning process aims to;

a. Ensure all planned activity has a clear link to our Strategic Framework 2019-24 through the priorities framework and operational headings. The Priorities Framework has been created by the Senior Operational Leadership Group and the Executive Team, analysing the existing policy environment (here)
b. Identify any potential for delivering activity on a 'Once for NES' basis, reducing the potential for duplication
c. Identify any potential for delivering activity on a 'Once for Scotland' basis.
d. Highlight any interdependencies – eg where Directorates will require digital support to deliver their planned outcomes.
e. Reduce the degree by which recurrent expenditure is currently supported by non- recurrent funding
f. Incorporate any savings expected from the existing Improvement programmes:
   - Consolidation of Training Programme Management,
   - Dental Outreach,
   - Continuing Professional Development and
   - SMARTER ways of Working (incorporating working practices/policies, new technologies and use of work spaces)
g. identify further opportunities for efficiency savings, either by identifying ways of doing things differently or opportunities for cross-collaboration or modifying or stopping activities.

2.2 The complete AOP process runs from September until the following March and follows the high level timescales detailed below, we are currently in line with the planned timetable.

September	•Finance and Planning directorates issue timelines and guidance
October	•Directorates Draft activities & targets •Develop associated financial plans
November	•Peer review of financial and operational plans •Produce indicative budgets
December	•Consolidate information & submit draft AOP •Compare draft financial plan to funding
January	•Progress update to Board •AOP assessment & feedback from SG
February	•Detailed draft budget to F&PMC for review •Submission of final AOP to SG
March	•Draft budget submitted to Board for approval

3.0 Planning Assumptions

3.1 Our planning assumptions have not changed from those previously reported and include:

a. Non-Agenda for Change staff - Pay Inflation is based on 2.5% for each of the 3 years - funded by SG
b. Agenda for Change staff - pay inflation as per the 2020/21 pay scale already agreed – funded by SG
c. Incremental pay increases as staff progress though the pay scales will not be funded, therefore the cost will have to be absorbed by directorates
d. No real terms uplift is being assumed; therefore, directorates will also need to absorb non-pay inflationary increases.
e. The £1.5m in relation to the National Boards £15m savings target removed from NES in 2019/20 will be returned, and no further contribution will be required.
f. No further general efficiency target from Scottish Government given the assumption of no baseline uplift.
g. Any funding gap relating to the historical underfunding of Medical Training Grades will be met by SG
h. £1.5m will be generated from a Recruitment lag across Directorates. This arises from pay savings from the point a post is vacated until it is filled with either a temporary or permanent member of staff. This is not a recruitment freeze. Savings are anticipated to be £2.3m in 2019/20 due to significant levels of vacancies arising during restructures throughout the year.
i. All funding requirements are captured including those which will require SG funding.

4.0 Current position

4.1 Directorates have now submitted the spend plans required to deliver the outcomes described in the AOP during 2020/21. These plans have been reviewed by Finance and are still being finalised although we do not now anticipate significant movement.

4.2 The table below shows a similar position to last year where a combined recurrent deficit of £12.5m is being offset on a non-recurrent basis through recycling training grade funding, recruitment lag, procurement savings, and increased income leaving a balance to be underwritten by Scottish Government of £2m.

4.3 The estimated value of the residual medical training grade deficit has reduced from last year and the reasons for the reduction are detailed in Appendix 1.

Table 2: Summary of draft NES baseline 2020/21 Budget position

	Medical Training Grades		**Rest of NES**		
	Recurring £000s	**Non recurring £000s**	**Recurring £000s**	**Non recurring £000s**	**Total £000s**
Anticipated budget available	**263,365**	**0**	**200,133**	**0**	**463,498**
Directorate budget submissions 20/21	275,235	0	199,822	(54)	475,003
Additional Funding requests	0	0	790	153	943
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Budget required	**275,235**	**9,597**	**200,612**	**99**	**485,543**
		284,832		**200,711**	
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Proposed actions to reduce gap					
Recruitment Lag				1,500	1,500
Recycle Training Grade funding		17,917		0	17,917
Other Income				330	330
Procurement savings				300	300
Total gap reductions	**0**	**17,917**	**0**	**2,130**	**20,047**
Remaining Gap	**(11,870)**	**8,320**	**(479)**	**2,031**	**(1,997)**
		(3,550)		**1,553**	(1,997)

4.4 To reach this stage, cost pressures arising from incremental increases, non-pay inflation and essential growth have already been absorbed within directorate budgets. These have been addressed through a range of measures, including increasing income, staffing restructures and efficiencies within directorates

Table 3: Cost pressures contained within existing position

Cost Pressure	£'000
Incremental Pay Increases	£443
Non-Pay Inflation	£115
Service priorities	£328
Reduction in Income	£133
	£1,019

High level directorates figures

4.5 Table 4 below shows the breakdown of the overall baseline corporate position and includes the anticipated level of non-baseline funding that will be received from Scottish Government.

Table 4: Indicative budget and budget required shown by Directorate

Directorate	Indicative Budget (NES Baseline)	Budget Required (NES Baseline)	Baseline Variance		SG & Other funding anticipated	Total Anticipated Funding
Medical Quality Management	77,275	77,268	7		11,594	88,862
Medical SPDS	6,248	6,250	(2)		63	6,313
Medical TPM	15,171	15,336	(166)		4,573	19,910
Medical Professional Development	5,701	5,721	(21)		1,939	7,660
Medical Pharmacy	1,667	1,633	34		11,356	12,988
Medical Total	**106,061**	**106,208**	**(147)**		**29,524**	**135,733**
Dental	42,910	43,145	(235)		4,153	47,298
NMAHP	10,453	10,359	95		5,855	16,213
Psychology	12,567	12,567	(0)		19,128	31,696
Healthcare Sciences	2,864	2,978	(113)		6	2,984
Optometry	1,019	1,019	0		181	1,199
NES Digital Services	0	0	0		8,318	8,318
Digital	8,822	9,286	(463)		4,348	13,634
Workforce	4,440	4,410	30		4,066	8,476
Finance	2,433	2,475	(42)		107	2,582
Properties	3,891	3,929	(38)		564	4,493
Facilities Management	703	713	(10)		0	713
Planning	1,323	1,354	(31)		18	1,372
Provision	2,646	138	2,508		(0)	138
Total Non Medical Training Grades	**200,133**	**198,581**	**1,552**		**76,268**	**274,849**
Medical TPM Training Grades	263,365	266,915	(3,550)		9,608	276,523
Grand Total	**463,498**	**465,496**	**(1,998)**		**85,876**	**551,372**

4.6 Within Provisions budget for Depreciation (£1.2m), the apprenticeship levy (£0.3m) and a contingency for Fixed term contract liability and redeployment costs (£0.7m) are offset by Vacancy savings (£1.5m), procurement savings (£0.3m) and the 20% topslicing of income generated by directorates as a contribution to overheads (£0.3m)

Additional Funding requests

4.7 Where directorates have outcomes that need to be funded by NES baseline but they have no existing budget to cover the expenditure they submit an additional funding request as part of the Operational Planning process.

4.8 This year requests total £1m and include spend in areas such as increasing numbers of Dental and Healthcare Science trainees £330k, user computing replacement programme £90k, fit out of an assessment centre (spend to save) £100k and increasing workforce costs associated with the National Programme Trainees joining our lead employer programme £170k. A full list will be included in the March paper when finalised.

Savings

4.9 To prepare for financial pressures arising from increased costs or reduced funding, Directorates have been asked to plan for the impact of a 10% reduction to their non pay budgets. This scenario planning will enable the creation of some flexibility to meet any efficiency targets which may be required. A 10% saving on non-pay (Training Grades, ACT, provisions and pay related eg staff paid via SLA are excluded) equates to around £3m. The potential areas for saving are assessed in terms of their impact, and the associated risk posed to the organisation. The first areas which will be considered by directorates are the areas which generated the underspend which has arisen during 2019/20.

4.10 Any anticipated savings relating to the four Improvement Programmes (Consolidation of Training Programme Management, Dental Outreach, Continuing Professional Development and SMARTER ways of Working (incorporating working practices/policies, new technologies and use of work spaces) will be reported to FPMC in February and to the Board in March. Cash releasing savings are unlikely to relate to 2020/21.

Medical Training Grades

4.11 Medical Training Grades shows a recurrent budget pressure of £12m, which has arisen because the level of recurrent funding provided to NES via increases to our baseline has not kept pace with the cumulative impact of pay and HMRC policy changes.

4.12 In addition, there are recurrent cost pressures of £9.6m arising from;

a. Expansion posts relating to 2014, 2015, 2016 and 2017. From 2018 any agreed expansion posts which have filled have been funded on a non-recurrent basis by SG.
b. Remedial trainees where Trainees require extra time in post to complete their training,
c. GP Maternity costs where trainees are not part of the funded training establishment.
d. Double running in Hospital due to trainee numbers being above training establishment i.e early return from maternity leave when post has been filled by another trainee for the training year, extension of CCT date due to extended absence during training period.

e. Increased costs of GP Trainer Grants from higher headcount of trainees (practices with a LTFT trainee still receive full payment) and more remedial trainees where the trainer is then paid at a higher rate.
f. Post CCT extension costs where Trainees can opt to extend their trainee placement by up to 6 months while they secure a consultant role.

4.13 This combined pressure of £21.5m is reduced to £3.5m through savings from Trainees working Less than Full Time (LTFT) and savings which are created by the payment of Hospital baseline vacant and Out of Placement (OOPs) Trainees being held at 16/17 prices which is significantly lower than the budgeted price.

4.14 In the budget set for 2019/20 the anticipated gap in Medical training Grades of £6m was offset via other NES budgets to £4.9m which Scottish Government agreed to underwrite. As detailed in Appendix 1 the level of additional funding expected to be required from SG for Medical training grades in 2019/20 is £2.5m, a reduction of £2.4m. This is because, although for 2019/20 we are forecasting increased costs within remedial, GP maternity costs, Double running and Post CCT extensions, these are being increasingly offset by the continuing trend towards more Trainees choosing to work less than Full time (LTFT) and the level of savings available from the payment of vacant and OOPs being held at 16/17 prices being higher.

4.5 Medical Education Package (MEP)

4.15 Information on MEP is provided below for information only. It is fully underwritten by the Scottish Government and is included within the estimated non-recurring funding highlighted in section 4.20 and 4.21.

4.16 A decision was taken by the Scottish Government in 2015/16 that non-EEA overseas medical students attending Scottish Universities should contribute towards the costs of their clinical teaching within the NHS in Scotland in the form of an ACT levy which commenced in August 2016.

4.17 The Scottish Government has directed that the income raised from the introduction of the levy be used to fund a set of measures known as 'the Medical Education Package'. The components of this package are;

a. Widening access places – 50 additional undergraduate medical places for five years. This will reach steady state in 2021/22.
b. A Graduate Entry Programme ScotGEM, delivered in partnership between Dundee and St Andrews Universities – first intake 55 students. This is a 4 year degree and will also reach steady state in 2021/22.
c. A return of service bursary scheme for the ScotGEM programme and;
d. A pre-medical entry programme of 50 students

4.18 NES has been asked to manage the collection of the levy from Universities and the payments to the Scottish Funding Council, Students Awards Agency Scotland (SAAS) and students.

4.19 It is recognised that the total cost of the Medical Education Package is projected to be more than the funding raised by the Levy, however the Scottish Government has agreed that additional funding will be provided each year to cover this gap, the requirement of c£4.2m for 2019/20 has been received in full. This figure rises to approximately £9.5m by 2022/23 as shown in table 5 below. These figures have reduced from those anticipated last year as we have since

received confirmation that the COMET and HCP students will not funded through MEP as we had previously anticipated.

Table 5: MEP Gap between Income and Expenditure:

	2020/21	2021/22	2022/23
Anticipated gap in Funding for the Medical Education Package	£7.5m	£9.3m	£9.5m

Scottish Government Funding – Non-Recurring & Earmarked

4.20 As detailed in table 4 the estimated level of funding which will be received from Scottish Government in 2020/21 is around £85m of which approximately £43m has been confirmed. This follows the trend of recent years which has seen the amount of non-recurrent funding increasing each year. Once finalised we will be working with colleagues within Scottish Government finance to highlight the allocations which we feel could be added to our baseline and therefore allocated recurrently.

4.21 Some of the larger anticipated allocations within the £76m include:

a. Mental Health Funding (unconfirmed c £13m)
b. Expansion posts including GP100 (confirmed c£10m)
c. Medical Education Package & ACT (confirmed c£12m)
d. Pharmacy Education & Training (confirmed c£11m)
e. Aberdeen Dental School (confirmed c£3m)
f. NMAHP - Chief Nursing Officer directorate (unconfirmed c£3m)
g. The proposal of additional HCS Trainees (unconfirmed c£1.2m)
h. NDS* (unconfirmed current cost estimate included of £8m)
i. Transformation - National Workforce Priorities only (unconfirmed c£2m)

*It is now anticipated that NDS will not be baselined in 2020/21 but will come in as earmarked recurring. The level of direct NDS funding and associated deliverables is currently being agreed with Scottish Government.

5.0 Risks

5.1 The figures in this report are draft and are still going through a review process before being finalised. Even then budgets will change as the underlying assumptions surrounding how the figures have been calculated, or the level of funding available, change. Some specific risks associated with the figures in the report are detailed below.

a. The tables within this report do not include expenditure where we know policy changes or recommendations will impact on our outcomes but we do not yet know enough detail to estimate what funding would be associated with this, eg the proposed new Medical School.

b. Our current ability to recycle Less Than Full Time (LTFT) gaps within Medical Training grades arises from the fact that recruitment on a WTE basis only occurs where we have been specifically advised by SG to do so. If this were to be implemented across all specialties (as many wish) this would put a very significant pressure on the Training grade budget as the funding which flows from LTFT gaps would not be available for other unfunded cost pressures within the Medical training grade budget such as expansion posts.

c. Whilst the recycling of budgets from LTFT gaps and vacancy savings have been necessary to reduce the recurrent pressure within Training grades and fund expansion posts, these policy decisions in effect push additional costs to placement boards. Trainees going LTFT reduces the payments made to Boards for that rotation period in line with the trainees reduced wte, this leaves a financial pressure in Boards where the vacant wte is not filled by Locum Appointment for Training (LAT) (These are paid by NES). The Boards also absorb the pressure created by baseline vacancies being paid at 16/17 rates and the current rates for backfill. This price pressure will continue to increase as the gap between the frozen 16/17 price and current rates widen.

d. The increasing level of non-recurring funding continues to put pressure on our core infrastructure and our ability to deliver long term, core objectives as resource is increasingly required to focus on the outcomes associated with the non – recurrent funding.

e. No adjustments have been made to reflect the Scottish Governments recent communication of the additional recurrent contribution to the National Boards collaborative savings target being required. A meeting will be held with Scottish Government colleagues at the end of this month to discuss how realistic this is given the underlying recurrent deficit on training grades. However, it is recognised that efficiencies may need to be identified to deal with this pressure.

f. Some contingency has been built into the figures above to allow for any liability faced by NES through the continuation of contracts beyond March 31st where non-recurrent funding will not be confirmed by Scottish Government until later in the year but an assessment of these costs is currently underway and a final corporate provision included in the final paper in March.

6.0 Next Steps

6.1 Once the Scottish Budget is published, we will know the level of funding available to us. If required, we will implement a process to rank efficiencies put forward and identify measures which will need to be enacted to balance the budget.

6.2 In February Finance and Performance Management committee will receive detail on any efficiencies required to balance the 2020/21 budget and also information on the estimated financial position for future years.

6.3 An update on the future years position, efficiencies and any material changes to these figures will be provided at the Business section of the Board development day in February.

6.4 A final submission and our final AOP will be made to Scottish Government at the end of February.

7.0 Recommendation

The Board is asked to;

- note and comment on the current draft financial position for 2020/21.
- note the next steps required to finalise the 3 financial plan for 2020/21 – 2022/23.

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January 2020

Medical Training Grade Recurrent Funding and Non Recurrent Recycling

Appendix 1

Medical Training Grades	19/20 Original budget Recurring £000s	19/20 Original budget Non recurring £000s	20/21 Op Plan Recurring £000s	20/21 Op Plan Non recurring £000s	Variance £000's	Comments on variance
Anticipated budget available	245,719	0	263,365	0	17,646	Pay inflation and pension increase
Directorate budget submission 19/20	258,397	0	275,235	0	16,838	Pay Inflation and Pension increase
Initial Gap	(12,678)		(11,870)		808	Financial implication of trends changing in placement of trainees and % of LTFT gaps
Budget Gap	(12,678)	0	(11,870)	0	808	
Recycling Adjustments						
Recruitment Lag						
Foundation Expansion underfunding		(400)			400	Double counted in 19/20 in error
Expansion 2014 - Core & ST		(450)		(450)	0	NES contribution remains same
Expansion ST 2015		(366)		(408)	(42)	Inflation
Expansion ST 2016		(585)		(574)	11	1 wte decrease & inflation
Expansion ST 2017		(906)		(969)	(63)	Inflation
Core/ST LTFT 2015 combined fractions		(829)		(209)	620	Posts removed from Jul20
Core/ST LTFT 2016 combined fractions		(305)		(104)	201	Posts removed from Jul20
Remedials		(1,496)		(2,256)	(760)	Increase in wte, inflation & GP in practice budget rate increase
GP Maternity		(1,273)		(1,640)	(367)	Increase in wte, inflation & GP in practice budget rate increase
Double Running		(1,097)		(1,251)	(154)	wte increase, pension increase & inflation
GP Trainer Grants		(750)		(750)	0	Would transfer to TPM Workstream
Post CCT		(183)		(730)	(547)	wte increase & inflation

Medical Training Grades	19/20 Original budget Recurring £000s	19/20 Original budget Non recurring £000s	20/21 Op Plan Recurring £000s	20/21 Op Plan Non recurring £000s	Variance £000's	Comments on variance
Quality Lead Sessions		(145)		(151)	(6)	Would transfer to SPDS Workstream - still to be included for 20/21
TPD Expansion		(128)		0	128	Captured as SG Unconfirmed in 20/21
Shadowing		(105)		(105)	0	
Hospital less than full time savings incurred across FY1, FY2 and C/ST		6,080		6,939	859	5 wte higher LTFT trainees in C/ST partly offset by less in FY1 & FY2
GP Practice ST1 & St3 vacancy savings		7,267		7,651	384	2 less vacancy in 20/21 offset by budget rate increase
Hospital Core/ST vacancy savings i.e. vacancies paid at lower rate		2,222		2,678	456	Extra vacancy savings from rate remaining fixed
Hospital OOP savings		0		649	649	OOP Savings now paid at lower rate
Workforce Mgmt Training Scheme		125		0	(125)	Workforce Savings from 19/20. 20/21 tbc
Remaining Gap	**(12,678)**	**6,676**	**(11,870)**	**8,320**		
		(6,002)		**(3,550)**	**2,452**	

NES **NES/20/16**
Item 11
January 2020

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

NES Risk Register – for submission to January 2020 Board meeting.

2. Author(s) of Paper

Stewart Irvine, Acting Chief Executive

3. Purpose of Paper

The purpose of this paper is to present the NES Risk Register as at January 2020.

4. Key Issues

NES leadership arrangements have changed since the last Board meeting in October. The Risk Register has been reviewed and risk owners have been updated in light of these changes. The mitigating measures of risks 7, 10 and 11 have been updated to more accurately reflect the current position.

The Risk Register is now a standing item at NES Executive Team meetings to ensure that corporate risks are reviewed collectively.

5. Recommendation(s) for Decision

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

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January 2020
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NES Corporate Risk Register - January 2020

Risk No.	Description	Risk Owner (Lead Director)	I x L	Current Period: Inherent Risk	I x L	Residual Risk	Mitigating measures	Appetite	Last Period: I x L	Last Period: Residual Risk
	Strategic Policy Risks									
R1	Pressures on the system result in education and training being considered as less important	NES Executive Team (Stewart Irvine)	4 x 4	**Primary 1**	**4 x 4**	**Primary 1**	1. NES Board to advocate and promote the importance of education and training 2. Revised NES Strategic Plan clearly articulates the importance of education and training to a sustainable workforce. This has been well received		**4 x 4**	**Primary 1**
R2	Scottish Government budgetary decision results in an uplift 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 3**	**Primary 2**	1. NES Board approves annual budget which includes measures required to reach a balanced position. 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 3. Close working underway with SG to address the underlying deficit resulting from the expansion of TGs and uplifts that have been less than cost pressures in this area. SG have agreed to underwrite the in-year deficit position.	**Open**	**4 x 3**	**Primary 2**
R3	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 (Stewart Irvine)	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**
R4	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 (Stewart Irvine))	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**	1. Maintain clarity in relation to NES's role and influence - recent example is presenting a paper on PGMET to Chief Executives. A further paper was discussed at a Management Steering Group in September 2019. 2. Work with Boards to ensure optimal deployment of staff		**3 x 4**	**Primary 2**
R5	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 (Stewart Irvine))	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 manage relationships with other Board/organisational Chairs - Chair's regular Newsletter now being issued to other Chairs.		**3 x 4**	**Primary 2**
R16	The UK fails to achieve a trade deal with the EU by the end of 2020 and this results in disruption to NHS services	NES Executive Team (Stewart Irvine)	4 X 5	**Primary 1**	**3 x 5**	**Primary 1**	1. The main impact of a 'no deal' Brexit is likely to be felt by Territorial NHS Boards rather than directly by NES. We would seek to mitigate the impact on those Boards by the same means as for a major incident/flu etc 2. Regular updates from SG at CEs and HRD meetings		**3 x 5**	**Primary 1**
R17	The National Digital Platform is not delivered in line with the Digital Health and Care Strategy.	NES Executive Team (Geoff Huggins)	4 X 4	**Primary 2**	**4 X 3**	**Primary 2**	1. Working with SG to agree an 'Interim Commision' to give clarity on expectations re deliverables and timelines 2. Continued engagement with key stakeholders, despite challenges 3. Moving governance arrangements from a sub-Committee to a Standing Committee		**N/A**	**N/A**

NES Corporate Risk Register - January 2020

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	Mitigating measures	Appetite	Last Period: I x L	Last Period: Residual Risk
	Operational/Service Delivery Risks									
R6	In the face of new and existing demands, NES is unable to allocate resources to support priority activities in an agile and responsive manner	NES Executive Team (Stewart Irvine)	5 x 5	**Primary 1**	**3 x 4**	**Primary 2**	1. Joint Senior Leadership & Senior Operational Group meeting has taken place to discuss efficiencies plan 2. Continued focus on improving processes to release capacity - with plans to support this with QI coaching 3. At a Strategic Level argument to be made about requirement to invest in workforce organisation.		**3 x 4**	**Primary 2**
R7	Turnover in key roles leads to loss of expertise/corporate knowledge resulting in negative impact on performance	NES Executive Team (Stewart Irvine)	4 x 4	**Primary 1**	**3 x 3**	**Contingency**	1. Key roles and succession plans to be reviewed by the Executive Team 2. Executive Team reviewing approach to Talent Management linked to workforce planning	**Open**	**3 x 3**	**Contingency**
R8	Organisational or other changes lead to dissatisfaction and disengagement of staff	NES Executive Team (Stewart Irvine)	4 x 4	**Primary 1**	**3 x 3**	**Contingency**	1. Strong partnership working arrangements in place and maintained through regular contact with the Employee Director and via the Change Management Programme Board.		**3 x 3**	**Contingency**
R9	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 and Business Continuity Plans have been approved by the Executive Team 2. The plans have been tested in a desk top exercise and recommendations have been written up and considered by the ET		**2 x 4**	**Housekeeping**
	Finance Risks									
R10	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. For 2020/21 budget this assumes no material changes which impact the Scottish Budget (6 Feb) from the UK budget which will be released on 11 March.	**Averse**	**3 x 3**	**Contingency**
R11	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 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. For 2020/21 budget this assumes no material changes which impact the Scottish Budget (6 Feb) from the UK budget which will be released on 11 March.		**3 x 3**	**Contingency**

NES Corporate Risk Register - January 2020

Risk No.	Description	Risk Owner (Lead Director)	I x L	Current Period: Inherent Risk	I x L	Current Period: Residual Risk	Mitigating measures	Appetite	Last Period: I x L	Last Period: Residual Risk
	Reputational/Credibility Risks									
R12	NES is not able to demonstrate the impact from the interventions that it has developed and delivered	NES Executive Team (Stewart Irvine)	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	**Cautious**	**3 x 4**	**Primary 2**
R13	NES does not deliver leading to a loss of reputation and confidence from stakeholders	NES Executive Team (Stewart Irvine)	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		**3 x 2**	**Contingency**
	Accountability/Governance Risks									
R14	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**	**Housekeeping**	1. Standing committees responsible for each governance domain 2. Each committee provides annual report to Audit Committee 3. Comprehensive programme of internal audit 4. An Assurance framework has been developed in line with the 'Blue Print for Governance' and the Assurance and Audit Committee Handbook	**Averse**	**2 x 2**	**Housekeeping**
R15	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**	**4 x2**	**Contingency**	1. Statutory and relevant data security processes in place, with specific reference to the new General Data Protection Regulations. 2. Specific additional policies, procedures and practices being put in place to ensure robust security applies to the National Digital Platform.		**3 x 2**	**Contingency**

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

NES/SFC Joint Work: 2018-2019

2. Author(s) of Paper

Helen Raftopoulos – Assistant Director - Health & Care, SFC/NES
David Felix – Postgraduate Dental Dean, NES

3. Purpose of Paper

To report to the board on the activities undertaken as part of the NES/SFC joint work in 2018-2019.

4. Key Issues

1 The Chairs and Chief Executives met on 19 November 2019 and reviewed activities undertaken in 2018-2019 as part of the relationship between SFC and NES.

2 The Chairs agreed to continue the Memorandum of Understanding (MoU) for a further three years (2020-2023) and agreed to continue with the actions included in the Joint Action Plan (2020-2023). The MoU is attached at Annex A. The Chief Executives also highlighted the need for the Joint Action Plan (JAP) to remain flexible so that both organisations can respond to new challenges in the health and social care sector. The agreed JAP is attached at Annex B.

3 Annex C provides a report on activities in 2018-2019. Work continued on putting in place effective intelligence exchange and analysis regarding trends in the NHS workforce, supporting the Government's widening access ambitions to medicine, developing the outcome agreements to meet SG health objectives, with some focused work around supporting changes to the education of paramedics and the Scottish Ambulance Service.

5. Educational Implications

The partnership work and the Joint Action Plan enable both organisations to respond efficiently to the changing service landscape and new models of care and patients' changing needs through education provision. The overall aim is to reduce duplication of effort and develop effective and efficient solutions to educational

issues. The Plan continues to highlight the role of strategic liaison between the two organisations to ensure that advice to Scottish Government is based on best evidence.

6. Financial Implications

The actions included in the Joint Action Plan may require both organisations to commit resources to support the objectives. Elements of the plan are therefore subject to the availability of funding in both organisations.

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

This work is aligned to all five key areas of focus in the 2019-2024 NES Strategic Plan and in particular:

a) High quality training programmes and placement learning

b) Improved opportunities to access learning

c) More accessible and flexible resources for remote and rural learners

d) Greater awareness of career opportunities in health and care for young people and school leavers

e) Higher education outcome agreements that meet the needs of health and care

f) Widened access to higher education and improved recruitment in key areas

g) Sufficient education and training capacity to meet future workforce needs

8. Impact on the Quality Ambitions

The work undertaken as part of the Joint Action Plan responds to Scottish Government's aims included in the National Health and Social Care Workforce Plan and has the potential to make a significant impact in supporting the recruitment and retention of staff to ensure an NHS workforce which is fully fit for purpose, in the right place, with the right numbers.

The actions are also aimed at meeting the First Minister's aspirations for widening access.

9. Key Risks and Proposals to Mitigate the Risks

1 2The key risks associated with the delivery of the Joint Action Plan are ensuring that the resources are available to undertake this work and that robust data is available to monitor progress towards key outcomes such as widening access.

2 To mitigate against these risks, the Joint Action Plan Group, composed of senior officers in both organisations, monitor all actions on a regular basis, and agree which actions should be prioritised.

3 The Joint Action Plan also includes greater collaboration on data collection and analysis, which should not only improve our understanding of equality and diversity issues but will also improve the evidence on which to base implementation of Government policies related to the health and social care workforce.

10. Equality and Diversity

The Memorandum of Understanding and the Joint Action Plan set out the high strategic direction for partnership working between NES and the SFC. Analysis of the relevance of this work to the equality duties and the wider inequalities agenda highlights some specific areas where NES and the SFC can work together to support improvements:

1. Activities related to data collection will improve the capacity for equalities analysis.

2. Partnership work in a range of areas, and specific actions relating to widening access to education in medicine and dentistry will further support the Scottish Government's aims of reducing health inequalities, as well as widening access to education.

3. The development of outcomes with current providers of pre-registration nursing is intended to address gender underrepresentation.

11. Health Inequalities

Partnership work in a range of areas, and specific actions relating to widening access to education in medicine and dentistry will further support the Scottish Government's aims of reducing health inequalities, as well as widening access to education.

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]

13. Recommendation(s) for Decision

The Board is invited to:

a. Note that the Chairs have agreed to continue the joint work and have signed a Memorandum of Understanding for a further three years (2020-2023)

b. Note the progress with the NES/SFC Joint Action Plan in 2018-2019

c. Note the NES/SFC Joint Action Plan for 2020-2023.

NES
January 2020
HR

Paper 2

Scottish Funding Council
Promoting further and higher education

NHS
Education for Scotland

A Memorandum of Understanding (MoU) between The Scottish Further and Higher Education Funding Council and NHS Education for Scotland (2020-2023)

Introduction

1 The objective of this MoU is to set out the terms which the Scottish Further and Higher Education Funding Council (SFC), a Non-Departmental Public Body (NDPB) of the Scottish Government established formally on 3 October 2005 under the terms of the Further and Higher Education (Scotland) Act 2005 and having a place of business at Donaldson House, 97 Haymarket Terrace, Edinburgh EH12 5HD and NHS Education for Scotland (NES) established as a Special Health Board by the NHS Education for Scotland Order 2002 Scottish Statutory Instrument 2002, No 103 and having a place of business at 102 West Port , Edinburgh EH3 9DN, have agreed will apply to their future cooperation and collaboration to achieve the objectives set out in annual successive mutually agreed Joint Action Plans.

2 The purpose of this MoU is to ensure that the two organisations complement and strengthen each other's respective roles and functions in seeking to meet Government priorities, develop joint ways of working to help meet the skills needs of the health sector, avoid duplication of effort and resources, and wherever possible, seek to foster collaboration among the key stakeholders.

3 This MoU is not a contract, is not legally enforceable and does not transfer any functions and responsibilities. However, SFC and NES

agree to adhere to the principles within the MoU showing proper regard for each other's activities.

4 SFC and NES will keep this MoU and Joint Action Plans under review as set out in paragraphs 9-26, updating them as necessary.

Functions and Responsibilities

NHS Education for Scotland

5 NES is a special health board, responsible for supporting NHS frontline services delivered to the people of Scotland by developing and delivering education, training and workforce development for those who work in and with NHS Scotland. The business of NES covers the undergraduate, postgraduate and continuing professional development continuum supported by effective research. NES has a role in enabling excellence in health and care through education, workforce development and support.

6 NES has statutory responsibilities set out in its Commissioning order, The NHS Education for Scotland Order 2002: SSI 2002 No. 103, as amended by The NHS Education for Scotland Amendment Order 2006: SSI No 79. These provide for NES to be a Special Health Board for the whole of Scotland and for it to exercise all functions of the Scottish Ministers in relation to education and training relating to the health service, including but not limited to: making facilities available for education, research and training; and co-ordinating, funding and advising on education and training for all persons providing or intending to provide services under the National Health Services (Scotland) Act 1978 (article 4).

The Scottish Funding Council

7 The Scottish Further and Higher Education Funding Council (SFC) is a Non-Departmental Public Body (NDPB) of the Scottish Government and was established formally on 3 October 2005 under the terms of the Further and Higher Education (Scotland) Act 2005. The Council replaced the former Scottish Further Education Funding Council (SFEFC) and the Scottish Higher Education Funding

Council (SHEFC) and brought together funding and support for Scotland's colleges and universities under one body.

Scope of this Memorandum of Understanding

8 This MoU relates to the areas of interface between SFC and NES. It does not place additional responsibilities on either organisation; or imply any transfer of responsibility from one to the other; or sharing of statutory responsibilities.

Management of this Memorandum

9 The responsibility for monitoring performance against the terms of this agreement will rest with the Chief Executive of SFC and the Chief Executive of NES.

10 Responsibility for developing the annual Joint Action Plans will rest with a NES/SFC Group composed of senior officers in the appropriate Directorate or Branch.

11 The Chairs and Chief Executives will meet on an annual basis to review the Joint Action Plan actions and objectives , with the SFC and NES Boards reviewing the MoU and outcomes from the Joint Action Plan at the end of the three year period."

12 SFC and NES agree to exchange such information as is necessary to fulfil their commitments as set out within Joint Action Plan.

13 Wherever possible, both organisations will seek to avoid duplication of work and will identify and capitalise the added value of working together.

14 Where possible, SFC and NES will jointly commission specific projects in ways that seek to minimise non-essential bureaucracy and maximise efficiency and effectiveness.

15 It is understood by SFC and NES that all statutory requirements applicable to both organisations will be fully respected as will the requirements of the Data Protection Act 1998 and the Freedom of Information (Scotland) Act 2002.

16 Subject to its obligations under the Freedom of Information (Scotland) Act 2002, each organisation will take appropriate steps to protect the confidential nature of documents and information

that the other may provide including draft reports, identified problem areas or financially sensitive information. Personal information is subject to the Data Protection Act 1998 and should not normally be disclosed without the consent of the subject.

17 Each organisation will endeavour to ensure that their staff is aware of and understand the content of this MoU – and of any revisions- and the expectations it places on individual members of staff.

18 Any proposed significant amendments to this MoU, or to the agreed Joint Action Plans and any of the joint actions will be put to the Chairs and CEOs for consideration.

Resources

19 In their partnership work, SFC and NES will seek to make the most effective use of existing resources within both organisations.

20 NES and SFC will jointly fund a post with responsibility for ensuring the effective communication between the two organisations and to manage elements of Joint Action Plans.

21 Both organisations will allocate appropriate and sufficient resources to achieve the outcomes set out in Joint Action Plans.

22 In all cases where resources are committed to joint activities or actions, agreement will be reached before any liabilities are incurred.

Reconciliation of Disagreement

23 Any disagreements relating to this MoU will normally be resolved amicably at the working level. If this is not possible, senior managers at both organisations should seek to settle any issue. The Chief Executives of SFC and NES will jointly be responsible for ensuring a mutually satisfactory resolution and will become personally involved only where necessary.

Review of this Memorandum of Understanding

24 This MoU will be reviewed annually by senior managers in both organisations.

25 This MoU and the working arrangements will also be reviewed as necessary following any pertinent changes to legislation, policies, procedures and structures of the parties concerned.

26 This Memorandum of Understanding will have a minimum duration of three years and shall be extended thereafter subject to mutual consideration and agreement.

Signed: _____ Date: 19.11.2019

David Garbutt
Chair, NHS Education for Scotland

Signed: _____ Date: 19/11/2019

Dr Mike Cantlay OBE
Chair, Scottish Further and Higher Education Funding Council

Annex B

NES/SFC Joint Action Plan 2020-2023

1. Jointly advise and support SG in progressing key policy areas with a focus on widening access and participation to health and social care professions

1.1 Medicine:

- Advising on intake to Scottish Medical schools and the impact this has on post–graduate training, in particular foundation training, and addressing medical workforce supply;

2. Strategic liaison and development of joint response to issues raised at the Board for Academic Medicine and the Medical Undergraduate Group and UKHEAC.

- Jointly fund a clinical research fellowship to support work around career choices in medicine.

2.1 Nursing and Midwifery:

- Providing advice and support to SGHSCD in relation to nursing and midwifery education policy development and implementation, building on the progress achieved through 'Setting the Direction' . In particular, this will include:

  i. Continue supporting the development of the key principles for commissioning pre-registration education and the development of an improved commissioning model that takes full account of nursing and midwifery workforce development and education, commissioning, including flexible routes, levels of study and governance;
  ii. Strategic liaison on issues raised at the Nursing and Midwifery Student intake model reference group;

2.2 Dentistry:

3. Advising on intake to Scottish Dental schools and the impact this has on addressing dental workforce supply;

4. Strategic Liaison on issues raised at the Board for Academic Dentistry.

1.4 UK Wide:

- Liaison on issues raised at UKHEAC and other UK healthcare partners.

5. Support the health and education sectors in addressing changes to the NHS workforce across all professional and occupational groups.

    - Monitoring of health related outcomes included in the SFC outcome agreement process with a focus on developing metrics for the medical and dental outcomes.

    - Development of a coherent and collaborative response to any policy changes that affect the training and education of the health & care workforce

    - Liaison on the development of a common approach to changes to the training for pharmacists;

6. Put in place effective intelligence exchange and analysis to support forward planning in the NHS workforce and educational provision

7. Work with SGHSCD on understanding differences in data collection on the controlled subjects in particular and the healthcare subjects in general;

8. Adjustment of reporting of data to meet the needs of SGHSCD including Information exchange to enable progress with the indexing of medical and dental students.

9. Provide joint advice on issues related to the sustainability of provision in healthcare subjects in Scotland.

10. Develop a strategy to support and increase research into pedagogy and the education of the NHS workforce.

Annex C : Review of 2018-19 Joint Action Plan

Joint Action Plan

Background

At the NES/SFC Joint meeting held on 9 May 2008, the Chairs agreed to sign a Memorandum of Understanding between the two organisations and to develop a joint action plan. Both the NES and SFC Boards have received updates on progress on activity, as agreed in the Memorandum. The latest Plan covers the period 2017-2019. The purpose of this document is to present activities and actions in 2018-2019 against the objectives outlined.

Theme: Jointly advise and support SG in progressing key policy areas.

Action	**Dates**	**Comments/progress**
Medicine:		
Advising on intake to Scottish Medical schools and the impact this has on post–graduate training, in particular foundation training, and addressing medical workforce supply;	October 2018- April 2019	Main outcomes Supported the SGHSCD (and the Medical Undergraduate Group) in formulating the advice to Ministers on intake for 2019-20 in Autumn of 2018, with advice received on intake in January 2019 Continue to develop and monitor specific outcomes related to medicine (in particular more exposure to primary care and encouraging more Scottish students to stay and work in the NHS in Scotland) - target and indicators submitted by universities to SFC in September 2019 and comments have been sought from the key partners. Discussions with the universities due in November- December 2019. Provided advice and modelling to SGHSCD on increasing the number of funded places (Scots dom/EU) and reducing the number of RUK students within the overall intake Advice accepted and a phased increase of Scottish /EU students commenced in AY 2019-20. Met with all of the medical schools and the planners in January 2019 to discuss intakes and funded places for medicine in AY 2019-20, and particularly to discuss the new minimum intake target for Scottish domiciled and EU

		medical students. Supported the SGHSCD (and the Medical Undergraduate Group) in formulating the advice to Ministers on intake for 2020-21 meeting in June 2019.
Continue to advise SGHSCD on effectiveness of 50 additional widening access places in medicine;	September 2018- Jan 2019	Provided annual advice to SGHSCD on the 50 additional Widening Access places. Advice (to continue with existing widening access criteria for a further year) accepted. Intake guidance indicated that WA places continue to be under review. Further actions included in the specific health related outcomes such as: providing evidence of collaborative activities between and with Scottish medical schools to simplify and clarify the admissions process.
Implement SG policy related to international students studying medicine in Scotland and the payment of clinical placement costs (ACT-M);	May 2018	Developed paper on policy on international students which was discussed in May 2018. It was agreed that the focus should be to encourage more Scottish students to study medicine. An ACT- M levy for international students was introduced in August 2016 – now set at £10K per international student.

Nursing and Midwifery:		
Providing advice and support to SGHSCD in relation to nursing and midwifery education policy development and implementation, building on the progress achieved through 'Setting the Direction'. In particular, this will include: i. Continue supporting the development of the key principles for commissioning pre-registration education and the development of an improved commissioning model that takes full account of nursing and midwifery workforce development and education, commissioning, including flexible routes, levels of study and governance;	Autumn 2018	Advice to SGHSCD on allocation of funded places taking into account geographical and performance issues and change to process for determining funded places. Nursing and Midwifery Output Group met to agree and recommendation in April to June 2018. Intake student's guidance letter issued to Scottish Funding Council in November 2018. Support and advice enabled SGHD to prepare and gain Cabinet Secretary agreement rapidly. Provided advice to Scottish Government around tuition fees for nursing students, with a view to SAAS processing the tuition fees for nursing students from AY 2021-22.
ii. The development of a new process for the management and governance of pre-registration commissioning, including an enhanced data set;	Waiting for SG.	There has been no progress on this action in 2018/19. SG has put this work on hold meantime.
iii. Strategic liaison on issues raised at the Nursing and Midwifery Student intake model reference group;	Quarterly meetings with SG.	NES & SFC were key to developing solutions to current issues related to midwifery provision, and in particular in the Highlands and Islands regions. NES/SFC continue to monitor the effectiveness of the agreed solution through the performance management process or early statistical returns.

Action	Dates	Comments/progress
Dentistry:		
Strategic Liaison on issues raised at the Board for Academic Dentistry.	Board for Academic Dentistry meets quarterly.	- Intake guidance for dentistry provided in January 2019.
Support the development of any initiatives to widen access to dentistry.	August 2017- December 2018	Widening access outcomes related to dentistry have been included in the outcome agreement process. 2018- 19 activities and actions been submitted by the institutions and NES have provided advice and comments which broadly positive on actions. Feedback to institutions in November 2019 .
UK Wide: Liaison on issues raised at UKHEAC and other UK healthcare partners.	Quarterly meetings annually	Issues considered in 2018-2019 include: - the impact of the 1500 additional medical places and the introduction of new medical schools in England and the impact this may have on Scotland - Changes to pharmacy provision and the impact on Scotland - changes to the funding of nursing in England and difficulties in recruitment to nursing in England, ensuring same is not happening in Scotland and does not have detrimental effect for Scotland.

Theme: Support the health and education sectors in addressing changes to the NHS workforce across all professional and occupational groups.

Action	**Dates**	**Comments/progress**
Development of a coherent and collaborative response to any policy changes that affect the training and education of the primary care workforce; This includes changes laid out in the National Health and Social Care Workforce Plan –Part 3.	Quatery meeting in 2018-2019 Plan published in April 2018	Continue to develop health related specific outcomes which include greater exposure of medical students to primary care. NES have established an internal group to consider Primary Care placements in light of increased GP trainees. A number of developments are being trialled. Part 3 of the National Health & Social Care Workforce Plan indicates the multi-disciplinary approach needs to grow. This includes a wider multi professional team (paramedics, pharmacists and physiotherapists) in primary care. NES/SFC Joint Group will continue consider educational issues as SGHSCD implements the Plan.
Liaison on the development of a common approach to changes to the training for pharmacists;	Regular meetings in 2018	Provided advice (funding and policy) to SGHSCD on plans to change pharmacy training and the move from a 4 year degree to a five year degree and the impact this will have on Scottish pharmacy providers.
Development of a coherent and collaborative response to any policy changes affecting the training and education of healthcare support workers; and supporting the education sector in responding to these changes.	1 NSEA meeting in 2018-2019 period	A number of issues have been discussed including attraction and feeding into the SGHSCD wider marketing campaign for the NHS, recruitment and retention, Youth employment and recognition of prior learning.

Supporting the development and implementation of the CNO's Commission and representation on the Widening Participation Group and the wider clinical support worker workforce.	Implementation plan completed in August 2018	Developed and agreed health related specific outcomes which include actions to respond to the recommendation of the CNO's Commission (including strengthening access and articulation into pre-registration programmes). Implementation plan well underway working with wide range of stakeholders including SSSC, Scotland Colleges, Scottish Care, and Council of Deans for Health, Scottish Executive Nurse Directors, SQA, SCQF, and SWAP. The Recognition of Prior Learning (RPL) Guiding Principles were developed to help NHSScotland employees get recognition for learning from experience which occurs in the workplace and learning from experience in life, to support career development
Paramedic (Scottish Ambulance service) Education	Business case and tendering process completed by July/Aug 2019 December 2018	NES leading the development of a new approach to funding of paramedic education including tendering for providers of new provision. Five universities have been identified SFC represented on the Strategic and Operational Group and has provided advice on the impact of any options on the funding arrangements considered by the Strategic Group. 6 contracts successfully let to 5 Higher Education Institutions. SPiNE Steering Group continues.
Operating Department Practitioners	Tender evaluation July 2018	NES providing support to Territorial Health Boards in commissioning educational provision for their staff to meet regulatory requirements Contract successfully let to UWS. Programme started October 2019.
Prosthetics and Orthotics	April 2018- funding review completed August 2019	There are issues related the long term sustainability of Prosthetics and Orthotics. SFC has undertaken a funding review with options to be considered by SGHSCD, and will be supported with advice from NES.

Theme: Put in place effective intelligence exchange and analysis regarding trends in the NHS workforce and educational provision

Action	**Dates**	**Comments/progress**
Work with SGHSCD on understanding differences in data collection on the controlled subjects in particular and the healthcare subjects in general; Adjustment of reporting of data to meet the needs of SGHSCD.	Autumn 2018 onwards.	Exploring collection of supply data for AHPs with NES Workforce colleagues and Academic Heads for AHP programmes in Autumn 2018. Developed a tool to support better understanding of number of Scottish school students who enter medicine. SGHSCD request to start discussions with institutions on indexing medical students received in March2019. A group has been formed to take this forward with representatives from NES digital and institutions. First meeting was in September 2019 with a further meeting in December. Current data sharing agreement under review to ensure it is GDPR compliant.

Theme: Continue monitoring of jointly funded Quality Improvement Project

Action	Date	Comments/ Progress
Continue monitoring of jointly funded Quality Improvement Project (CSO/NES/SFC/HF)	Project dates 2014-2019	There have been further discussions on the long –term sustainability of the project as current funding is now ending. Options include support from core university funding and from potential customers of QI research.

NES **NES/20/18**
Item 12b
January 2020

NHS Education for Scotland

Board Paper Summary: Partnership Forum Minutes

1. Title of Paper

Minutes of the Partnership Forum meeting held on 30 October 2019: copy attached.

2. Author(s) of Paper

David Ferguson, Board Services Manager

3. Purpose of Paper

To receive the unconfirmed minutes of the Partnership Forum meeting held on 30th October 2019.

4. Items for Noting

5.1. Sturrock Report – Cabinet Secretary

The Partnership Forum received information on items discussed at the second meeting of the Cabinet Secretary's short-life working group set up to consider issues arising from the Sturrock Report.

5.3. Agenda for Change Pay Reform

The Partnership Forum noted that funding has been secured for the digital development of Turas Appraisal and Turas Learn.

6. Implementation of Once for Scotland Policies

A proposed Communications and Implementation Plan for the roll-out of Phase 1 of the Once for Scotland policies was approved. The importance of taking this forward in partnership was underlined.

7. Staff Experience Evaluation Report

The Partnership Forum discussed the principal recommendations for change and improvement in this report and agreed to provide feedback to Scottish Government on the points raised and as opportunities arise.

8. Healthy Working Lives Update

The Partnership Forum noted that NES has been successful in retaining the Healthy Working Lives Gold Award and discussed approaches to engagement

in and recognition of the work undertaken in relation to NES's delivery of associated activities and initiatives.

9. National Boards Shared Services Programme
An update was provided on the work being taken forward in relation to the National Boards Shared Services agenda.

10. iMatter Action Planning: Corporate Target
Members were pleased to note that NES has achieved a completion rate of 94% in relation to iMatter action plans.

15. Job Evaluation Annual Performance Report
Members noted a letter from the Scottish Terms and Conditions Committee regarding a requirement for a Job Evaluation Annual Performance Report. The first annual return will be due in September 2020.

5. Recommendations

None.

NES
November 2019
DJF

Unconfirmed

NHS Education for Scotland **NES/PF/19/37**

PARTNERSHIP FORUM

Minutes of the eighty-sixth meeting of the Partnership Forum held on Wednesday 30th October 2019 at NES, Westport 102, Edinburgh

Present:
Liz Ford, Employee Director (Joint Chair)
Dorothy Wright, Director of Workforce
Lynnette Grieve, Staff Side Representative, Unison
Linda Walker, Staff Side Representative, GMB (by VC link)
David Cunningham, BMA Representative (by VC link)
Morag McElhinney, Principal Lead (HR)
Kristi Long, Senior Specialist Manager, Workforce

In attendance:
David Ferguson, Board Services Manager (minute-taker)

1. Welcome and Introductions
The Chair welcomed everyone to the meeting.

2. Apologies for Absence
Apologies were received from Caroline Lamb, Chief Executive (Joint Chair), David Felix, Postgraduate Dental Dean, Jackie Mitchell, RCM representative, and Ros Shaw, RCN representative.

3. Partnership Forum Minutes 2nd September 2019 (NES/PF/19/27)
The minutes were approved as an accurate record. **Action: DJF**

4. Partnership Forum Actions 2nd September 2019 (NES/PF/19/28)
All action points from the last meeting were noted as being completed or in hand.

The following points were noted or discussed:

- The Stress Survey report will be circulated to members once it has been to the Staff Governance Committee meeting on 7th November 2019. **Action: DJF**
- The Joint Local Negotiating Committee will hold its first meeting on 20th December. Morag McElhinney and David Cunningham were thanked for their contributions to the sign-off of the required Recognition Agreement.

5. Matters Arising from the Minutes

5.1 Sturrock Report – Cabinet Secretary

Dorothy Wright provided a verbal update, as follows:

- Stewart Irvine attended the second meeting of the Cabinet Secretary's short-life working group on 28th October 2019. The items discussed included examples of good practice and associated tools; iMatter; 'Our Culture Matters'; the appointment of an Independent National Whistleblowing Officer; and the benefits of a positive working environment.
- The short-life working group emphasised the importance of good data, close scrutiny, whole system approaches and robust methodologies.

A brief discussion produced the following points:

- It was noted that there have still been no feedback on the NHS Boards' responses to the Sturrock Report.
- Draft whistleblowing standards are due to be laid before the Scottish Parliament and the new NHS Board Whistleblowing non-executive members are expected to be appointed by the end of 2019.

5.2. Staff Engagement: Involved in decisions that affect me

Dorothy Wright advised that the Executive Team has approved in principle the introduction of a new digital solution (Trickle) and that a short-life working group has been set up to take matters forward in partnership.

5.3 Agenda for Change Pay Reform (Appraisal, including Statutory and Mandatory Training)

Dorothy Wright reported that funding has now been secured for the digital development of Turas Appraisal and Turas Learn, with work on this due to take place in the first few months of 2020.

Liz Ford drew attention to some staff anxiety in relation to the reforms including the prevention of increments being paid if the required essential learning is not undertaken. It was noted that this would be exceptional.

5.4 East Region Recruitment Transformation: Update

Dorothy Wright advised that the East Region Recruitment Transformation model is now in the design phase and that three options are currently undergoing financial appraisal.

Arrangements are in hand for communications and training in relation to the introduction of the JobTrain system.

Governance Items

6. Implementation of Once for Scotland Policies (NES) (NES/PF/19/30)

Morag McElhinney introduced a paper seeking approval for the proposed Communications and Implementation Plan for the roll-out of the 'Once for Scotland' policies in NES. The following points were highlighted:

- The purposes of this plan are to provide a framework for ensuring that information flows support the effective management and delivery of the project and to provide appropriate training material, resources and information in relation to each policy in order to help support the consistent application of the Once for Scotland policies.
- It is intended that the support and training will include Vimeo content and drop-in sessions.
- The issue of ensuring consistent approaches to training in relation to the new policies will be discussed at a Deputy HR Directors meeting on 17th January 2020.

In discussion, it was agreed that the roll-out of the Once for Scotland policies should be undertaken in partnership. This could take the form of joint messages conveyed via Vimeo content and management and staff side involvement in the drop-in sessions (VC links may be required to facilitate this).

Following discussion, the proposed Communications and Implementation Plan for the roll-out of Phase 1 of the Once for Scotland policies was approved and a number of ideas were suggested to deliver staff side engagement and support in relation to the roll-out of these policies. **Action: MMcE and LF**

7. Staff Experience Evaluation Report (NES/PF/19/31)

A paper had been circulated to provide an opportunity for discussion of the evaluation report produced by the University of Strathclyde. Particular attention was drawn to a letter from Scottish Government providing a summary of the principal recommendations for change and improvement.

The following points arose in discussion:

- It was agreed that a 'one size fits all' approach to iMatter is not appropriate and that NHS Boards should be able to adapt iMatter so that it is relevant to their requirements and best use can be made of it.
- For example, there is a need to reflect on how teams operate within NES and more generally as approaches to team working develop and to take appropriate account of doctors in training.

- There is a need for a sustainable digital infrastructure and the availability of complete data-sets.
- There is a need to reflect all aspects of the Staff Governance Standard in relation to Dignity at Work issues.
- It was highlighted that there has been no engagement with Equality and Diversity (E&D) Leads on this development to date. This will be raised with the E&D Leads network soon. **Action: KL**

In conclusion, it was agreed that NES is well-placed to engage with and influence Scottish Government in relation to the development of staff experience measures and that feedback should be provided on the basis of the foregoing discussion. **Action: DW**

8. Healthy Working Lives: Update (NES/PF/19/32)
A paper had been circulated to provide advice on recent developments in relation to NES's delivery of Healthy Working Lives and to seek views on approaches to engagement and recognition of this work. The following points were highlighted by Morag McElhinney:

- NES has been successful in retaining the Healthy Working Lives Gold Award.
- The cross-directorate Healthy Working Lives Working Group is functioning well.
- Some of the activities and initiatives are being taken forward in response to recommendations from the stress survey and the Fairer Scotland assessment of the Healthy Working Lives Strategy, which have both provided useful quality data.

Discussion took place on the points raised in section 13 of the cover paper and the following points resulted:

- It is challenging to ensure adequate engagement across all NES sites, given the relatively small numbers of staff in some locations.
- It was recognised that engagement relies on the goodwill and commitment of some members of staff.
- Although the work undertaken by Directorate representatives is voluntary and outwith their core NES roles, it was agreed that this work should be acknowledged in some way. Further discussion on how this might be taken forward will take place in due course, including acknowledging the development that accompanies taking on this role.
- It was agreed to offer the LCGs the opportunity to engage in the development of Healthy Working Lives initiatives moving forward. **Action: DW**

9. National Board Shared Services Programme (NES/PF/19/33)
Dorothy Wright introduced a paper providing an update on the work being taken forward in relation to the National Boards Shared Services agenda. The following points were highlighted:

- Attention was drawn to an update on the work of the Internal Support Services Transformation Board, which had been circulated by e-mail on 29th October.
- Particular attention was drawn to the parts of the paper relating to HR Shared Services.
- Work is ongoing to upload information to the HRConnect portal.
- Work is in hand to introduce a HR Helpdesk via Jira.
- Workshop discussions have been taking place on the concept of an Employee Relations Hub.
- Shared services in relation to transactional HR activity is inevitable and will be taken forward in partnership.

In discussion, it was noted that there is some concern regarding the risk of losing specialist HR knowledge and expertise under shared services, although it was confirmed that, in future, this knowledge and expertise would still be available where it has added value.

10. iMatter Action Planning: Corporate Target
Dorothy Wright was pleased to report that NES has achieved a completion rate of 94% in relation to iMatter action plans. This outcome was commended by members.

11. Policies
There was no update on this occasion.

For Information and Noting
12. Managing Health, Safety and Wellbeing Committee minutes (NES/PF/19/34)
The minutes of the meeting held on 24th July 2019 were noted.

13. Change Management Programme Board minutes (NES/PF/19/35)
The minutes of the meeting held on 10th July 2019 were noted.

14. Director's Letter – DL(2019)14 – Early May Holiday 2020
Dorothy Wright drew attention to a recent letter from Scottish Government regarding a change to the date of the Early May Holiday in 2020. Although it was noted that this holiday does not apply to NES, copies of the latter will be circulated for information. **Action: DW**

15. Any other business

15.1 Job Evaluation Annual Performance Report (NES/PF/19/36)

Members noted a letter from the Scottish Terms and Conditions Committee regarding a requirement for a Job Evaluation Annual Performance Report. The first annual return will be due in September 2020.

16. Date of next meeting

Wednesday 22nd January 2020, DDEC, Dundee

NES
November 2019
DJF/dw

NES **NES/20/19**
Item 12c
January 2020

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Training and Development Opportunities for Board Members

2. Author(s) of Paper

Joy Harvey, Executive Officer (Chair & Chief Executive's Office)

3. Purpose of Paper

To provide details of any upcoming training and development events for Board members, together with details of opportunities for Board members to gain a deeper understanding of NES business.

The attached paper provides the normal detail of structured training events available for Board members. It also responds to feedback from Non-Executive Board Members that opportunities to engage further with the core educational functions of NES would be beneficial. This is intended to allow members to gain a fuller understanding of day to day business and allow interaction with colleagues and trainees. Teams within NES have provided dates of forthcoming events e.g. training courses and training days for trainees.

Board members should note that in relation to the opportunities for Board members to gain a fuller understanding of our work, the nature of some of these is that they will not be able to accommodate more than one Non-Executive member at a time. We will therefore need to ensure that we co-ordinate requests to participate in these events.

Please contact the Chair & Chief Executive's Office (ceo.nes@nes.scot.nhs.uk) for further details on these opportunities.

4. Recommendation(s) for Decision

This paper is for information.

NES
January 2020
JH/CE Office

Appendix 1 - Training and Development Opportunities for Board Members

Structured Training

On Board Scotland Training		
Date	**Location**	**Cost**
2020		£395.00 plus VAT per place.
19 March	Grand Central Hotel, Glasgow	
19 June	Stirling Court Hotel, Stirling	
8 September	Radisson Blu Hotel, Edinburgh	
4 December	Stirling Court Hotel, Stirling	
10 December	The Effective Audit and Risk Committee	

Development Opportunities with a focus on understanding more about NES's work.

Turas Learn		
Date	**Event**	**Location and Link**
2020		
24 January 2020	Sexual offences: working together practice update for Scotland' conference.	For info this is a conference that will be run by NES – there is not much information on the Events website yet, but a short briefing can be found here.

Medicine*		
Date	**Event**	**Location**
2020		
30 April - 1 May 2020	The Scottish Medical and Education Conference	Edinburgh International Conference Centre

NMAHP		
Date	**Event**	
2020		
18 February 2020	Non-Invasive Pre-Natal Testing (NIPT) Resource launch event	Edinburgh

26 February 2020	Celebrating & Sharing the Work of Scotland's Dementia Specialist Improvement Leads (DSILs)	Golden Jubilee, Clydebank, Glasgow
3 March 2020	HCSW East Region Event	Edinburgh
3 March 2020	AHP Careers Fellowship Celebration Event	Edinburgh Training & Conference Centre
11 March 2020	Dementia Champions Cohort 10 Graduation	
29 April 2020	AHP Careers Fellowship Cohort 2 Induction Day	Rooms 1 & 2, Westport
30 April 2020	The National NMAHP Conference	Edinburgh Training & Conference Centre

Procurement		
Date	**Event**	**Location & Link**
2020		
28 April 2020	P4H (Procure for Health)	EICC, Edinburgh Link

Dental		
Date	**Event**	**Location**
2020		
28 February 2020	CPD conference (Update in Dentistry)	Dundee, Apex Hotel

Quality Improvement Programme Events to December 2019		
Date	**Event**	**Location**
Scottish Improvement Leaders (ScIL) Programme		
14 – 16 January 2020	ScIL Cohort 23 Workshop This is the second three-day workshop of 3 workshops for the cohort and has a heavy focus on data. No preference on which of the 3 days to attend.	Golden Jubilee
21 – 23 January 2020	ScIL Cohort 21 Workshop This is the third and final three-day workshop of 3 workshops for the cohort and is focused on the presentation of data and information.	Golden Jubilee
28 – 30 January 2020	ScIL Cohort 20 Workshop This is the third and final three-day workshop of 3 workshops for the cohort	DoubleTree Aberdeen City

	and is focused on the presentation of data and information.	
10 – 12 March 2020	ScIL Cohort 22 Workshop This is the third and final three-day workshop of 3 workshops for the cohort and is focused on the presentation of data and information.	Golden Jubilee
Scottish Quality and Safety Fellowship (SQSF)		
10 March 2020	Fellowship Networking Event This one-day event will showcase all the learning gained from Cohort 11 Fellowship participants completing their international study trips, focusing on how the learning can be applied to the Scottish system	Radisson Blu Edinburgh
Masterclass		
11 March 2020	QI Masterclass 2020 This annual masterclass is open to all QI Alumni and members of the Q Initiative, with 250 places available. The theme this year is twofold: • developing relational skills to co-produce improvement through authentic relationships • develop storytelling skills such as public narrative to unleash people's intrinsic motivation to change	EICC

NES **NES/20/20**
Item 12d
January 2020

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Growing the next generation of GPs – Professor John Gillies report entitled '*Undergraduate Medical Education in Scotland – Enabling more General Practice based teaching'*

2. Author(s) of Paper

Dr Amjad Khan – Director of Postgraduate GP Education
Professor Moya Kelly – Director of Postgraduate GP Education

3. Purpose of Paper

The purpose of this paper is to provide the board with a summary of the Gillies report and its implications for NHS Education for Scotland (NES).

4. Key Issues

There are two recommendations within this report that are linked to NES:

i. Recommendation 5 - The GP teaching tariff should be increased from £40 to £85 per session maximum payment of £255/session)

ii. Recommendation 6 - Review of GP category B teaching should be undertaken by NES with relevant stakeholders (Category B teaching is that which occurs outside of the clinical placement for example a GP delivering teaching at the medical school. Category A teaching is that which occurs in the clinical placement for example the direct teaching from GPs within the practice setting).

5. Educational Implications

1 Scottish Government and the Board for Academic Medicine established a short life working group in 2018 to consider ways of increasing undergraduate education in primary care settings from the current 9% to 25%. NES was represented on this group.

2 The group was set up in response to the challenges facing the recruitment and retention of GPs. There is increasing evidence that greater exposure of medical students to teaching by GPs and in a primary care setting increases the likelihood of the student pursuing a career in this specialty. This was highlighted by Professor Val Waas in her report 'By Choice and not by chance'.

3 The Gillies report highlighted issues which may hinder the growth of teaching in a primary care setting from its current base. These challenges included physical capacity, finance, available doctor time and digital connectedness.

6. Financial Implications

1 Medical ACT funding (£75,466,744) is provided by the Scottish Government to help support the additional costs of teaching undergraduate medical students within the NHS in Scotland. NHS Education for Scotland (NES) receives the funding from Scottish Government and the NES Board decides the actual amount to be distributed to the NHS Boards.

2 The Primary Care Division of Scottish Government have agreed to provide £2.5m from the Primary Care Fund from 2020/21 to fund the proposed increase in the GP teaching tariff, and this has been included in the NES Operational Plan for 2020/21. It remains to be determined if this will be recurrent or non-recurrent funding.

7. Which of the 5 Key Areas of Focus in the NES Strategy for 2019-24 does this align to?

Theme 2 – National infrastructure to improve attraction, recruitment, training and retention
Theme 3 – Education and training for a skilled, adaptable and compassionate workforce

8. Impact on the Quality Ambitions

Increasing undergraduate education in primary care would help towards increasing the General Practice workforce and thus patient care.

9. Key Risks and Proposals to Mitigate the Risks

A potential impact of increasing undergraduate education in Primary Care is on the placement experience of GP Registrars. An additional risk is the requirement of the new GP contract for greater training of Allied Health

Professionals in Primary Care such as Pharmacists and Paramedics further impacting on available training capacity.

NES has a multi-professional group (Chaired by Professor Moya Kelly) whose title is 'Educational Capacity and Learning Group', with representatives from Pharmacy, Paramedics, NMAHP and undergraduate, to look at new models of training in Primary Care. New models will be piloted in the new year which would increase the use of non-training practices.

10. Equality and Diversity

An evaluation may be needed to assess the impact of increasing undergraduate teaching and the new teaching tariff in primary care on GP training and long-term recruitment and retention.

11. Health Inequalities

In the medium to long term, the impact of an increased tariff for undergraduate medical education may result in an increased number of students opting for General Practice specialty training, thus aiding recruitment and retention. This in turn will have a positive benefit on the health of the population.

12. Communications Plan

Communication regarding the new tariff will be from Scottish Government and managed through the Medical ACT budget. The details will be communicated through the governance structures set up for Medical ACT.

13. Recommendations for Decision

The Board is invited to note the attached SG report.

NES
January 2020
AK

Undergraduate medical education in Scotland:

Enabling more general practice based teaching

Final Report

October 2019

Scottish Government
Riaghaltas na h-Alba
gov.scot

Contents

Recommendations

Recommendation 1 (Scottish Government and Health Boards)

Capital investment in primary care by Health Boards must include provision of fit for purpose space that can be used for educating the primary care workforce of the future.

Recommendation 2 (Scottish Government)

The new NHS Scotland Capital Investment Strategy is due to be published shortly. It is recommended that this should make the case for investment in primary and community care facilities recognising specifically the need to include facilities to train the workforce of the future.

Recommendation 3 (Scottish Government)

The SWAN (Scotland wide Area Network) programme should develop direct ties and representation with the R100 (Reaching 100%) delivery team in Scottish Government both to better understand the timeframes for the remaining very hard to reach locations and to influence decisions on how the R100 priorities are decided about which locations should be prioritised i.e. those where GP surgeries are without connectivity and could therefore have access accelerated.

Recommendation 4 (Universities and Health Boards)

Universities currently have information on problems with broadband and Wi-Fi access for their students. To provide a national picture, Universities and Health Boards should survey digital access for undergraduate teaching practices and premises across Scotland and plan to address access difficulties where this is possible, over the next 12 months.

Recommendation 5 (Universities/ NES ACT)

The tariff for clinical teaching in primary care (category A) should rise from £40 per student per session to £85. A ceiling value of £255 for three or more students should apply. Current falls in practice teaching capacity across Scotland suggest that this should be implemented as quickly as possible.

Recommendation 6 (Universities/ NES ACT)

Further work needs to be done by NES together with relevant stakeholders to streamline the current range of category B tariffs in Primary Care ACT. This should produce a simplified range of tariffs applicable to all medical schools within 12 months.

Recommendation 7 (Universities/ Board for Academic Medicine/ Universities Scotland/ Scottish Funding Council)

As part of progressing UG education in primary care, each medical school should develop over the next 12 months the outline implementation plan that they have submitted (chapter 5) for increasing teaching in primary care, as well as a strategy to develop and grow the GP educator workforce to increase teaching capacity. This should ensure that GP educators have a strong and effective voice within school decision making structures.

Recommendation 8 (Universities/ BfAM/ Universities Scotland/ Scottish Funding Council)

A national level group for GP Heads of Teaching or equivalent in Scotland reporting to the Scottish Deans Medical Education Group should be formally established. The aims of this should be to strengthen educational leadership, build on the implementation plans referred to in recommendation 7, and share innovations to increase capacity and further curricular development.

Recommendation 9 (Universities/ Health Boards/ Board for Academic Medicine/ Universities Scotland/ Scottish Funding Council)

Monitoring of these recommendations, supported by the GP Heads of Teaching group, should be undertaken with reports six monthly to the Scottish Deans' Medical Educator Group for review by the Board for Academic Medicine and Scottish Government. There should be an independent review of progress after 12 months.

Recommendation 10 (Universities/ Scottish Funding Council)

The investment involved in increasing undergraduate education in primary care requires rigorous evaluation from the outset. This should include (i) the indexing of all medical students at Scottish Universities at matriculation with a view to linking this data with existing data available through UKMed (ii) further educational research into attitudes of students and graduates in relation to careers in GP, all with a view better to understand the career choices of graduates. A programme of funded educational research will be required.

INTRODUCTION

This report reflects a great deal of work done over the past year by the *Increasing Undergraduate Education in Primary Care* group. I would like to express my thanks to all members of the group for their contributions and commitment to this work.

Change in undergraduate medical education in Scotland is needed because of increasing numbers of people with complex multimorbidity and because of the rapid demographic shift in our population towards older people. This has substantially increased demands for health and care services in hospitals, primary care and in the community. There is a consensus, supported by robust evidence, that developing primary and community services is better for older people and better for population health. High quality accessible hospital care is certainly required, but its delivery is supported and best facilitated by admitting only those whose health and care needs cannot be delivered in the community. This requires that clinical capacity within general practice based primary care is expanded, a key aim of Scottish Government policy. This also requires a focused approach to increasing the GP workforce.

There are several strands to increasing the GP workforce. This report focuses exclusively on the potential contribution of increasing undergraduate education in primary care. The last few years have seen two major UK reports, *By Choice, not by Chance* (HEE/MSC 2016) and *Destination GP* (RCGP/MSC 2017) which give clear guidance for what needs to be done in Scotland. Addressing tribalism and negativism, changing financial models underpinning education, providing quality placements in general practice that demonstrate the difference it can make, and providing positive role models for students are all essential. Increasing near peer teaching is imperative. Academic general practice leadership is vitally important so that students recognise the breadth and complexity of general practice care, and so that they become aware of and are stimulated by the complex intellectual challenges. The establishment of the short life group on academic training pathways in general practice in Scotland reporting to the Board for Academic Medicine, under Professor Frank Sullivan as Chair, is an important parallel development to this group's report.

It became clear, during the course of the 15 months of the life of this group, that a strategic approach to address these issues that have to date limited general practice education, and setting out practical ways to address them, was needed. In addition, the recommendations offer an opportunity to look creatively at expanding placements in both remote and rural practices and areas of deprivation. Out of hours GP services, though currently under workforce pressures, have great potential for more undergraduate general practice education.

It is also very clear that developing improved working across and between many of these organisations will be necessary for an increase to be achieved and maintained. In particular, the output of this group offers an opportunity to strengthen links between undergraduate and postgraduate medical education, and between Universities and Health Boards. Several examples of this are given in the report.

My recommendations, informed by the work of the group, cover three areas: addressing the issues identified by the teaching capacity survey, strengthening the GP educator workforce to deliver increased capacity to teach, and monitoring and evaluation of the required changes.

The teaching capacity survey showed that lack of space in primary care is a major issue, exacerbated by the growing multidisciplinary workforce. Further investment in premises is urgently needed. Policy should dictate that any new capital developments must always include provision for educating the primary care workforce of the future.

Digital infrastructure is improving rapidly through the roll out of the Scotland-wide Area Network (SWAN). However, coordination between this programme and the R100 Scottish Government project ("Reaching 100%" or R100 commitment) to provide super-fast broadband to all Scottish homes and businesses by 2021, would enable symbiotic success of these related activities. Access problems which interfere with education and assessment persist, especially in remote and rural areas. A survey of teaching practices to identify issues raised by students and faculty and a plan to address these within 12 months is needed.

The number of GP undergraduate teachers across Scotland is falling; inadequate reimbursement is a directly contributing factor. The valuable work undertaken by the NES Primary Care ACT review suggests that the category A tariff for clinical teaching should rise to £85 per session. The complex Category B tariffs require further work to produce a simplified range within 12 months.

More undergraduate teaching in primary care requires a strengthened voice for GP educators within medical schools. Each medical school should further develop their current commitments to expand undergraduate teaching in primary care, outlined in chapter five, as well as developing a strategy for developing and growing the GP educator workforce that will be needed to deliver this. A national level group for GP Heads of Teaching is proposed to strengthen educational leadership, encourage innovation and contribute to monitoring progress on these recommendations.

These substantial changes of investment require both monitoring and rigorous evaluation. I suggest six monthly monitoring reports to the Scottish Deans' Medical Educator Group with review by the Board for Academic Medicine. Evaluation should include educational research into the attitudes of students and graduates, as well as detailed tracking of career intentions and choice through UKMED.

All medical schools are, of course, required to produce pluri-potential doctors who meet the GMC Outcomes for Graduates. An increase in exposure to general practice and primary care will contribute to *all* graduates having a better understanding of how the NHS works as a system and how primary, secondary and social care can best collaborate for the benefit of our patients. As a senior medical educator in Scotland has suggested, these proposed changes can help to produce *'not just more GPs, but really good doctors.'*

There is now a real opportunity to achieve this through an evidence-based approach to undergraduate medical education, founded, in Sir Lewis Ritchie's words, on 'pulling together'. It is important that we grasp it. *Carpe diem*.

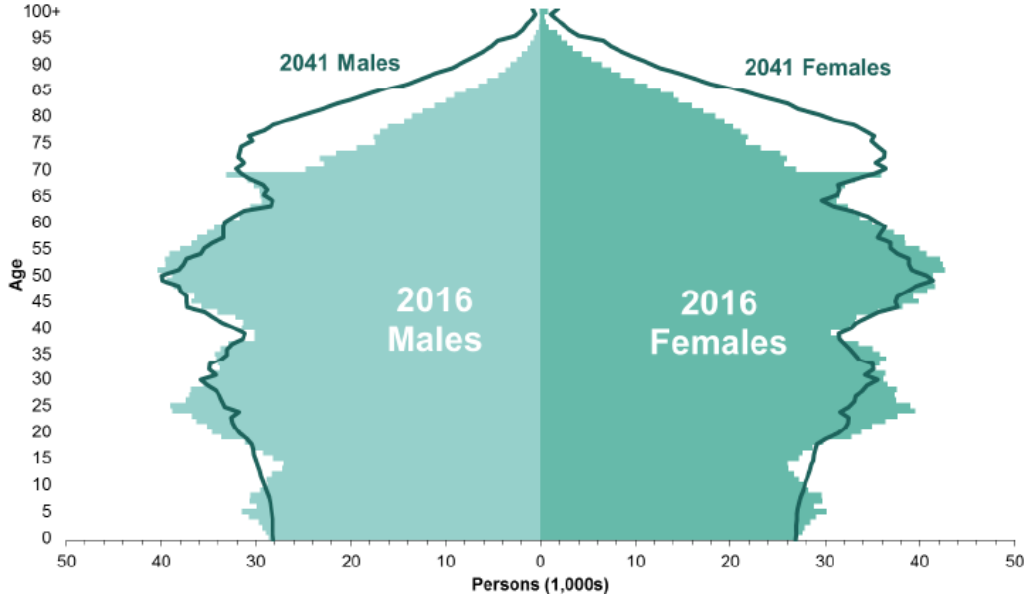
Professor John Gillies OBE FRSE FRCGP FRCPE
Deputy Director, Scottish School of Primary Care
Chair, Increasing undergraduate education in primary care group
August 2019

CHAPTER ONE: CONTEXT

Introduction

Across the UK and internationally, demand on our primary care services is steadily increasing due to a combination of an ageing population, rising levels of multi-morbidity and increasing patient expectations. According to National Records of Scotland (NRS, 2017) the number of people aged 65 and over is estimated to increase by around 45% from 1.00 million to 1.44 million by 2041, leading to substantial rises in those with long-term conditions and a rising demand on services. To be fit for purpose, the healthcare system *must* innovate and modernise, focus on developing preventative models of care to improve long-term outcomes. It must be financially sustainable and structured in such a way as to reduce pressure on the workforce while meeting the needs of the population of Scotland.

Figure 1: Estimated and projected age structure of Scotland's population, mid-2016 and mid-2041



To deliver this modernised health care system NHS Scotland has committed to the Chief Medical Officer's vision of *"Realistic Medicine"* (Scottish Government, 2016a); putting the person receiving health and care at the centre of decision-making and encouraging a personalised approach to their care. Its aims of reducing harm and waste, tackling unwarranted variation in care, managing clinical risk, and innovating to improve, are essential to a well-functioning and sustainable NHS. The CMO has stated that by 2025 all health care professionals will deliver care aligned to these principles. In order to realise this ambition, it is imperative that we examine how and where we educate our future health professionals.

The *Health and Social Care Delivery Plan* (Scottish Government, 2016b) sets out the ambition of shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when appropriate. To help deliver this, *The National Health and Social Care Workforce Plan: Part 3 – Improving workforce planning for primary care in Scotland* 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 vision closely reflects the 21 underpinning principles on the future of primary care set out by Scotland's health professional groups in 2016 (QNIS,RCGP 2016).

The Plan sets out a series of ambitious commitments to significantly expand and strengthen the primary care workforce, backed by a historic increase in investment of £500m in primary care by 2021 (including £250 million in direct support of general practice). This includes an intention to deliver an additional 2,600 nurse and midwife training places by 2021-22, an investment in general practice and community nursing, increasing the number of health visitors by 500, and a commitment to recruit at least 800 (headcount) additional GPs over the next 10 years to address predicted increases in demand and ameliorate current vacancy and workload issues.

To help to increase the medical workforce (including the General Practice workforce) substantial investment in excess of £23 million has been made by Scottish Government. By 2021 undergraduate medical places will have been increased by 190 (22%) over 2016 levels. Additional places have been commissioned with a focus on encouraging graduates into shortage specialties and locations. Sixty new places commencing in 2019/20 will have a strong focus on general practice based education. In addition, 100 additional General Practice Specialty Training (GPST) posts were introduced in Scotland from 2016 to develop future capacity in the GP workforce.

The increase in the primary care workforce is being supported by refocused roles for clinical and non-clinical staff. 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. The new GMS Contract (Scottish Government/BMA, 2017) 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, enabling access to the right professional at the right time, will deliver improved patient outcomes and a more proportionate use of resources.

Current context

Delivery of primary care

Under the current model of undergraduate medical education, approximately 90% of medical education is delivered in secondary care while an estimated 90% of patient contacts are delivered in primary care (Hobbs et al, 2016). Annually in Scotland we see over 4 million attendances in hospital outpatients and admit approximately 1.2

million people to hospitals (NHS NSS, 2018a). However, with an estimated 25 million appointments in general practice in Scotland annually (Scottish Government, 2016c) there is both necessity and opportunity to shift the balance of where future doctors learn and importantly what they learn. GPs in Scotland constitute 27% of the medical workforce.

Clinical decisions made in primary care impact, directly and indirectly, on activity and costs elsewhere in the healthcare system. This can include the number of unplanned admissions, rates of referral for new outpatient appointments, A&E attendances and prescribing costs. Primary care is therefore able to influence the level of demand for other care settings, acting as a 'navigator' to secondary care, developing anticipatory care plans, coordinating care, screening and health promotion. Primary care is particularly well placed to support self-management and shared decision-making by helping patients to fully understand and manage their problems, promoting a focus on prevention, rehabilitation and independence.

The dramatic demographic change in our population and shortening hospital stays are also both drivers for increasing undergraduate education in primary care. In addition, continuity of care is now recognised as making a significant contribution to reducing mortality (Pereira Gray et al., 2018). Continuity is important for high quality clinical care and also enables students to learn about the course of illness in patients. It may be easier to achieve through increased provision of general practice based primary care.

The work of the late Barbara Starfield over a period of more than twenty years showed that increasing the supply of primary care physicians (GPs) results in lower mortality from cancer, heart disease, and stroke as well as all-cause mortality; better self-reported health; reduced hospital admissions and decreased infant mortality. There is also an impact on health inequalities and a reduction in cost (see, for example, Caley, 2013).

Recently published evidence from the United States (Basu, et al., 2019) supports Starfield's findings. An increase in the supply of primary care physicians is associated with a decrease in population mortality, and conversely a decrease in GP supply is associated with an increase in mortality. Any reduction in GP numbers in Scotland relative to population is therefore a matter of serious concern. Don Berwick (Berwick, 2012), President of the Institute for Healthcare Improvement, and an important advocate for person-centred care, suggested this in his ten top tips for the NHS:

> '*Reinvest in general practice and primary care. These, not hospital care, are the soul of a proper, community-oriented, health-preserving care system. General practice, not the hospital, is the jewel in the crown of the NHS. It always has been. Save it. Build it.'*

GP Workforce

The evidence tells us that high quality exposure to GP and primary care during the undergraduate years makes it more likely that students will choose a future career in

general practice (see, for example, Health Education England/ Medical Schools Council 2016). There are also likely to be benefits for all medical students from increased exposure to general practice in gaining an understanding of whole system working, and the importance for patients of being able to move seamlessly from primary to secondary care and vice versa.

There is new evidence from the Scottish Medical Education Research Consortium (SMERC) that medical students from less traditional backgrounds are more likely to work in underserved areas and in primary care on qualification (NES, 2018). In a large recently published study using the UKMED database (Kumwenda et al, 2018) of 6,065 doctors entering specialty training after Foundation Year 2 posts, they found that the trainees coming from a family background where no parent was educated to a degree level and those entering medicine as mature students were significantly more likely to choose general practice or mental health. This has clear implications for UK medical school admissions policy.

Bringing together the considerable weight of the educational and the health services evidence, it is therefore vital that we collaboratively find ways of increasing the amount of high quality undergraduate teaching that takes places in primary care and by GPs during the undergraduate years. The Scottish Funding Council (SFC) has set out an aspiration in its outcomes agreement with Scottish universities, to work to increase the percentage of teaching that takes place in general practice to 25% of the clinical curriculum. All of this provides a useful impetus for all involved to work together to increase undergraduate education in primary care.

The desire to increase education in primary care needs to be seen in the context of a primary care system that is already under considerable pressure, with nearly a quarter (24%) of GP practices responding to the 2017 Primary Care Workforce Survey reporting GP vacancies, compared with 9% in 2013 (NHS NSS, 2018b). In addition, 6% of responding GP practices reported vacancies for registered nurses. Workload challenges are well documented. 37% of Scottish GPs feel overwhelmed on a weekly basis (RCGP Scotland 2019). Despite these pressures, patients remain 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.

The current workload stresses are exerting considerable pressures on the ability of primary care to deliver undergraduate and postgraduate teaching. Scottish medical schools typically report increasing difficulty in recruiting practices and in delivering placements in primary care. For instance,

- Glasgow and Dundee medical schools seeing the number of practices involved in teaching fall by over a third in the last 6-7 years. There have also been falls in Aberdeen and St Andrews.

- Glasgow reports increased difficulty in recruiting GP tutors to teach vocational studies in years 1 and 2; with rate of ACT reimbursement being quoted as the most significant factor.

- Dundee sought to introduce 2 half-day sessions in general practice per student in each of years 1-3 but couldn't recruit sufficient placements, having to limit them to 1 session for each student in years 2 and 3.

These recruitment problems currently put further pressure on GP educators and staff to try to maintain currently levels of undergraduate teaching. Increasing clinical teaching in primary care, and by GPs in medical schools, therefore brings with it both significant opportunities but also a number of complex challenges for NES, medical schools, service planners and the NHS. If the ambitions set out in the primary care workforce plan and in the SFC outcomes agreement are to be met, a systematic approach to increasing undergraduate education in primary care needs to be prioritised and developed. Individual initiatives on their own will not be sufficient

Short Life Working Group

Under the joint auspices of the Scottish Government and the Board for Academic Medicine, an *Increasing Undergraduate Education in Primary Care Working Group* was established in 2018 to consider ways of increasing undergraduate education in primary care settings. The Group was chaired by Professor John Gillies with representation from all Scottish medical schools, the Royal College of General Practitioners Scotland (RCGP Scotland), Scottish General Practitioners' Committee (SGPC), National Education for Scotland (NES), the Scottish Deans' Medical Education Group (SDMEG), Scottish Funding Council, student representation and the Scottish Government (full remit and membership is provided in Annex A).

The aims of the Group were to:

- Determine the current level of undergraduate teaching in primary care in Scottish Medical Schools;
- Establish the number of GPs who currently teach, their capacity to increase teaching time and mechanisms to support them do so;
- Identify GPs who don't teach who would like to do so and mechanisms to support them do so;
- Understand the infrastructure, physical and digital, needed to support an increase in undergraduate teaching;
- Investigate factors that have a positive influence, including innovative practice within Scotland and elsewhere, and barriers to change;
- With support from NHS Education for Scotland, consider the role of funding in increasing clinical placements in primary care.

The group met approximately every 2 months between March 2018 and May 2019 to discuss and share key learning on the barriers and facilitators to increasing undergraduate teaching and discuss innovative teaching approaches being used across Scottish medical schools. Professor Gillies conducted a series of meetings with key stakeholders during the duration of the group including with the Scottish Deans' Medical Educators Group and the Scottish Academics GP Heads of Teaching Group. An intern supported the work of the group as part of the Scottish Graduate School of Social Science-Scottish Government for a three-month period from October 2018.

In addition, NHS Education has established the *Educational Capacity Group*, chaired by Professor Moya Kelly, to review current training capacity in primary care, identifying the training needs of learners from all disciplines delivering primary care. This group, with multi-disciplinary membership including representatives from Medicine, Pharmacy, Nursing, Allied Health Professionals and undergraduate medical schools, has postgraduate education as its initial focus. There are clear synergies across the groups with joint representation to ensure a joined up approach across undergraduate and postgraduate training with the awareness of need to develop capacity for both.

As set out in Chapter 3, a concurrent review of Additional Cost of Teaching (ACT) funding, provided by the Scottish Government to cover the cost of teaching medical undergraduate students, has been undertaken by NHS Education for Scotland (NES).

CHAPTER TWO: CHALLENGES AND FACILITATORS TO INCREASING UNDERGRADUATE EDUCATION IN PRIMARY CARE

There is a range of UK and international evidence on factors that affect career choice among undergraduate medical students. Understanding these drivers, both negative and positive, is essential in developing approaches which actively encourage students to consider general practice as a career choice. Equally, there are a range of organisational and structural issues that can impact on teaching capacity at both medical school and practice / community level. These issues are explored in more detail below and help inform both the approaches to innovative practice highlighted in section 4 and the recommendations that follow.

Influences on career choice

The ambition to increase the primary care workforce and deliver increased education and training in community settings has to be considered in the current context of a range of challenges including addressing widely held negative perceptions of careers in general practice. In a response to a crisis of GP numbers more than twenty years ago, Sullivan and Morrison (Sullivan and Morrison, 1997) suggested that medical schools needed to 'broaden the range of entrants, make general practice attachments mandatory and at least six weeks long'. We have come a long way since 1997, but the journey is not yet over.

Student perceptions

The Royal College of General Practitioners and Medical Schools Council's (RCGP/MSC, 2017) *Destination GP* report found a range of issues relating to promoting general practice as an excellent career choice.

Peers and role models

Peers at medical school are one of the most influential groups on students' views of future career choices. However, over 9 in 10 (91%) medical students believe their peers hold negative views about general practice. The RCGP/MSC analysis reported that students are most likely to associate the profession with being "boring", "lower status than other medical professions" and "less intellectually challenging". It is concerning that students' peers' attitudes towards general practice are much more likely to have a negative impact on students' likelihood of pursuing a career in general practice (33%) than a positive one (13%). There is therefore a pressing need to challenge these perceptions.

The RCGP/MSC survey also found that GP tutors in medical schools have a particularly positive impact, with 71% of students saying this group made them want to work in general practice more (only 12% saying the opposite). GP Society events also appear to have a positive impact, with 41% of students saying attending had a positive influence on their interest in general. This is reinforced by positive feedback from a successful recent Scottish Universities GP society event in Aberdeen. (see boxed text on p 42).

Clinical placements:

Previous studies (Alberti et al., 2017; Wiener-Ogilvie et al., 2015) found the presence or quantity of undergraduate placements in general practice to be associated with increased entry to general practice training and careers. The RCGP (RCGP/MSC, 2017) found that GPs interacting with students on placements are the most influential group on students' perceptions of general practice, with four fifths (81%) of students reporting that this group had most influenced their perceptions. Similarly, Wiener-Ogilvie et (2015) survey of foundation trainee doctors across Scotland found "undergraduate GP placement was reported as the strongest influence in favour of a career in General Practice followed by discussion with family and friends and discussion with specialty trainees". This influence was particularly marked in graduates from Aberdeen and Dundee medical schools. In addition, the RCGP survey reports that those who say they are most influenced by GPs on placements are more likely than other students to associate general practice with the positive phrases such as "continuity of care" and "varied", and less likely to use terms like "boring" and "lower status". One Foundation Year doctor interviewed to inform this report noted:

> *In clinical years, so that is the final three years, I think I had a total of six weeks in general practice, out of three years. It actually wasn't that much and I would definitely have liked to have done more. I could have benefitted from more experience of general practice.*

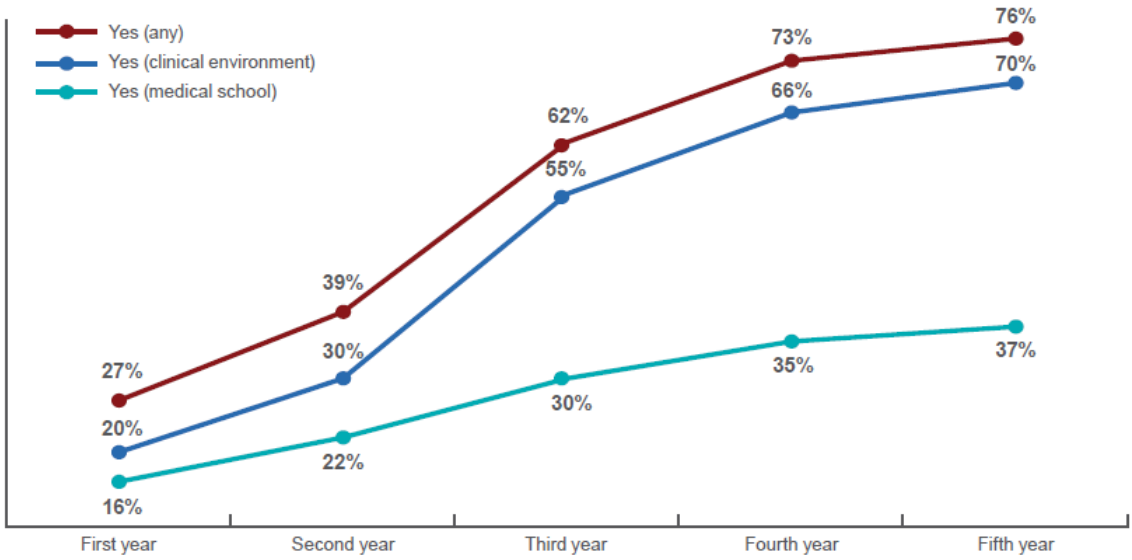
The quality of placements is also important. A focus group study of students from nine UK medical schools reported that they were more likely to pursue a career in general practice if their placements were of good quality, provided authentic practice experience and showed the impact which GPs can make. This is consistent with a Scottish study that found that Foundation Year doctors were more likely to consider a career in GP if they had had good quality experience of undergraduate general practice placement.

As well as quality of exposure itself, longitudinal placements (>6 months) are associated with increased likelihood of pursuing GP as a career compared to traditional block placements (Amin et al, 2018) and this may reflect their capability to deliver the experience students identify as influential to career choice. Longitudinal programmes are found to promote a number of characteristics including clinical responsibility, developing a broad skill set, patient-centred practice and holistic practice (Walters et al, 2012) which can all complement primary care practice. Research also suggests that longitudinal programmes can also lead to reduced exposure to potentially negative effects of institutional hidden curricula (Hirsh et al. 2012). Furthermore, longitudinal programmes claim to offer a nurturing environment by placing greater focus on strategies to deal with the challenges of primary care.

However, clinical placements are also known to expose students to negative views about general practice and this builds over their time in medical schools (RCGP/MSC, 2017). By their fifth year, three quarters (76%) of students have encountered negativity towards general practice from academics, clinicians or educational trainers. Seven in ten (70%) have encountered this in a clinical setting.

The study showed that no less than 79% of students believe doctors and other staff on placements have negative associations with general practice. When the students' experiences of negativity towards general practice were examined, they most commonly cited issues concerned referrals (37%), which often involved secondary care clinicians criticising referrals they had received from GPs.

Figure 2: Whether students have encountered any negativity towards general practice from academics, clinicians and/or educational trainers over time (RCGP/MSC, 2017)



Attitudes within medical schools

Despite GPs comprising around 27% of the medical workforce, the UK's academic GPs account for only about 6% of all clinical academics. Academic leadership and role modelling is important to ensure that students recognise the breadth and complexity of general practice care, and that they become aware of and are stimulated by the complex intellectual challenges. GP academics will also play an important role in supporting undergraduate tutors to deliver high quality education (HEE/MSC, 2016).

Concerns about isolation

The RCGP report found that a concern around isolated working was the second most common reason given for not wishing to pursue a career in general practice, and that this concern built up over the students' time in medical school.

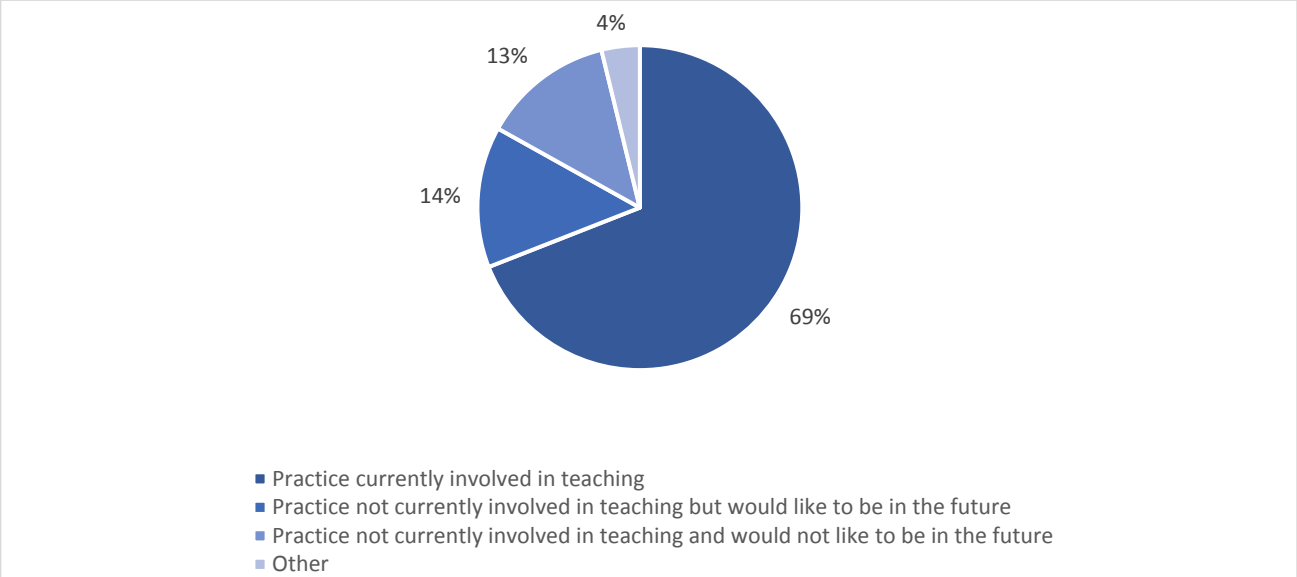
General Practice Perspective

As part of the work of the Group, a survey of current and anticipated future capacity in general practices to support undergraduate education in general practice in

Scotland was conducted over the summer of 2018. The survey, which had an overall response rate of 44%, built on a previous survey undertaken in NHS Highland earlier that year. The key aim of the survey was to identify current and future teaching capacity, including perceived barriers and facilitators to increase teaching in primary care.

The majority (69%) of practices who responded to this survey are currently involved in undergraduate or postgraduate teaching at some level. About half of those who are not currently involved said they would like to be in the future, with a similar proportion saying they would not like to be involved (see Figure 3). Note that the question about future involvement was not asked of practices in NHS Highland.

Figure 3: Practice involvement in teaching



Likelihood of involvement in teaching varied according to the list size of practices. Practices with a list size of less than 4,000 patients were less likely to be currently involved in teaching than larger practices. Those practices which said that they currently had at least one GP vacancy were also less likely to be involved in teaching.

Critically, respondents described a tension between teaching and clinical service. This tension was manifested as competition for the resources of time and space which has been exacerbated by rising clinical workload and inadequate staffing levels in many practices. Respondents described staffing gaps or inability to secure locums as barriers to becoming involved in teaching. For some practices the pressures of providing clinical service alone or lack of time resource to adequately support teaching efforts was enough.

> *"I work full time in general practice and would very much like to teach. We had representatives from [Scottish University] attend and would like to offer us this. However, such is patient demand we would need to take on more staff and the costs would not be recuperated."*

Four sets of factors were identified as potential barriers to teaching: organisation interface, practice, patient and personal.

Organisation interface

A range of perceived barriers to involvement in undergraduate teaching were reported, although many of these described perceptions of undergraduate teaching requirements which were factually misinformed (e.g. needing to have MRCGP, teaching always involves school holidays). This suggests a need to better inform the GP workforce on the range of teaching opportunities available as well ensuring ready access to accurate information on the different accreditation processes and qualifications required.

Other reported barriers included:

- Perceived onerous application and ongoing accreditation processes;
- Feeling disconnected from the teaching organisation;
- Structure of teaching.

Practice level

Many of the respondents described lack of space hindering development of teaching in their practice.

> *"Room space within the practice. We would like to be more involved and have the teaching capacity to do this but are constrained by our building and have not had any support from [NHS HEALTH BOARD] to help accommodate more students/trainees."*

Specific issues for more peripheral (including rural) practices included:

- Transport for learners;
- Learner preferences to be more central leading to fewer allocations;
- Multiple sites made teaching logistically more challenging for practices with branch surgeries;
- Accommodation costs needing to be met by some practices and the need to arrange accommodation were barriers.

> These issues of limited space, GP shortage and accommodation costs are highlighted in the vignette from Biggar Medical Practice (page 28)

Some respondents felt that changes to clinical service delivery due to new developments could be detrimental to teaching. This included the move to a doctor first telephone triage system; recent practice mergers or practice collapses; practices becoming established as 2C practices having been taken over by the health board, thus creating uncertainty over future sustainability.

Patient factors

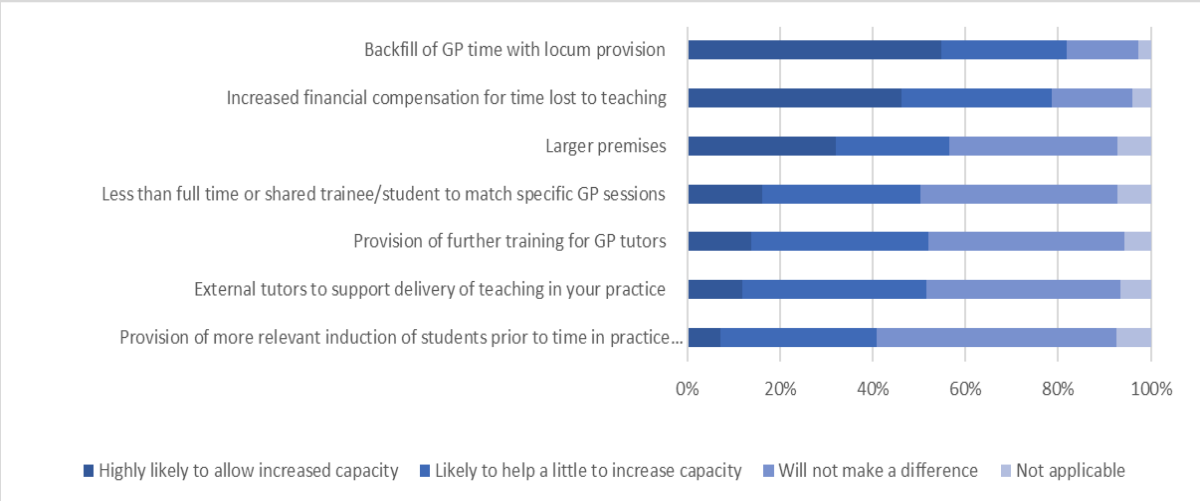
Increased patient demands, including more complex cases and increased frailty, were also noted to have increased pressure on practices. GPs were also mindful of not overburdening patients with teaching involvement (noting potential 'patient fatigue' with repeated requests for involvement with teaching).

Personal factors

Personal barriers mentioned included a lack of confidence, access to tutor training, enthusiasm and lack of experience. It was recognised that teaching can potentially be stressful and tiring. Working patterns were highlighted as an issue including several GPs identifying part-time or locum working as a barrier. A number of GPs mentioned career stage (early and late) as a potential barrier to taking on teaching commitments.

Respondents to the GP Capacity Survey were asked what would allow their practice to take on a role in medical education or increase current capacity to do so. The proposal which respondents felt would make the most difference to capacity was the backfill of GP time with locum provision, with 82% of respondents agreeing that this would be "highly likely" or "likely" to help. This was closely followed by 79% of respondents citing increased financial compensation for time lost to teaching.

Figure 4: Proposals to increase current capacity



The proposal which was felt would have least impact was the provision of more relevant induction of students prior to time in practice. Only 41% of respondents felt that this would make a difference to capacity.

These views were common across all types of practice, although small practices (list size of less than 2,000 patients) were generally more likely to say that the proposals would make no difference to their capacity. Practices which had declared a GP vacancy were less positive about the suggestion of increased financial compensation

than those which were at full complement and they had a stronger preference for the proposal to backfill GP time with locum provision.

A recent review (Barber et al 2019) of undergraduate educators from four medical schools in England found very similar barriers to general practice UG teaching. In addition, they cite lack of support from the medical school, patient fatigue and the development of different models of employment of GP (salaried/ sessional/ locum) as barriers.

CHAPTER THREE: FUNDING AND INFRASTRUCTURE

Medical ACT

Scottish Government financially supports the delivery of undergraduate medical education in three ways: by support to universities via the Scottish Funding Council, to the NHS Boards via ACT (additional cost of teaching) funding which is currently administered and allocated by NHS Education for Scotland ("NES"), and via the Students Awards Agency Scotland (SAAS).

ACT is provided by the Scottish Government to cover the additional costs of teaching medical undergraduate students within the NHS in both primary and secondary care. ACT funds are distributed using an allocation model which is based on student numbers (stage one) and on the amount of teaching activity (stage two). The allocation of funds to primary care is based on a cost reimbursement model whereby GPs are paid for what they specifically do, which is ring-fenced within the ACT budget. For secondary care teaching, Boards receive a 'share' of the available funding relative to amount of teaching they deliver, the latter being calculated using a Measurement of teaching (MoT) tool. ACT funds are also used to support student travel, accommodation and subsistence costs in relation to undergraduate placements and this amount is also ring-fenced within the annual budget.

The ACT budget set by NES for 2018-19 was £77.2m and within this the contribution towards GP ACT was £7.1m (around 9% of total).

Brief history of ACT – "direct" and "indirect" ACT

ACT was originally introduced in 1977 and was based on an English formula (which was called the Service Increment for Teaching - SIFT). ACT was based on the difference in costs between teaching hospitals and a sample of 45 District General Hospitals (in England and Wales). The total level of ACT funding in Scotland at that time was £86.6m pa.

Prior to the transfer of responsibility for ACT to NES in 2005, a review undertaken under the auspices of the Standing Committee on Resource Allocation (SCRA) identified 2 funding streams: (i) Direct Costs – equivalent to £57m (66%) and (ii) Indirect Costs – equivalent to £29m (34%).The direct cost element subsequently came to NES for management, and has risen over time (mainly as a consequence of passing on annual uplift) to the current level of circa £77m.

The indirect cost element was baselined to Health Boards around the same time. This section will focus only on direct cost element of ACT administered by NES. Similar support for the clinical placement costs of undergraduate medical students exists in other parts of the UK, where the direct and indirect cost elements have been kept in one 'pot' and managed by the relevant statutory body. As a consequence, identifiable 'SIFT' funding per student is significantly higher than direct ACT funding in Scotland.

Current GP ACT

Historically, primary care services were initially excluded from ACT funding until the early 1990s. The first allocation of ACT monies was made to primary care in 1992. GP ACT, like the hospital counterpart, is split into Category A and Category B costs. In general, Category A weeks are spent in placement in practice with a GP, usually for 1:1 teaching which currently attracts a sessional rate of £40 per student across Scotland. This payment amount was agreed by stakeholders, although the rate has not been subject to revision since 2010 and as such is due for review.

Category B costs relate to formal teaching or other teaching-related activities which take place outwith clinical placements, often on campus but also within a General Practice setting. There is variation between the type of activity and rates of remuneration provided by medical programmes.

NES Primary Care ACT Review and Work of Group

The key aims underpinning the management of Medical ACT are to deliver the highest possible quality of undergraduate medical education within the NHS to support the teaching of medical students in Scotland; to ensure a transparent and equitable approach to the distribution of ACT funding; to achieve best value through robust performance management of the use of ACT funding. NES commissioned a review of the costs of primary care ACT, which began in April 2018. The NES Review was necessary for a number of reasons namely:

- the increasing difficulties in providing teaching by GPs in primary care
- the emergence of new modes of delivery of undergraduate medical training in primary care, including the launch of ScotGEM in 2018 and new models with NHS Boards for which costs were not fully quantified
- the aspiration to increase the proportion of undergraduate medical teaching that is delivered in primary care.

The intention of the review was to quantify the current actual contribution and costs of Primary Care teaching and to describe the total contribution GPs make to the curriculum for each programme. A detailed exercise was conducted by the Medical ACT team to collate data from each medical programme relating to GP teaching, placement and support costs, along with the costs associated with travel and subsistence. In addition data was sought on activities delivered by GPs outwith these areas including those that were unfunded. The results confirmed that GPs contribute to medical undergraduate teaching in a variety of different ways and an important goal of this review was to reflect that diversity and to devise a means of capturing the actual impact on GPs' time.

There were close working relationships between the NES Primary Care ACT Review team and the undergraduate group (including joint group membership). The ACT Review is due to be published imminently and key findings from the review have helped shape the recommendations made in this report. The findings from the NES ACT review are attached in Appendix C.

Implications of current levels of ACT funding in general practice

Chapter 1, current context, sets out some of the difficulties experienced by Scottish medical schools in recruiting practices and delivering placements, resulting in declining numbers of practices taking part in teaching. We have detailed large falls in the number of practices teaching in Glasgow and St Andrews over the past three years, and a failure to recruit for expansion of GP teaching in Dundee in 2018. A specific example for a practice in Lanarkshire which gave up GP teaching due to multiple factors is given on page 28. We are aware that these difficulties in providing placements has triggered at least one medical school to ask the relevant Health Board to offer higher rates of remuneration than the historical rate of £40 per session.

Chapter 2 sets out in detail the evidence from the capacity survey. When asked what would make the most difference to capacity, 82 per cent of respondents said the backfill of GP time with locum provision, closely followed by increased financial compensation of time lost to teaching (with 79 per cent of respondents agreeing).There is no doubt that issues with recruitment and space within premises are all limiting factors. However, it seems clear from the context and the evidence of the capacity survey that the current level of reimbursement of £40 per session is inadequate to maintain current levels, and that undergraduate education in primary care will not increase at this level, and is likely to decline. Lack of resourcing for undergraduate education is also specifically mentioned as a barrier by Barber et al (2019).

What does it actually cost a GP practice to teach an undergraduate medical student?

A review of the costs of teaching in primary care was undertaken in 2017 by Professors Rosenthal, McKinley and Campbell for the Department of Health and Social Care (England), in association with Health Education England (HEE). The study methodology considered the various direct and indirect costs associated with teaching undergraduates in primary care and examined data collated from a sample of 50 practices, approximately 2 per medical programme. The study is currently in press but the authors have shared in personal communication their finding of an average cost per half-day student placement in general practice of £111, which is in stark contrast to the current payment rate in Scotland of £40. Publication of this study is due in 2019.

In late 2018, a similar exercise was undertaken in Scotland, using the algorithm employed by Rosenthal, McKinley and Campbell, which was shared by kind permission. The Scottish study, led by Dr Amjad Khan of NES, examined a sample of 8 GP Practices in association with 5 Medical Programmes (excluding ScotGEM) and was conducted using a combination of face to face visits to practices and by telephone conversation with the GP and/or Practice Manager. Given the small sample size, variations in the way that teaching was delivered and the size of the groups attending for education sessions, it was not possible to subject the data to the same detailed statistical analysis employed by the English study. However, a median cost of £85/student per 4 hour session**,** was calculated, which is broadly comparable to the English data.

Of note**,** the primary unit of analysis recognises the difference between single student placements and those placements where a group of students attends at the same time. This is important as the average number of students per placement varies between practices with values ranging from 1 student per placement to almost 10 (median = 2 students per placement)*,* depending on the year of study and the type of activity being delivered. It is not assumed that groups with multiple students would attract a sum of £85 for an infinite number of students, but rather a ceiling payment per session would be applied, based on a value agreed by stakeholders.

Raising the ACT tariff for GP education

The strategic direction of travel as set out in the 2020 Vision and Health and Social Care Delivery Plan is to shift the balance of care from secondary to primary care. It is important to remember that 90% of healthcare contact happens in community settings and not hospital and it is important that we educate the doctors of the future accordingly. Currently 27% of doctors in Scotland are GPs. In addition, experience in general practice and primary care is important for *all* doctors, whether or not they choose to become GPs, as an understanding of the social determinants and cultural context of how people become ill is largely gained outside hospitals.

This substantiates the need to increase the amount of education that takes place in primary care and is taught by GPs. While it has been a longstanding principle that GP teaching should be treated on an equitable basis with hospital teaching, there is good evidence from the current decline in UG teaching practice numbers and the capacity survey that this principle will not support an increase undergraduate education in primary care. To increase from a baseline where 9% of teaching currently takes place in primary care, it will be necessary, as part of a package of measures, to urgently raise the ACT tariff for GP education.

It was agreed by the Group that there are three important principles that require to be considered in the context of potentially raising the tariff for GP ACT. These are that GP ACT should:

(i) adequately compensate those educating and training our future doctors and be attractive enough to allow new practices to come on board as demand for training in primary care settings increases;

(ii) be affordable to the public purse;

(iii) not destabilise secondary care ACT.

Modelling a tariff of £85 for Category A costs

- Based on the Khan data, NES have, at the request of the Group, modelled the financial implications of uplifting the £40 tariff for Category A costs to £85 on the basis of the status quo level of GP teaching for each of the programmes.
- Appendix D provides the financial implications of uplifting the rate to £85 for Category A costs based on current levels of activity. The calculations are based on curriculum data for Category A costs obtained from 5 Medical Programmes (Aberdeen, Dundee, Edinburgh, Glasgow and St Andrews).

- The financial impact of increasing the tariff from £40 to £85 for Category A teaching (no change to amount of GP teaching delivered) would be to increase costs for GP ACT by just over £2.5m.

What about rates for multiple students attending for group teaching?

The primary unit of analysis used in the survey by Khan was the cost per student session. This recognises the difference between single student placements and those placements where there is a group of multiple students attending at the same time. This is important as the average number of students per placement varied between practices in the sample with values ranging from 1 student per placement to almost 10 (median = 2 students per placement). In considering the scenario of multiple students attending for teaching, the cost of backfilling a GP's time may be the more appropriate figure to adopt where more than two students are attending, as the GP is unlikely to be able to run a surgery in that scenario. For example, the proposed payment for teaching 3 students would attract a rate of £255 per session (3x£85). This amount is comparable to a current reasonable market rate for a GP to attend an external meeting or to obtain a locum at standard costs. The group therefore agreed that a ceiling tariff value should be adopted at the level of 3 or more students.

Category B costs

The question of altering the rates for Category B teaching, as defined above, is considerably more complex. In contrast to the common rate for Category A teaching adopted by all medical programmes, there is wide variation between the type of activity and rates of remuneration provided by each of the medical programmes for Category B activities. Some examples for this (academic year 2017/18) are listed below and illustrate the heterogeneity that exists currently between programmes:

- **Aberdeen** – 15 GP practices deliver the Years 1 – 3 Foundation of Primary Care sessions. These are each remunerated via Service Level Agreement worth £13,149, which is the equivalent of 10% FTE Senior Clinical Lecturer contract for 1 session along with a £2016 practice fee. All practices deliver 2 out of 3 FPC years in any one academic year. In practice due to the remuneration method and timetable, the SLA cost for teaching is difficult to break down into a cost per teaching session.
- **Dundee** – A range of payments are in operation with rates of £40 per 2.5 hour session for a compulsory "experience" session in primary care to £40.19 per tutor per hour for small group sessions that generally last 2.5 hours. Each group has 40 students and involves two tutors, giving an approximate cost of £200 per session.
- **Edinburgh** – GP practices are paid a fixed rate per semester in year 1 (£1,257.60) or by quarter in year 2 (£3,795). The year 2 payment includes some funding for teaching facilities costs.

- **Glasgow** – Rates vary depending on type of teaching activity of which there are 4 different categories: Communication skills, Vocational studies, Clinical visit and GP visit. The sessional rates for these activities vary from £140 upwards. For some activities a fixed amount is paid by annual contract to a salaried tutor. Teaching facilities costs are also made if activities are based in a Practice.
- **St Andrews** (BSc Hons) – has the most straightforward rate of £161.81 which was paid across all sessions until late 2018 when it was increased to £180 per session

As each medical school uses a different method or methods of reimbursing practices or individual GPs for Category B activities, the group agreed that harmonisation of costing and reimbursement would be desirable to achieve a common rate or range of rates for category B teaching across all medical schools. This would also simplify the administrative procedures for Medical ACT within Universities and NES. However further work is required with input from relevant stakeholders in collaboration with NES to take this aspect further. Beyond that, it is likely that as the amount of teaching in primary care is increased towards 25%, according to aspirations of Scottish Government and Scottish Funding Council, ACT support costs could also be expected to increase further. Similarly, increasing teaching capacity to include more remote placements could also impact on travel and support costs for students who are placed outwith central areas. Currently it is difficult to predict the exact quantum of increase that would be required for the ACT budget to support both of these aspects. It is therefore essential that each of the medical programmes has a robust understanding of their current Primary Care support costs so that this amount may be captured accurately following any proposed change in policy.

Looking to the future

One criticism that may be made of the approach outlined in this report is that is looks at Primary Care ACT costs in isolation. Currently primary and secondary care work on the basis of different models - ACT is distributed through measurement of teaching in secondary care as opposed to cost reimbursement which applies in primary care. These differences reflect that the majority of GPs remain independent contractors, as opposed to consultants who are employees. GPs therefore do not have teaching in their job plans as can exist in secondary care.

While it is recommended that in order to encourage the changes we want to see that the category A tariff is raised to £85, it is arguable that more fundamental changes are required. While it is beyond the scope of this report, it is considered that, in the medium term, there would be merit in considering whether the current ACT model across both primary care and secondary care requires to be reviewed in a more fundamental manner. It could be further argued that such a review should not be limited to ACT but rather consider the overall approach to the funding of undergraduate medical education. Either way consideration should be given to alternative models of distributing monies to support undergraduate teaching, particularly against a background of changing models of delivering undergraduate education, different career pathways in general practice and constrained public finances.

Physical Infrastructure

Discussions with key stakeholders and analysis of the capacity survey show clearly that lack of physical space is seen as a major factor in limiting expansion of undergraduate education in primary care. This is particularly significant given not only the commitment to increase GP numbers but the growing need for training and clinical supervision of the wider MDT, including ANPs, pharmacists, paramedics and MSK physiotherapy practitioners.

Currently approximately 40% of GP premises are privately owned, 25% leased and the rest (35%) in health centres. It should be noted that it is difficult to provide completely accurate figures due to the number of branch sites and overlapping forms of ownership (a GP may own a building which the health board is operating another practice in without a lease for example).

As far as privately owned premises are concerned, the Scottish Government has already announced £50 million of GP Premises Sustainability Loans. These loans are available to an amount of up to 20% of the premises value as a GP surgery, except in exceptional circumstances where more may be provided. The Scheme aims to ease the financial risk associated with GPs owning their practice in turn helping to improve GP recruitment and retention.

As far as those premises owned by Health Boards are concerned, the Scottish Capital Investment Manual (SCIM) provides guidance to be applied in the development of all infrastructure and investment programmes and projects within NHS Scotland. Depending on the level of investment, investment decisions are either made at Health Board level or nationally by the Capital Investment Group (CIG). The CIG reviews all business cases for capital investment projects which are above a Board's delegated limit. In practice the vast majority of infrastructure investment comes through the CIG. All capital investment cases must include a strategic assessment of the need for service change. It is recommended that in future there should be a specific requirement for future training and clinical supervision requirements to be considered in all business cases that come before the CIG.

It should also be noted that the Scottish Government has asked NHS National Services Scotland to prepare a business case for digitising GP patient records. This will focus on the benefits of releasing space for clinical and teaching use. It will use information provided by a survey of GP premises funded by Scottish Government. The survey, to be completed by the end of May 2019, will provide information on the condition of properties as well as the use and size of rooms. Digitising GP patient records would incur significant costs but have the potential to increase physical capacity. It seems likely that the effectiveness, and cost-effectiveness of undertaking digitisation will often depend on the physical layout of each practice.

The biggest strategic issue however is that further capital investment in primary and community services is required. As care is increasingly shifted towards primary and community care settings, it is inevitable that space to educate and accommodate the workforce of the future, particularly the expanding multi-disciplinary team, will be required. A new NHS Scotland Capital Investment Strategy is due to be published

shortly. It is recommended that this should make the case for investment in in primary and community care facilities recognising specifically the need for that to include purpose specific facilities in which to train the workforce of the future.

Biggar Medical Practice and medical students

Biggar Medical Practice has enjoyed a successful partnership with University of Glasgow Medical School for many years. Reports from students are always suggestive of an enjoyable rural placement offering a wide variety of experience. Sadly in the past year we have encountered numerous difficulties which has forced us to remove our support for students. We face challenges in areas such as IT, accommodation, physical working space and GP cover for student clinic.

Having recently lost a GP to early retirement we cannot justify reducing appointment numbers for student led clinics. We have also seen an increase in the MDT use of our practice which means we can no longer offer our students regular working space within our practice building. We have no library space or meeting rooms. Difficulties regarding accommodation are ongoing and we have offered subsidised accommodation to our students. Often the grant from the university is not enough to cover the cost of local accommodation. Being a rural practice students often note the broadband connectivity in poor and this in turn forces them to travel home at weekends to do course work. The sad impact of this being the students don't stay over the weekends to enjoy the richness of rural living.

We are hopeful of supporting medical students in the future, however there are numerous challenges to manage first, the most challenging being physical space.

Digital infrastructure

The Scottish Government Digital Health & Care Strategy 2018 in combination with ever more digital based education services, and indeed the more general move to digital services in our everyday life, is predicated upon connectivity. This issue is most pressing in remote and rural areas and significant focus and resource needs to be brought to bear. Families who move to remote and rural areas, whether they are health, social care or education professionals, expect high quality broadband connectivity. Absence of this is a barrier to recruitment. Access to university e-portfolios and educational material in general practice is very variable and tends to be worse in remote and rural areas and in independently owned GP premises.

The 'once for Scotland' approach to digital development will increasingly bring this into sharp relief if connectivity in these remote and independent locations is not significantly improved. The roll out of fibre-optic cable to cabinet through the Scotland Wide Area Network (SWAN) initiative is intended to offer high quality broadband to all general practices. Of the nearly 800 premises in the programme 60 remain unconnected, almost all of these in remote and rural areas with complex and challenging topography. This last single digital percentage will take a significant and

disproportionate amount of resource to connect and timescales are unclear. On a positive note, the SWAN / Capita team have recently announced that the bandwidth restriction on fibre connections is being lifted and speeds for those practice premises will double over the course of the next few months. In addition, a recent bid to the European Space agency (in collaboration with NHS Cornwall) to develop a proof of concept for health services in remote and rural using satellite connectivity was approved. It is hoped this work will provide connectivity for the hard to reach practices and augmented connectivity (with much improved speeds) for those who have some connection.

This is a Scottish Government issue more generally; a lack of connectivity will increasingly exacerbate potential inequalities, social as well as health specific ones, if not fully addressed. Efforts to coordinate SWAN with the R100 project, which recently received an additional £600m, should be undertaken. This would allow for a better understanding of the timeframes for the remaining very hard to reach locations, and influence decisions on R100 priority areas, such as those places with GP surgeries without connectivity that urgently require access to be accelerated.

CHAPTER FOUR: INNOVATIVE APPROACHES TO INCREASING PRIMARY CARE EDUCATION

Introduction

Whilst appropriate funding and infrastructure to promote General Practice as a positive career destination is vital, consideration must also be given to what changes can feasibly be made alongside this to capitalise on this investment. As noted previously, research by McDonald, Jackson, Alberti and Rosenthal (2016) suggests that medical schools with greater proportions of curriculum time in general practice produce more future general practitioners. This suggests an imperative to increase this percentage, if a meaningful positive impact is going to be made to future GP recruitment.

However, increasing GP contribution to medical school curricula is not simply a matter of moving teaching from secondary to primary care. GP capacity is already stretched and limited, as was evident in the teaching capacity survey undertaken as part of this review. Therefore, there will not be only one solution to increase the proportion of undergraduate medical education in primary care, but a range of innovative approaches which can be tailored to local circumstances.

Cross-institutional discussions through the GP Heads of Teaching, and the expert workshop, have highlighted a range of existing and developing innovative approaches to teaching. This chapter highlights these innovations, as well as some from further afield, which could provide models for future primary care-based and delivered education.

These innovations can be considered on a number of levels and include campus-based and placement-based components of medical school curricula. Medical school curriculum innovations can be further divided into those directed towards the broader undergraduate curriculum and those which are targeted at the GP-focused curriculum content.

1. External Innovations

<u>External Partnerships</u>

Traditionally, medical students have undertaken clinical placements in secondary care, general practice, and sometimes the voluntary sector. Over time, the diversity of placements at some medical schools has increased and this diversification should continue.

Diverse placements not only provide a pragmatic solution to capacity issues, but may also facilitate students' development as holistic practitioners. This approach is in keeping with *Realistic Medicine*, (Scottish Government, 2016) and supports the 2020 workforce vision of a multi-professional, team-based, integrated model for primary care (Scottish Government, 2015).

Examples of creative placements outlined below indicate settings outwith GP surgeries where students can also get primary care experience and exposure to the principles of General Practice.

Community hospitals

Teaching sessions in community hospitals expose students to caring for patients with a focus on rehabilitation or palliative care. These placements provide an opportunity to teach students generalist principles at a “bridging” point between primary and secondary care.

St Andrew’s students undertake day long placements in community hospitals where they benefit from clinical mentoring and opportunities to work with, and learn from, their peers in a clinical environment. GPs are paid a sessional rate to facilitate these sessions, which is at a preferential rate compared with having a student in a practice. The teaching GPs do not have the pressure of service commitment which allows them to focus on teaching. These placements aim to provide students with positive GP role models, identified as essential in promoting General Practice as a career destination within the Health Education England/Medical Schools Council (HEE/MSC, 2016) document *“By choice - not by chance”.*

Third sector

The third sector is currently under utilised for placements and could provide a wealth of holistic, first patient contact community-based education. Many third sector bodies provide health and social care support for patients with a range of physical and mental health conditions. As well as the advantage of avoiding the need for clinically-trained teaching staff when capacity is tight, students are exposed to the breadth of the health and social care system in Scotland, highlighting the vital role of the third sector. There are many such organisations; for example, Grampian has over 700 organisations listed in which students could potentially learn.

Working with other community-based partners

In all Scottish medical programmes, students spend time with a range of providers of community-based health services, reflecting the multi-professional, team-based approach to primary care. These placements facilitate development of holistic medical practitioners and could be expanded with appropriate funding and support. Although many sectors face capacity challenges, learning from and with colleagues such as pharmacists, occupational therapists, physiotherapists and health visitors can create more informed and effective future members of primary care teams.

Out of Hours

The Out of Hours (OOH) service is another valuable learning environment, which, whilst clinically stretched, is currently under-utilised for undergraduate medical education. Variety and challenge are highlighted through the Wass report

(HEE/MSC, 2016) as essential to promote General Practice; both of which are readily visible within the urgent care services.

Cross-institutional collaboration

The process of undertaking this has facilitated further productive collaboration between Scottish Heads of GP Teaching, for example the shared development of curriculum innovations and management of teaching capacity.
While the GP HOTs group will need to provide the main leadership for delivery of expansion and innovation in undergraduate general practice teaching across Scotland, it is not a formally recognised group. In order to support delivery of the desired outcomes, further development and recognition of this group and its role will be required.

Potential future collaborative developments could include:

Shared learning resources

Investment in the development of new teaching resources and sharing of existing local resources provides opportunities to share good practice and facilitates innovation. For example, GP Live (an innovation from Aberdeen) is now being introduced at Dundee. GP Live uses technology-enhanced learning; streaming GP consultations in real time from practices to campus-based groups of students, facilitated by GP tutors. Development could enable these consultations to be sent to multiple sites simultaneously.

Building on this, investment in the creation of a secure shared library of teaching consultations and other online resources could be explored. While creation of significant new resources requires investment, these could be utilised both across institutions and healthcare professions to provide economies of scale.

Placement swaps

Strategies to increase diversity in each medical school's placements might involve sharing learning environments. For example, the Universities of Glasgow and Aberdeen plan student swaps between 'deep end' and remote and rural practices so that students experience GP environments that may not be readily available from their own institution. This will support students keen to explore a diverse range of primary care placements, and may prompt students to consider future practice in underserved areas (Sen Gupta *et al.*, 2014). Shared "accreditation" and student skills/experience passports would facilitate this initiative.

Student "Passporting"

Student "passports" are being introduced at Dundee. Passporting facilitates transitioning between health board areas and can provide reassurance that core requirements have been met regardless of which medical school students are from. For example, a passport could document requirements such as an up-to-date immunisation record, CPR certification, hand washing and occupational health

assessment. Potentially, this could be extended to a competency based 'skills passport', as long as it did not detract from individual programmes' curricula, nor become too onerous for students and staff.

Shared practice accreditation

Each Higher Education Institution (HEI) has its own accreditation process for teaching practices. This involves a combination of paperwork and practice visits which may be duplicated for the small number of practices which teach for more than one medical school. Sharing HEI accreditation would create ease and efficiency of systems which could be linked with accreditation for postgraduate training or teaching of other healthcare professionals in conjunction with NHS Education for Scotland (NES).

Although shared accreditation would be less burdensome to practices and HEI staff, it is acknowledged that relationships between medical schools and practices are important (Alberti and Atkinson, 2018). Relational continuity keeps tutors and practices up to date with curriculum changes and facilitates support if student or practice issues should arise which impact on teaching capacity or capability. Consideration would also need to be given to how each medical programme would ensure its individual quality assurance processes were met through development of a formal process for sharing concerns across institutions.

<u>Placement innovations</u>

The traditional apprenticeship GP placement model of one student per practice gives students the opportunity for individual supervision and mentoring. This is often highly valued by students. However, this model is costly in time and resource and may inadvertently add to students' perceptions that general practice can be a lonely place to work (RCGP/MSC, 2017).

Alternative models are given below, all of which focus on maintaining the quality of the placements. Some involve a greater number of students per practice, whilst others focus on promoting general practice as a positive career destination.

Hub and spoke model / GP teaching centres

A hub and spoke model involves a practice functioning as a GP teaching centre. The hub is a GP practice in which "academic"/teaching GPs have protected time for teaching activities. The hub supports neighbouring practices (spokes) to teach, with students rotating around the hub and the range of spokes available at that locality. This model has the potential to support teaching in traditionally hard to recruit areas (e.g. remote and rural practice) by giving students experience of a variety of practices.

Cell structure

Many medical programmes have or are developing a cell structure approach to GP attachments e.g. in remote and rural or deprived areas (Dundee, Edinburgh, Aberdeen and ScotGEM). Using this model, Aberdeen organises teaching and

attachments in geographically related practices and incorporates weekly day-release programmes in which locality tutors take turns to facilitate small groups of students (typically 4-6). The cell structure fosters students' independence and self-direction, and they benefit from peer support in their small groups.

Shared / group-based placements

Related to the cell approach, some programmes send multiples of students to individual placement sites. This reduces the number of clinical tutors required and facilitates peer support/peer learning, within small groups. It has potential financial benefits at practice level as funding is per student rather than per session. It is relatively simple to set up where space allows. As students are based at one placement location, rather than rotating through different sites, arrangements can often be built on existing teaching practices and infrastructure.

Glasgow sends 3rd year students to practices in groups of two or three for a total of seven days across a four month period. This model works well and is particularly attractive to part-time GPs who may feel unable to commit to a 'block' of teaching due to their working pattern. It has facilitated teaching 'on days off' for some part-time GPs keen to be involved in teaching as part of a portfolio career. Where this has worked well, individual GPs and their practices have agreed various models of payment or 'time back in lieu' (Pope, 2018).

This model benefits the service as additional appointments are provided via student led surgeries and benefits the students as GPs can focus on their learning needs rather than trying to juggle teaching with their own daily clinical workload. GPs are paid on a per student basis and traditionally have been able to choose the group size. However, due to recent capacity issues, tutors who traditionally preferred taking two students have been asked to host three students.

In addition, to meet recent capacity pressures, Glasgow has sent several pairs of students to year 4/5 placements which have historically always been one to one. During a curriculum transition, to manage placement capacity Edinburgh has allocated pairs of students to placements for a one year period.

Longitudinal Integrated Clerkships

Longitudinal Integrated Clerkships (LICs) are defined as placements where students participate in the comprehensive care of patients over time, and are an evidence-based innovation that demonstrably promotes General Practice as a career (O'Donoghue, McGrath and Cullen, 2015) and leads to increased recruitment to rural and community based careers (Walters *et al.*, 2012). This model of teaching and learning has been used for many years in North America and Australia and is now taking off in the UK and Scotland, with the University of Dundee and ScotGEM programmes at the forefront. At Dundee up to ten self-selected students are placed singly or in pairs in a practice for a whole academic year (40 weeks) and all ScotGEM students, in year 3 of their programme, will participate in a LIC.

However, it is noted that if all students in Scotland were to be given the opportunity to undertake a LIC, every practice in Scotland would have to take a medical student and targeting interested students and practices may be a more viable option. Self-selection, in itself, demonstrably increases the positive impact of a placement (Pfarrwaller *et al.*, 2015).

While 40-week LICs require more placement capacity, it is possible for practices to host a LIC student alongside students on shorter placements. International evidence suggests LIC students make a positive contribution to the work of the practice leading to more economic sustainability (Worley and Kitto, 2001) and do not impact on GPs' consultation lengths (Walters *et al.*, 2008).

Interprofessional education (IPE) placements

There are now more formal learners in general practice, undergraduate and postgraduate, and across health care and allied professions. Although this could be a potentially crowded environment, it allows great opportunities for interprofessional learning. Learners can be supported by a wide range of professional teachers, leading to better use of limited learning time in the clinical setting.

IPE is widely promoted and further development and roll outs of these models will need greater cross-organisational collaboration. Recent examples include a pilot of 5 different IPE models involving pharmacy and medical students from Aberdeen, Dundee and Robert Gordon Universities. Their team has undertaken work to identify common outcomes expected across healthcare professional programmes to start to inform further development of such initiatives (Steven *et al.*, 2017). Funding for these more complex teaching models needs to be considered as currently different funding streams exist to support different learners with some learners coming with no or little funding. At a time of teaching capacity pressures, an educational hierarchy based on differential funding levels could be detrimental.

One Foundation Year doctor interviewed as part of this review noted:

> *One thing we did have in med school which I thought was great was that we had some things with nursing staff, student nurses, which was great; meeting with physios and stuff... Having those multidisciplinary sims was great, which we never had for GP actually and GP is just as much an MDT thing really… Maybe that would have been a helpful thing to realise GP is not just about you sat in a room seeing one person.*

Near Peer learning in the clinical environment

A strong theme from the expert workshop was around trainee or junior GPs becoming more involved in teaching, both in clinical practice and in universities. Evidence of teaching is a curriculum requirement of GP trainees and Foundation doctors (RCGP, 2012; UKFPO, Academy of Medical Royal Colleges Foundation Programme Committee and UKFPO, 2016). In contrast to hospitals, where teaching

by doctors in training is ubiquitous (Bindal, Wall and Goodyear, 2009; Hill *et al.*, 2009), teaching by junior doctors in general practice is somewhat limited.

Teaching by trainees was thought to not only be a way to not only aid teaching capacity, but also to expose students to positive near peer role models. Previous work has highlighted an enthusiasm for teaching amongst GP trainees (Halestrap and Leeder, 2011) and interviews with FY doctors have echoed this:

> *I think it is quite valuable having more junior people doing the teaching because we know what is expected of medical students, whereas I think the more senior you get, you kind of forget what's important to pass exams and be a good foundation doctor.*

However, there are a number of barriers to expansion of near peer teaching. These include matching learners needs with near peer teachers' expertise, trainers' perceptions of trainees' ability to teach, lack of formal training programmes for trainees teaching and practicalities such as learner overlap (Dodd *et al.*, 2009; Silberberg, Ahern and van de Mortel, 2013; Kirby *et al.*, 2014; Pope, 2018). A 2016 survey of Glasgow University undergraduate teaching practices identified that only 39% were also postgraduate training practices. This is similar to the figure of 45% from an England-wide study (Rees, Gay and McKinley, 2016). To ensure that all students have opportunities to have contact with GP trainees, campus-based near peer teaching needs to be further developed alongside practice-based initiatives.

Showcasing General Practice

The Unique Selling Points (USPs) of General Practice are often assumed to be implicit within clinical teaching and on placement, but have been described as unclear to some undergraduate medical students (RCGP/MSC, 2017). All programmes are working towards actively promoting General Practice's USPs and St Andrews have designed an innovative GP showcase day to achieve this. In this initiative, multiple students are sent for a day to a teaching practice identified as 'high performing' from student feedback. On these visits, General Practice is actively promoted via group discussions and learning experiences.

2. Curriculum innovations

<u>Integration of General Practice in Broader Medical School Curriculum</u>

The integration of general practice within overall medical school curricula sends a powerful message to students that general practice is of equal status to hospital medicine. This equality is highlighted through a number of current curriculum innovations utilised to varying extent within Scottish medical schools, addressing both the formal and informal curriculum as recommended in *By Choice, not by Chance* (HEE/MSC, 2016).

Contribution to systems-based learning

GPs lead on the management of most common chronic diseases in clinical practice, yet teaching on these topics is often delivered by secondary care colleagues who

care for the most complex minority of patients and in a setting where the complications and inter-connectedness of multi-morbidity is not always addressed. Formats such as joint specialist and GP lectures demonstrates the equal importance of both doctors in managing common diseases, provides students with a more authentic understanding of the patient journey and care delivery within the NHS as well as exposing students to role modelling of interprofessional respect. Through a raised profile of GPs across a range of curriculum content, the breadth of a generalist's knowledge can be showcased and be seen as equally valued as a specialist's narrower yet deeper knowledge.

Case based learning

Medical schools use a combination of purpose-written and real life cases to facilitate students' learning in clinical practice. Consideration should be given to how general practice is represented within purpose-written cases. GPs should contribute to ensure cases represent the breadth of clinical presentations across primary and secondary care. For example, ScotGEM utilises a case-based learning approach, with learning centred around a case of the week in years 1 and 2 of study. Each clinical case is displayed to students on a web-based platform ("Kuracloud"), with specific linkage to student learning outcomes.

In Sheffield University, students discuss real life cases from their hospital placements in GP-led small group learning sessions. Utilising GPs to lead these sessions highlights the breadth of knowledge of general practitioners as they are able to discuss cases from a wide range of specialties and across the continuum of presentation, management, disease progression and patient experience.

Careers Days contribution

Representation of General Practice in medical school Career Days is vital. Destination GP (RCGP/MSC, 2017) highlighted that many students were unaware of possible career trajectories within general practice. Careers events should take place across all years of medical schools' curricula and should showcase the diversity of career opportunities available to GPs, including academic general practice and portfolio careers.

BMedSci in Health Sciences – Primary Care

A recent innovation has been the creation of BMedSci Health Sciences – Primary Care option for students at Edinburgh University. This has proven popular with 15 students choosing to undertake this course in academic year 2018-19. It highlights that general practice is an intellectually and clinically stimulating discipline, and aims to foster GP academics. (see details below) Although this option may help promote a variety of careers in general practice, this or any similar courses which might be developed are not currently eligible for GP ACT funding as they are considered 'out of programme' opportunities.

The BMedSci – primary care course comprises:

- A compulsory ‘Research Skills in Health Sciences’ course (20 credits)
- A Primary Care Course (20 credits)
- A Clinical Placement (10 credits)
- A taught elective course (20 credits)
- A Literature Evaluation and Review (10 credits) undertaken prior to a research project
- A 10-week research project. (40 credits) - Projects will include preparation of a dissertation and an oral presentation.

New curriculum models

New curriculum models, such as LICs and ScotGEM aim to create new and exciting opportunities for students to learn in general practice. More recently, 3 further Scottish medical schools have been awarded additional student places from 2019, each aiming to promote general practice in differing ways:

- 30 additional places at the University of Aberdeen: all students will undertake an enhanced GP programme, with a set minimum of teaching time and an additional range of GP options. This is a multi-pronged approach, integrating GPs into the formal teaching curriculum at the Medical School within clinical blocks alongside secondary care colleagues, and implementing a number of new experiences, including embedding students in the Third Sector and Out of Hours care. Alongside these changes they are developing the role of existing GP tutors in the community and expanding opportunities for GP mentorship. Clinical teaching is transferring from traditional ward based settings into Primary Care, including community hospital teaching and case based learning.

- The University of Edinburgh is developing a new MBChB programme for existing healthcare professionals aimed at training graduates who will be more likely to enter general practice postgraduate training. Commencing in September 2020 for 25 students, it is unique in that its target students are existing healthcare professionals, who will study part-time (for the first 3 years), and most of the time they will be learning remotely. Their clinical contact in the first 3 years will be almost exclusively in general practice, then they will join the mainstream programme for the final 2 years.

- Glasgow is taking a two-pronged approach to strengthening the role of general practice in their curriculum. Firstly, there is expansion of contribution from general practice and GPs throughout the 5 years of the course for all students e.g. via the New Year 3 GP teaching week (see below). Secondly, the creation of the new COMET (Community Orientated Medical Experience

Track) offers 30 students the opportunity to participate in a GP focused stream within the MBChB programme. Successful applicants will experience an enriched programme of immersive primary care in a range of practices with the aim of inspiring the GPs of the future.

ScotGEM: Generalist Clinical Mentors

ScotGEM offers a four-year MBChB training focused on 'rural generalists' for graduate entrants. The course is therefore atypical in that it has licence to select students from the outset interested in this more community-based approach with an explicit emphasis on general practice.
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Based upon the need to offer a truly generalist experience that aligned with a Case Based Learning curriculum it was concluded that the only clinicians who could do so, including accessing a full range of patients for teaching, were GP's. The programme thus prioritised expenditure on a GP led clinical programme throughout years one to three. Though this aligns extremely well with many aspirations within the Wass report it also necessitated a new approach of sufficient appeal to recruit portfolio career GP educators

Generalist Clinical Mentors (GCM) teach the Clinical Interaction Course (all consultation, clinical and procedural skills) for half a day within the medical school, have groups of 6-8 students in practice for a day each week and have half a day preparation time. The aim being to provide core teaching by enthusiastic role models based in community practice demonstrating a clear bridge with more structured aspects of their learning. The CLIC teaching is structured and focused with a two-year competency-based learning outcomes plan. The 'GCM Days' are designed with local opportunities in mind (e.g. access to a community hospital ward or not) and blend the weekly CBL start/wrap up with a broad range of GP based learning.

Glasgow's Year 3 GP teaching week

Phase 3 of course is based on a specialty week structure (e.g. cardiology, respiratory). From 18/19 a new GP 'week' has been added to this phase of the curriculum. This 'week' is comprised of 3 GP led teaching days, the content of which has been based on 3 key documents: SAPC and RCGP Curriculum Guide 'Teaching General Practice'; GMC Guidance 'Outcomes for Graduates'; and Realistic Medicine

The content aims to highlight key principles of good quality primary care at the heart of which is working in partnership with patients and generalist principles. The format includes:

- Inspirational talk from a carer and presentations from leading academic GPs on topics such as social determinants of health, multi-morbidity, treatment burden, polypharmacy and self-management.
- Case focused lightning talks from early career academic GPs – to promote academic GP as a career and also to demonstrate how we use evidence to inform decision making
- GP ST delivered Case Based Learning Sessions to highlight key principles of primary care
- Student presentations feeding back learning from multi-morbidity Case Studies
- Senior GP academic revision GP surgery – highlighting GPs use learning from all the other specialty weeks in their daily work.

GP Teaching Fellows

In recent years, there has been a large increase in the number of hospital-based clinical teaching fellows (Furmedge et al., 2013). The current separate funding streams for postgraduate and undergraduate training and teaching make creation of a similar scheme in primary care challenging. These roles are beginning to appear in England and have been positively evaluated (Thampy et al., 2018). It is proposed that their cognitive and social congruence with medical students not only makes them effective teachers but also positive role models for choosing a career in general practice.

ScotGEM GP Teaching Fellows: a potential catalyst for increasing capacity

ScotGEM is generating excitement and enthusiasm, offering options to innovate with many GPs considering the programme a strong prospect for building the workforce. There is an urgent need for new solutions as more of the same will not suffice and this might include a policy of growing our future educators. The suggestion of creating UG Teaching Hubs has particular resonance in rural areas where there is no nearby university department and are typically 'hard to recruit' Consequently, ScotGEM is exploring ways of supporting such developments with their particular boards as a means of developing new capacity and future educators.

The proposed model could involve strategically sited early career GP Teaching Fellows, co-funded with boards, as part of a Teaching Hub supporting a small number of 'spoke' practices or teaching delivered within health centres or community hospitals in specific geographical locations. For instance, supporting a group of Longitudinal Integrated Clerkship students via a local GCM tutor. The aim is to aid rural recruitment and free more experienced local GPs to teach as well as aligning ScotGEM with the national goal of increasing capacity and enabling it to play a key role in catalysing innovation at a local level. These one-two year appointments would include a mix of clinical service, teaching and personal development opportunities.

GP-focused curriculum content

Consideration also needs to be given to GP-focused curriculum content. This includes both core curriculum content and the variety of options available for additional GP exposure. There is significant variation across UK medical schools in the quantity of their curriculum which is GP-focused (Alberti *et al.*, 2017). Creation and delivery of new content should be informed by '*Teaching General Practice'*, a joint SAPC and RCGP guidance document, and should aim to highlight the evidence base underpinning general practice as well as generalist principles (Harding, Hawthorne and Rosenthal, 2018).

Curriculum options/ electives/ student selected components

All medical school curricula include a degree of 'self-selected' content i.e. opportunities for students to choose areas they are interested in studying while demonstrating the learning outcomes required of them (GMC, 2015). This includes, but is not limited to, electives, student selected components (SSCs) and intercalated degrees.

Historically, in some medical schools, general practice has been underrepresented within these options due to minimal or absent funding. These options are often

popular with students e.g. SSC focusing on Remote and Rural Practice (Aberdeen). The greater flexibility this teaching format can afford facilitates creation of engaging and relevant student learning experiences such as undertaking BASICS training, mountain rescue and coast guard experience. Opportunities such as this can excite students about a career in remote and rural general practice.

The role of Student GP Societies

A key recent development has been the establishment of student GP societies across all Scottish medical schools. Supported by both RCGP and the HEIs, a factor in the success of these groups has been that they are student-led. Planning, managing and delivering a range of activities, students' enthusiasm for general practice can be harnessed. Working in partnership with medical schools, these students can help inform curriculum innovations going forward and can provide useful insights into the perceptions of general practice in the wider student body.

GP Societies in Scotland

The Wass recommendation (10) taken forward in Scotland in the shape of a *Discover GP* conference in Aberdeen in February 2019. There were plenary sessions delivered by prominent GPs, including Carey Lunan, Chair of RCGP Scotland. There 109 attendees, including 92 students, 14 foundation doctors and 3 physicians associates.

- Collaborative effort from all Scottish GP societies, supported by the RCGP Discover GP team and the local faculty.
- 34 GPs who volunteered their time to run sessions and inspire the next generation of general practitioners
- Part of an annual programme of seven regional conferences bid for by GP
- Feedback was excellent with many people saying that they were 'inspired' and 'excited' by the 'diversity', 'flexibility' and 'breadth' the specialty offers.
- 95% of attendees stated that the event had quite positively or really positively changed their perception of what a GP does
- 90% stated that the event had quite positively or really positively changed their perception of the future of general practice
- 100% stated that the event had quite positively or really positively changed their perception of becoming a GP

This successful event demonstrated the real value of raising the profile of GP societies through well publicised events for students and FY doctors. Such events are likely to be of value in increasing numbers of medical students who pursue a career in general practice.

3. Innovations in developing GP teaching workforce

Diversity of teaching opportunities

The GP workforce is changing – fewer GPs are becoming partners and more GPs are working part time or seeking portfolio careers (NHS NSS, 2018b). To increase teaching capacity, teaching opportunities must be available to all GPs. New models such as the creation of the Generalist Clinical Mentor model (GCM) are one way of doing this. The options of fixed commitment or flexible teaching involvement is another.

Developing the GP academic workforce

GP academics play a crucial role in promoting a career in general practice to students. The decline in the number of GP academics within Scottish medical schools over the past six years is a cause for serious concern. GP academics provide profile for the discipline within medical schools as well as being role models for future GPs and GP careers. They undertake much needed research in primary care for the rapidly changing and ageing population of Scotland and focus on evidence-based solutions to problems. Perhaps most importantly, in the face of recent evidence (RCGP/MSC, 2017) of the impact of denigration of general practice on students' career choices (destination GP), GP educators can challenge prevalent negative attitudes to general practice careers held by many students and clinical academics. In Holland, recruitment to general practice is good, and there are strong links between academic departments and provision of primary care. Raising the visibility of academic general practice may be important in encouraging curiosity and improving recruitment (Wass, 2019; Mulla, 2018).

Strengthening primary care educational leadership

Throughout the duration of the working group, the GP Heads of Teaching group (GP HoTs) has demonstrated the value of sharing ideas around undergraduate education and working collaboratively to innovate. Working in partnership with their medical school teams, they are forging the future of undergraduate GP education in Scotland. This aims not only to produce more future general practitioners but also to create a future medical workforce with a greater understanding and respect for the pivotal role of general practice in the NHS.

GP Champions in NHS Tayside

NHS Tayside has recently created a post of “GP Champion”. The overall purpose of the role is to support GP-based learners in the secondary care setting. In particular, the GP Champion will support undergraduate learners who are on Dundee School of Medicine’s Longitudinal Integrated Clerkship (DLIC) programme (year 4 Dundee students and ScotGEM year 3 students), by facilitating access to learning in secondary care settings, contributing to planned teaching sessions and assessment within the programme. DLIC students self-direct their learning, linked to the patients they see and attend services individually to meet their self-identified learning needs. As this is often with short notice, or none at all if a patient is admitted with an acute illness, this kind of support will greatly ease their access to secondary care learning environments. The Champion will also raise awareness and understanding in secondary care of the DLIC and its requirements.

A secondary aspect of the role is to support GP Specialty Trainees working in the hospital. This group have individual educational needs which are different from those of hospital based specialty trainees. The post holder will liaise with the GP TPDs/APGD in the deanery to define GP Trainees' learning needs in secondary care, and identify and facilitate relevant educational opportunities. We expect that this initiative will enhance the learning of both undergraduate and postgraduate GP based learners by making it easier for them to access relevant secondary care experience and teaching.

CHAPTER FIVE: MEDICAL SCHOOL PLANS TO INCREASE UNDERGRADUATE EDUCATIONAL CAPACITY IN PRIMARY CARE

Introduction

The previous chapter on innovations developed by the GP HoTs indicates the potential to substantially increase undergraduate education in primary care. While that chapter covers a great many different approaches, this chapter contains the current commitments to change from all Scottish medical schools.

The following summarises potential early gains:

- Developing GP Teaching Centres in which GPs support multiple learners in clinical practice concurrently
- Using live streamed consultations in group teaching sessions
- Making more clinical teaching sessions in the Medical Schools jointly designed and delivered by primary and secondary care faculty
- Establishing GP led small group sessions to discuss cases encountered in all clinical settings
- Establishing 'near peer' teaching to include working with the Scottish Deanery to facilitate involvement of FY doctors and GP Specialty Trainees
- Considering how to extend GP led teaching into community hospitals and other community healthcare settings including the Third Sector

It is recognised that increasing undergraduate education in primary care is challenging and will take time. 'Quick wins' are limited and many of the initiatives required to develop increased capacity across the whole primary care system (including increasing the number of GPs) cannot be achieved by medical schools alone.
A summary of the current plans from each medical school is set out below.

Aberdeen

The University of Aberdeen is taking a multi-pronged approach to developing a GP enhanced programme for its students which offers them multiple additional opportunities to develop their understanding of general practice, in addition to excellent experience relating to other medical specialties. They are doing this by further strengthening the role of general practice in the curriculum, with GPs teaching alongside secondary care colleagues across clinical blocks and implementing a number of new experiences referenced earlier. These include embedding students in the Third Sector and Out of Hours care. Alongside these changes they are developing the role of existing GP tutors in the community, expanding opportunities for GP mentorship and expanding the clinical teaching time in Primary care, including community hospitals and using case based learning. An additional 30 student places is facilitating the development of multiple opportunities across the curriculum for students to select further GP experience during their studies. Further details below:

GP Enhanced MBChB Programme Curriculum Model

The University of Aberdeen GP Enhanced MBChB Programme will follow a core and options curriculum model. To reduce the risk of potential reinforcement of negative views and divisions between hospital-based disciplines and general practice, we have made a positive decision to adopt a core and options model for our GP Enhanced MBChB Programme. In this *all* students will experience a GP Enhanced programme where ultimately a minimum 28% of clinical teaching is experienced in a GP context. The figure for community-based placements would be significantly higher than this and is steadily increasing as care moves to the community. These additional placements in the community context feature widely in the curriculum and would include some which are hospital based clinician led and others where there is a combined GP / hospital based clinician activity e.g. diabetic care in North East, mental health (72 sessions in Year 4), child health and care of the elderly.

Dundee

The overall curricular time for students in GP focused or placement based teaching varies between 8% to 12.5% across Years 1 to 5 (with an option in Year 5 to increase to 25% via an immersive clinical placement in rural practice).

Dundee would ideally increase the clinical placement time across all five years, however, teaching capacity in general practice means this is unlikely to be feasible in the near future. They therefore propose to look at sustainable alternatives that give students opportunities to experience the breadth, complexity and intellectual challenge of general practice, to work with positive role models. This could include, for instance, in Years 1 to 3, introducing a series of either one GP day per fortnight or a half day every week, plus two GP weeks per year for a mixture of classroom based learning activities and half day placement in local practices. This might involve:

- Case based student led clinical reasoning focused sessions – mixture of prepared cases progressing to real cases from clinical experiences over years 1-3. Small group format: 8-10 students max (currently in development) with continuity of tutor
- GP Live (GP facilitated discussion of live streamed real consultations – currently in pilot phase)
- ‘Experiences’ in a mixture of clinical, campus and Third Sector organisations, includes Interprofessional Education (IPE). These currently exist but need refining and expanding.
- GP led small group sessions with continuity of tutor (already exist but to be expanded significantly)
- Formal involvement of GP-STs in teaching
- Whole consultation simulation
- Continue patient journey sessions

In Year 4 and 5, planned or aspirational activities include a continuation of four week immersive GP placements and LIC option for 10 students in Year Four; development of GP Teaching Centres to address capacity issues; whole consultation simulation in Year 4; and student-led clinics for real patients in Year 5.

Edinburgh

Edinburgh are currently reviewing arrangements for delivery of the MBChB programme from 2020 onwards. This will involve changes mostly in years 1 and 2 and year 4. A number of these proposed changes are described below:

Year 1

- The innovative Health, Ethics and Society module will continue with patient case studies delivered through GP practices focusing on the patient's experience of illness, and role and importance of family in promoting and maintaining health.
- Introduction of "live-streamed" GP consultations. This will occur in semester 1 to introduce the students to the nature of GP consultations and communication.
- Patient stories: Interview older patients about their life. The cases will be selected by GP practice. This will include care home residents. The focus will be on talking to patients and becoming comfortable in writing narrative accounts. Students will produce a biography of the patient (not only health focused)
- Introduction to Clinical Practice to start in Year 1 delivered through local GPs. This component will focus on history taking and communication.

Year 2

- Introduction to Clinical Practice will continue through Year 2 with further teaching on history taking and clinical examination of all the major systems. This will be taught through local GPs as in Year 1.

Year 4

- GP placements will expand from four weeks currently to 10 weeks, with a focus on an embedded experience where the GP tutor will be able to provide detailed feedback on students' clinical ability. It is likely that practices will be required to take additional 2-3 students. This will also include out of hours shifts in GP. This component will also focus on the interface between GP and hospital by for example following patients to outpatient appointments or acute admission to hospital. This will also include a strand through the year called "Team" where students will need to work or meet with all the members of the team both in GP (e.g. Practice Manager, District Nurse, Pharmacist etc.) and provide a written report on their role. The same process will also run through Year 4 in hospital based placements. There will also be tutorials developed by GPs to groups of students in local practice placements. These will be case based and co-created with hospital specialists.

This is the most practically challenging aspect of the plan. It is already clear from multiple discussions with GP partners that this plan cannot be delivered without an increase in funding.

Year 6

- Aim for students to have a 4-6 week GP placement, which will be similar to current provision. The emphasis will be acting a senior student and seeing patients as first point of contact.
- Edinburgh is aiming to bring clinical exams forward to December, at the end of semester 1. This will allow us to develop semester into a Preparation in Practice module. This will have an assistantship and a local elective in either GP or hospital medicine. They will look to find partners in remote and rural locations for these.

Edinburgh's aspirations are for teaching in primary care settings to represent around 10% of the year one and year two curriculum by 2021; in year four 30% of clinical placement would be in primary care (a 150% increase on current levels) from 2021 onwards; while for year six the aspiration is 25% from 2023 onwards.

Glasgow

Glasgow intends to employ a multifaceted approach to increasing the profile of general practice in the curriculum. Alongside the introduction of the new COMET programme (see point 3 below), they are reviewing the curriculum experienced by all students. Future plans are underpinned by the current evidence base for effective interventions supporting medical students considering a career in general practice. Proposed or potential initiatives include:

- Enhancing Quantity and Profile of GP during Specialty Placements – in Phase 4 of the curriculum Glasgow are looking at a number of potential options, including amending timetables to provide a GP-delivered section of scheduled specialty teaching within their Integral teaching week and, with additional funding, a placement of students in GP for one half-day during each of the Specialty Blocks in ENT / Ophthalmology, Obstetrics, Gynaecology, Neurology / Cardiology, Musculoskeletal medicine, Paediatrics, and Psychiatry.
- Establishment of the COMET Programme to showcase and develop GP Leadership – in 2019 Glasgow will select its first cohort of students who have expressed an interest in taking on a career in General Practice. Over the remainder of the 4 years in the undergraduate curriculum they will roll out an enhanced exposure to the clinical and leadership challenges presented in primary care settings.
- Promotion of near-peer teaching – following a pilot of Near Peer Teaching by GP Specialty Trainees in third year, Glasgow will be exploring development of practice-based near peer teaching.
- Integration of GP throughout the broader curriculum – general practice lends itself to spanning across the medical school curriculum. In recognition of this, Glasgow have already started to explore promotion of the role of the GP as

the ‘Expert Medical Generalist’. This includes the proposed creation of a new ‘Expert Medical Generalist slot’ in year 3 specialty weeks from 2019 and a review of representation of general practice in teaching material used across the curriculum.

- Utilisation of Technology Enhanced Learning and Teaching (TELT) – development of online resources such as GP Live and Online Case Resources will enable greater numbers of students to experience the diversity of experiences available across the West and Scotland as a whole.
- Creation of attractive teaching opportunities for GP teachers in all capacities – investment in GP teaching has the potential to facilitate creation of innovative posts which have been employed successfully in other areas e.g. GP teaching fellow posts for GPSTs, hybrid service and teaching posts, academic and portfolio career opportunities. As a first step, we are in process of employing GPs as Heads of Senior Years (4 and 5) to provide role models for General Practice.

St Andrews

Currently approximately 20% of the BSc Hons clinical curriculum is within primary care. Their short term goal is therefore to increase this to 25% (in line with the SFC target). However, recognising the shortage in primary care physicians and problems within GP retention and recruitment, over the longer term they aspire to a greater shift towards primary care teaching.

Spanning short to long-term plans, St Andrews aims to cross fertilise ideas and innovations with the ScotGEM programme; for example, adoption of a more case-based approach to learning, alongside prominent positive GP role models.

Short-term (0 to 12 months)

- Increase the proportion of simulated scenarios and case-based discussions set in primary care
- Ensure resources that support learning events are relevant to primary care; for example, referencing primary care journals and guidelines
- Introduce joint teaching on placement, delivered by both primary and secondary care physicians
- Introduce joint lectures, delivered by both primary and secondary care physicians
- Directly address and discuss concept of “badmouthing” within lecture theatre event
- Recruit GP registrars for future GP careers events and near peer learning experiences
- Strengthen existing GP society, building on membership and provision of educational events

Mid-term (1 to 2 years)

- Provide Out of Hours (OOH) learning opportunities for students, with placements supported by GP tutors
- Introduce further community-based placement in year 1 of course
- Introduce community-based placements in year 3 of the curriculum (currently secondary care based)
- Provision of third sector placements in early years
- Share Quality Assurance visits of GP practices across institutions to reduce administrative load
- Build on existing GP Showcase day model, sending multiples of students to single sites, promoting “USPs” of General Practice

Over the longer term (two years plus) St Andrews will seek to build a bank of shared primary care learning resource between institutions, including placement sites for “swaps”. They also have an aspiration to build on community hospital teaching model, towards a teaching hub/centre but note that this would require significant additional resource.

Facilitating Innovation

The submissions by the GP Heads of Teaching and discussions at the Working Group emphasise that there are significant barriers to delivering increased capacity. In particular, GP HoTs have been clear that the implementation of many of the innovations noted in this chapter will require a significant uplift in the Category A tariff. They feel that a static tariff will not only prevent innovation but risks a decline in the number of practices taking students due to on-going workload issues. In addition campus-based teaching is also dependent on appropriate funding streams, GP tutor and team capacity, physical infrastructure, competing demands on curricular time and professional support staff.

GP HoTs further highlight that clinical placements are very changeable and dynamic, dependent on staffing on the ground, and wider pressures on clinical service provision. Flexibility is therefore essential within medical school plans, with a need to take a longer term view. While it is clear that an increase in the category A tariff is essential to increasing the GP tutor workforce, that in itself will not deliver an increase in education in primary care. That will require the implementation of all the recommendations in chapter 6.

CHAPTER SIX: SUMMARY AND RECOMMENDATIONS

Summary

Chapter two highlighted the range of barriers and facilitators to increasing undergraduate education in primary care. Chapters three to five outline the wide ranging systemic action that is required if we are to progress towards the goal of significantly increasing medical students' exposure to primary care placements and to GP educators. Individual initiatives, no matter how evidenced-based or innovative in nature, are unlikely to be sufficient. It is important to state that all curricula will have to ensure that students are prepared for the forthcoming GMC Medical Licensing Assessment (said to represent the minimum standard expected of a student graduating from a GMC approved programme). This will apply to teaching in general practice and other community settings as well as all other clinical contexts.

The breadth of membership of the working group indicates the complexity of the issues involved in increasing undergraduate education in primary care. The high attendance, joint working and engagement of group members has been impressive and has enabled clear recommendations. It is also very apparent that as we move forward to implementation, developing and sustaining improved working across and between many of these organisations will be necessary for an increase to be achieved and maintained. In particular, the output of this group offers an opportunity to strengthen existing links between undergraduate and postgraduate medical education, and between Universities and Health Boards. An example of this is given in the box on page 52.

RCGP Scotland has a significant role in many areas, but especially in supporting undergraduate GP societies, advocacy for strengthening education in primary care and providing independent feedback from GP educators in the profession. The recently published RCGP Scotland document 'From the Frontline' recognises the importance of increasing general practice based teaching for undergraduates (RCGP Scotland 2019). The role of SGPC in advocacy for resourcing of GP education is also important. The principle set out in Sir Lewis Ritchie's 2015 report on primary care OOH services, that of pulling together to achieve a common aim, also applies strongly to all partners involved in increasing undergraduate education in primary care. A consistent and demonstrable approach by medical schools, and the wider profession, to address tribalism and negativism about general practice will also be necessary.

Throughout the life of this group, it has become clear from many sources that many GPs are stimulated and even 'rejuvenated' by undergraduate teaching if the time, space and financial support can be found to address the tension that currently exists between service provision and teaching. That is the purpose of these recommendations.

Health Boards and Universities: moving from cooperation to collaboration

As part of a structured approach to supporting Medical Education Delivery in NHS Highland, across several universities and in particular to support the growth in delivery in primary care the board established two groups to bring partners together- the NHS Highland Medical Education Strategic Board. This Board provides an opportunity for partners (UofA, UofD, ScotGEM, NES, NHSH) to share openly on changes and challenges regarding local, regional and national development in medical education and service delivery, particularly if one will have an impact on the other, and to then provide advice and support to each other as necessary. This Board also has a remit to share at a strategic level how, where and by who medical education is being delivered, good practice and successes for the Local Education Provider, Educational Organiser, students, clinicians and patients.

This group is informed by the Undergraduate Medical Education Committee (UMEC) which has responsibility for the oversight of the operational delivery of undergraduate medical training across NHS Highland. UMEC has a remit to support an increase in the capacity for providing medical undergraduate education teaching in both primary and secondary care and to support the development of local medical staff to be effective teachers and role models by providing educational opportunities and relevant CPD that meet their needs. UMEC has an important communications role ensuring communication to the local medical education faculty regarding local, regional and national developments in undergraduate medical education across primary and secondary care.

Developing the GP educator workforce

It is clear that in developing the necessary workforce, a 'more of the same' approach will fail. There is a real opportunity here for medical schools to develop teaching faculty in innovative ways, such as the Generalist Clinical Mentor model initiated by ScotGEM, which offer a diversity of teaching opportunities to GPs who may be partners, salaried or sessional employees. Innovative ways of delivering **'near-peer'** teaching by FY and GP trainees will also be important. The joint initiative between NES and University of Glasgow on utilising GP trainees in UG teaching sets out a model that could be applied with local adaptation across Scotland. (see Glasgow's year 3 teaching week on page 40) Recent evidence (Allsopp, 2019) also suggests that near peer teaching has a positive effect on GP trainees as well as on medical students. Among other positive findings they found 'increased resilience, increased desire to work as a GP, increased interest in medical education and an increased desire to stay and work locally.' These are potentially important findings for recruitment and retention in practices.

There are also other ways in which GP faculty could be developed and strengthened. **GP teaching fellows** (see SCOTGEM proposal on page 41) have considerable potential for expanding undergraduate education while also helping to develop and train the future GP educator workforce. Another potential development is on the basis of the post CCT positions being developed following the Shape of Training Review (Greenaway D. Shape of Training, 2013). These currently under development offer a blend of clinical experience in general practice for 4 to 6 sessions per week with the remainder of time spent in other clinical activities of relevance to general practice. However, the model also easily lends itself to post CCT educational models combining clinical work in a practice with delivery of UG education on a 'near-peer' basis such as is seen in the OOH Development Fellowship. They could also be developed rapidly, and may help to address the current workforce crisis in general practice in Scotland. Such a development also offers the opportunity for further collaborative working between NES, Health Boards and medical schools.

Looking forward, the contribution of **academic general practice** to the support and visibility of GP education and to providing role models for medical undergraduates is vital, as recognised in the RCGP Scotland 'Securing the Future' report, chaired by Sir Lewis Ritchie (RCGP Scotland 2009.) The short life working group on the Academic Training Pathway for General Practice in Scotland established under the chairmanship of Professor Frank Sullivan (Scottish School of Primary Care 2019) should provide much needed momentum for GP academic careers to counteract the current concerning decline in academic GP numbers in Scotland. It will provide an initial report to the Board for Academic Medicine in September 2019.

GP tutors are the core resource in all undergraduate GP education, yet it is clear that the role does not have the same profile and status as that of GP educational supervisor for postgraduate trainees. A Scottish Tutor of the Year award by Universities and/or RCGP Scotland may help to raise the profile. Support for postgraduate education certificates and diplomas could help to grow the educational workforce of the future. Forging links between undergraduate tutors and GP postgraduate educational supervisors could benefit both. A specific targeted recruitment drive for GP tutors, possibly organised collaboratively by all medical schools and relevant territorial health boards with RCGP Scotland support should be considered. Recent evidence from four medical schools in England (Barber et al 2019) suggested that a perceived lack of support from medical schools was a barrier to GP teaching. While Scottish medical schools engage effectively with GP tutors, some comments in the capacity survey suggest this is an area worth further examination.

Ensuring a variety of placements

By Choice not by Chance (HEE/MSC 2016) suggests that a *variety* of placements is important so that students are exposed to a wide range of general practices and understand the adaptive nature of generalist practice to local settings.

Out of Hours (OOH) services

GP OOH services across Scotland are generally not funded through NES ACT to provide undergraduate teaching but most provide postgraduate training for GP trainees. The most frequently seen age groups are the under 5s and the over 80s, which suggests that OOH services are a relatively untapped resource for good clinical GP experience and a great breadth of presentations. They potentially provide an excellent training environment for medical students seeing urgent primary care problems in a clinical setting led by GPs. The OOH setting requires staff to be confident working in isolation, deal with complexity and uncertainty and to be able to manage a wide variety of conditions. There is now a range of practitioners involved within Out of Hours services; this would allow students to experience how different practitioners work and how the team works together for the benefit of patients.

Current OOH staffing pressures are considerable and may limit expansion of teaching in the short term. However, due to the substantial clinical teaching potential and wide geographical spread, as staffing improves, OOH services should be included in plans for expansion of undergraduate education. OOH services could also contribute to some of the digitally supported tutorial methods as described in the report, e.g. supplying video consultations for the shared library that could be part of teaching in day time hours.

Remote and rural Scotland

Using Scotland's unique remote and rural geography and population for teaching is vital as they provide different clinical and organisational challenges to urban populations. Despite provision for transport and accommodation within NES GP ACT, some students and practices (see Biggar practice vignette and findings from capacity survey) report that these support arrangements do not work sufficiently well and that some practices have to subsidise accommodation costs and students' travel costs in some Health Boards. This situation represents a disincentive for both students and practices and limits practice engagement. As part of the development of general practice teaching, this issue should be addressed over the next 12 months through a collaborative approach between NES ACT, medical schools and relevant health boards.

There is also strong evidence (see, for example. Jones et al., 2014; WHO, 2010) that establishing a 'rural pipeline' which runs from encouraging rural school students into medicine, exposing undergraduates to rural general practice, and ensuring good quality rural postgraduate training and CPD will increase the supply of remote and rural GPs. As people in remote and rural Scotland suffer disproportionately from GP shortages at the moment, it is especially important that Universities and territorial Health Boards covering remote and rural parts of Scotland use these recommendations to increase remote and rural placements for students. An example of the breadth and depth of undergraduate teaching possible in remote areas is given below.

Welcoming Undergraduates to Benbecula Medical Practice: A Remote and Rural Experience

Our practice provides placements for undergraduate electives, with preference given to students who have a clear idea of what they want to learn while they are here. We pride ourselves on the support we give to students, who often say coming to us has been a high point in their undergraduate experience. All of our teaching is 1:1 and we try to give students as much patient contact as possible to help them develop their consulting skills. This is usually the highlight of their time with us.

We used to provide formal undergraduate placements for Dundee, but when the designated tutor retired, we were not able to sustain this. We still keep in touch with many of the students who came here; one has even come back to train us as part of a Scottish Core Obstetrics Teaching and Training in Emergencies Course (SCOTTIE) team.

As an example, our next undergraduate is coming for two weeks. She has already indicated that she is interested in palliative care, and wants to see how we can deliver this in a rural setting. Our practice covers the community hospital, which has a palliative care room, so she will spend some time there. We have organised a trip to Barra on the ferry with the MacMillan team, a VC with a hospice on another island, and a session with medical researcher with an interest in palliative care.

SCOTTIE: Scottish Obstetric teaching and training in emergencies course: https://www.scottishmaternity.org/scottie.htm

Areas of socio-economic deprivation

Scotland has also been a pioneer in exploring the needs of general practices and patients in the most deprived parts of Scotland – “GPs at the Deep End”. Placements in these practices offer undergraduates exposure to and an understanding of the importance of social determinants of health and adverse childhood experiences (ACE), as well as what is now called ‘deprivation medicine’. If we are to understand and address these challenges for the future, it is essential that many of our undergraduate students gain an understanding of the complex issues involved. In North Dublin, exposure to GP training specifically aims at training GPs with the capacity and desire to work in areas of social deprivation (Health Equity 2019). It is possible that undergraduate SSCs such as taught in Glasgow (see below) can have similar positive effects through role modelling and demonstration of authentic, quality general practice. Medical schools should aim to ensure that as GP placements increase, there is at least a proportionate increase in placements in areas of deprivation.

Special Study Component (SSC) in social determinants of health at the University of Glasgow

The SSC in Social determinants of health and health inequalities has been offered to Year 2 medical students at the University of Glasgow since 2014. The aim of the SSC is to develop understanding of the concepts of health inequalities and the social determinants of health within Scotland and their impact on health and health care provision.

Students spend time in a range of health and community settings, meeting patients, service users, volunteers and professionals. Placements include: Addictions team, Personality Disorder Team, Deep End GPs and Freedom from Torture. This is complemented by weekly academic learning on a range of health inequalities topics, including: adverse childhood experiences (ACEs), multiple exclusion homelessness, the inverse care law, LGBTQ+ health inequalities, and the social model of disability. There is an ongoing evaluation of the SSC aiming to assess if students have gained the intended learning as set out in the SSC ILOs and if so how this is achieved.

Student feedback on a community placement:
"When I become a doctor, I don't want prescriptions and medications to be the only solution I provide to my patients. [This placement] has really inspired me to want to use social prescribing in my own practice and provide my patients with sources of support from the community to improve their health and wellbeing." (Student from 2019 class)

Recommendations

Recommendations one to six, on physical space, digital access and educational tariffs follow directly from the findings of the capacity survey and collated evidence in this report.

Recommendations seven and eight cover growing the necessary GP educator workforce.

Recommendations nine and ten address monitoring and evaluation of the changes as they are implemented.

It was the view of the group that to achieve a well-managed increase in undergraduate education in primary care, these recommendations required to be implemented as a package rather than singly, recognising that timescales for implementation will be much longer for some than for others. Failure to address each of the areas covered by the recommendations is likely to prove a rate limiting step for many of the others.

Physical space for teaching

As shown by the general practice capacity survey and through discussions with stakeholders, it is clear that physical space is currently a major factor in limiting expansion of undergraduate education. This is likely to become more acute given existing Scottish Government commitments to increase the GP and wider MDT workforce.

Recommendation 1 (Scottish Government and Health Boards)

Capital investment in primary care by Health Boards must include provision of fit for purpose space that can be used for educating the primary care workforce of the future.

Recommendation 2 (Scottish Government)

The new NHS Scotland Capital Investment Strategy is due to be published shortly. It is recommended that this should make the case for investment in primary and community care facilities recognising specifically the need to include facilities to train the workforce of the future.

Digital infrastructure

Access to high quality broadband throughout the NHS in Scotland, and easy access to educational e-portfolios and educational material in all primary care premises are absolutely essential to maintaining and developing high quality undergraduate education in primary care and for assessment of students by Faculty.

It is significant that in its National Training Survey for postgraduate trainees in 2019, the GMC specifically asks about access to Wi-Fi on the basis that poor Wi-Fi *'can really affect the ability of trainees to learn and trainers to teach.'* This is also true for undergraduates.

Recommendation 3 (Scottish Government)

The SWAN programme should develop direct ties and representation with the R100 delivery team in Scottish Government both better to understand the timeframes for the remaining very hard to reach locations and to influence decisions on how the R100 priorities are decided about which locations should be prioritised i.e. those where GP surgeries are without connectivity and could therefore have access accelerated.

Recommendation 4 (Universities and Health Boards)

Universities currently have information on problems with broadband and Wi-Fi access for their students. To provide a national picture, Universities and Health Boards should survey digital access for undergraduate teaching practices and premises across Scotland and plan to address access difficulties where this is possible, over the next 12 months.

Funding for undergraduate medical education

The level of ACT funding was repeatedly identified as being too low currently. It was clear that many practices consider that they are effectively subsidising undergraduate education. Falling numbers of practices engaging in undergraduate education supports that view. Tariffs at their current levels are leading to a substantial reduction in availability of GPs for teaching and hence a negative feedback loop resulting in fewer GPs in future. The extensive work of the NES Primary ACT group and the NES validation of the HEE work on actual costs of teaching has suggested that the tariff for a student in practice in years three to six (category A) should be £85 per session. However, GPs are also required for category B educational activity (lectures, campus based teaching and assessment, admissions procedures etc.). It will be important that any increase does not destabilise a system which currently has limited capacity, but instead contributes to increasing capacity across the system. A variety of different tariffs and rates are used across medical schools for category B activities. While flexibility will be needed to address differing conditions across Scotland, there is a need to reduce the complexity that arises from this.

As discussed in chapter three, there would be merit in considering whether the current ACT model across both primary care and secondary care requires a more fundamental review. It could be further argued that such a review should not be limited to ACT but rather consider the overall approach to the funding of undergraduate medical education. Consideration should be given to alternative models of distributing monies to support undergraduate clinical teaching, particularly against a background of innovative models of delivering undergraduate education, different career pathways in general practice and constrained public finances.

Recommendation 5 (Universities/ NES ACT)

The tariff for clinical teaching in primary care (category A) should rise from £40 per student per session to £85. A ceiling value of £255 for three or more students should apply. Current falls in practice teaching capacity across Scotland suggest that this should be implemented as quickly as possible.

Recommendation 6 (Universities/ NES ACT)

Further work needs to be done by NES together with relevant stakeholders to streamline the current range of category B tariffs in Primary Care ACT. This should produce a simplified range of tariffs applicable to all medical schools within 12 months.

Developing the GP educator workforce

Increasing undergraduate education in primary care over the next few years will challenge current capacity, not just for teaching but for educational management and administrative support for delivery. The GP Heads of Teaching group has, during the period of the working group and in this report, demonstrated the value of sharing ideas around innovation in undergraduate education but has no formal recognition. There are also variations across medical schools in roles and status of GP educators.

Recommendation 7 (Universities/ BfAM/ Universities Scotland/ Scottish Funding Council)

As part of progressing UG education in primary care, each medical school should develop over the next 12 months the outline implementation plans that they have submitted (chapter 5) for increasing teaching in primary care, as well as a strategy to develop and grow the GP educator workforce to increase teaching capacity. This should ensure that GP educators have a strong and effective voice within school decision making structures

Recommendation 8 (Universities/ BfAM/ Universities Scotland/ Scottish Funding Council)

A national level group for GP Heads of Teaching or equivalent in Scotland reporting to the Scottish Deans Medical Education Group should be formally established. The aims of this should be to strengthen educational leadership, build on the implementation plans referred to in recommendation 7, and share innovations to increase capacity and further curricular development.

Monitoring and evaluation

Monitoring and evaluation of the wider reform of primary care, of which this work is part, is vital to understand progress being made and to indicate where additional action may be required. The Scottish Government has recently published a 10-year National Monitoring and Evaluation Strategy for Primary Care in Scotland (Scottish Government, 2019).

Significant work has already been done by members of the group on proposed measurement of progress on increasing undergraduate education in primary care. This is complex, as there are six different curricula and no existing standard method for measuring and recording GP involvement, some of which is informal and not easily quantifiable. Further work is needed to agree a standard data set for use by all medical schools. This should be mapped onto *'By Choice not by chance'*. The current GP HoTs Measures and Indicators paper is included as Appendix E.

Recommendation 9 (Universities/ Health Boards/ BfAM/ Universities Scotland/ SFC)

Monitoring of these recommendations, supported by the GP Heads of Teaching group, should be undertaken with reports six monthly to the Scottish Deans' Medical Educator Group for review by the Board for Academic Medicine and Scottish Government. There should be an independent review of progress after 12 months.

Recommendation 10 (Universities/ Scottish Government)

The investment involved in increasing undergraduate education in primary care requires rigorous evaluation from the outset. This should include (i) the indexing of all medical students at Scottish Universities at matriculation with a view to linking this data with existing data available through UKMed (ii) further educational research into attitudes of students and graduates in relation to careers in GP, all with a view better to understand the career choices of graduates. A programme of funded educational research will be required.

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Appendix A

Increasing Undergraduate Education in Primary Care Group: Terms of Reference

This Working Group has been set up jointly by the Scottish Government and Board for Academic Medicine (BfAM).

Remit

The purpose of this Group is to consider ways of increasing undergraduate education in primary care settings. There are three aspects to this:

CONTEXT AND BACKGROUND; WHERE WE ARE.

- Putting Undergraduate education in primary care in the context of other initiatives designed to address GP shortages as outlined in the National Workforce Plan for Primary Care;
- Carrying out a literature review;
- Determining the current level of undergraduate teaching in primary care in Scottish Medical Schools;
- Establishing the number of GPs who currently teach, their capacity to increase teaching time and mechanisms to support them do so;
- Identifying GPs who don't teach (including GPSTs) who would like to do so and mechanisms to support them do so.
- Understanding the infrastructure, physical and digital, needed to support an increase in undergraduate teaching;

HOW DO WE INCREASE EDUCATIONAL DELIVERY?

- Investigating factors that have a positive influence, including innovative practice within Scotland and elsewhere;
- Investigating barriers to change;
- With support from NES scope/model the extent to which existing ACT resource could be used to support this agenda;
- With support from NES scope/model/quantify the extent to which new ACT resource is required to support this agenda;
- Model the various impacts on service of (i) GPs spending more time teaching, (ii) some ACT resource being reconfigured from hospitals to community settings
-

OUTPUT

By Spring 2019, develop recommendations to increase education in primary care.

Governance

The Group will provide quarterly updates and a final report to the Board for Academic Medicine and the Scottish Government.

Membership

The Group will be chaired by Professor John Gillies, supported by the Scottish Government's Health Workforce Division and Primary Care Division. From time to time, the Group will also invite participation from other individuals to support the delivery activities. Full membership of the Group is as follows:

Organisation	**Representative**
Chair	John Gillies
Scottish Government Health Workforce	Stella Smith / Emma Watson
Scottish Government Primary Care	Naureen Ahmad / Lara Cook
Scottish Government Clinical Leadership Fellow	Rob O'Donnell / Kirsten Woolley
Scottish Government Health and Social Care Analysis	Iain MacAllister
University Medical Schools (GP Leads)	Maggie Bartlett, Chair of Community Based Medical Education (University of Dundee) Jon Dowell, Director of ScotGEM, (University of Dundee) Karen Fairhurst (University of Edinburgh) Ken Lawton, Head of GP and Community Teaching (University of Aberdeen) Lindsey Pope, Director of Community based Medical Education (University of Glasgow) Rebecca Walmsley (University of St Andrews)
RCGP (Scotland)	Alastair Forbes
NHS Boards	Dr Kerri Neylon, Medical Director, NHS Lanarkshire

	Lindsay Donaldson, Director of Medical Education, NHS Greater Glasgow & Clyde
Scottish General Practitioners' Committee (SGPC)	Andrew Buist/ Drummond Begg
NES	Geraldine Brennan Moya Kelly Amjad Khan Alastair McLellan
Scottish Deans' Medical Education Group (SDMEG)	Rona Patey
Scottish Funding Council	Helen Raftopoulos
Student Representation	Lekaa Rambabu + members of undergraduate GP societies
Secretariat	Gillian McCallum / Rachael Fairbairn

The Group will meet approximately once every 6 weeks in Edinburgh. Venue tba.

NES Medical ACT and Primary Care Review Group

The Working Group will be supported by the work of the NES Medical ACT and Primary Care Review Group which is working in parallel, reviewing approaches to measuring and resourcing undergraduate teaching in primary care through Medical ACT.

Appendix B

From medical student to GP: primary care leading in medical education delivery workshop notes

Summary

In this workshop, experts and stakeholders were tasked with generating solutions to questions relating to primary care, generalism and undergraduate medical education. Briefly, these were: How can more undergraduate teaching be moved to primary care and how can more general practices be involved in undergraduate education? How can primary care assist in the teaching of generalism and how can healthcare professionals be trained in less siloed ways, with more organisational partnerships?

These notes summarise discussions relating to these questions. Though the discussions were separated by individual questions, the suggestions given were, in many cases, overlapping so have been grouped here by theme.

These themes are as follows, with a brief summary of points in each:

Changing teaching in primary care: A number of examples given of innovative teaching methods; some suggestions for new models of teaching; suggestions that trainee and/ or junior GPs should be more involved in teaching; some cautions about various elements of teaching in primary care; and a discussion about the dynamic between teaching quality and quantity.

Primary and Secondary Care Interface: Suggestions to alter the relationship between primary and secondary care included primary care clinicians practicing and teaching in secondary care (and vice versa); in order to facilitate more teaching, various ways of altering GP practice structure were suggested; there was also some discussion about the advantages of teaching for GP practices.

Alterations to curriculum or placement structure: A common comment was on the importance of GPs being involved in university teaching; there were concerns about possible contradictions in teaching and alignment with the GMC MLA; several calls for increased undergraduate placements in primary care; suggestion that all FY2 doctors should spend time in primary care and that GPST training should be increased to 4 years and involve teaching.

Changing perceptions of general practice: A number of examples of “selling points” of GP were generated, though there was also discussion of negative perceptions of GP; it was suggested that the media and student societies could play a part in improving perceptions.

Contractual changes: Calls for altered or increased ACT payments; arguments that changes to GP contract should make teaching part of the core business of GP.

Theme detail

Changing teaching in primary care

Several examples were given of innovative primary care teaching methods. These included:

- A model in Calgary where one GP was allocated solely to teaching, with 4 undergraduate students in each session and involved additional appointments.
- Another featuring simultaneous student teaching, this time 3 students in separate consultations, monitored by video link
- Teaching taking place in out of hours services. Albany Medical School runs an out of hours clinic which is staffed by medical students
- GP Live, a system where consultations are broadcast in to lectures, was mentioned several times as a system useful for the junior curriculum as it provides insight to a large number of students with minimal extension to consulting times.
- Aberdeen “cell” model, where 6 students have a tutorial once a week, which encourages peer learning
- A consulting lab ‘mastery’ system of joint learning
- Anchoring learning in a patient case, for example as in longitudinal integrated clerkship learning or “following a patient”.

There were also suggestions for new models of teaching, including some teaching roles being taken on by other professionals in primary care, or whole practice based learning. There was a general suggestion to challenge the 1 to 1 learning model to increase capacity and that an educational model could be a lever for change in primary care (but that this would require additional ACT funding).

A recurrent line of comments were about trainee or junior GPs becoming more involved in teaching, both in clinical practice and in universities. Rationale for this were suggestions that this would aid teaching capacity, but also that trainees may be “better” role models and have more up to date knowledge. One GP tutor mentioned that opportunities to teach in universities were not offered to GPs until at partner level. Difficulties for universities to access non-teaching GPs to offer teaching opportunities were discussed, with the idea of a one point of advert suggested as a possible solution, and also that universities should attend GP options events to discuss teaching. Another suggestion was the development of some sort of GP training fellowship, where a GP with a special interest in teaching could have a role where part of their time was spent teaching in university and some of their time spent as a practice mentor.

There were warnings about the finding the right time in students’ training to introduce different types of learning, concerns about the effectiveness of observation as a teaching method, concerns about needing to unify teaching approaches for consistency and differences in language used between professions as well the necessity for “backfill” of GP time to cover additional appointments and administrative tasks and other resource issues including practice space and funding for travel.

A medical student suggested that quality should be prioritised over quantity, or depth, with a move to fewer sessions in GP placements, for example by having Mondays and Fridays off. At another table there was discussion, foregrounded by acknowledgement that placements in primary care are already highly evaluated by students, about increasing teaching in GP potentially lowering average quality of teaching and whether lowering in quality would be acceptable.

GP practice capacity and the relationship between Primary and Secondary Care

Several changes to the relationship between community and hospital settings with regards to teaching and patient care were suggested. These included hospital generalists coming out in to primary care, perhaps though joint clinics; the possibility of primary and secondary care sharing outpatient appointments; the need for acute clinicians to understand general practice better in order for there to be a shift of undergraduate teaching to primary care; that GPs should teach on wards (possibly trainee GPs may have more flexibility to do this); altering the balance between primary care and secondary care in terms of budget for education; that there could be links made to other community facing specialities and that GPs can complement secondary care teaching around topics like hypertension, perspectives about which in secondary care may be limited.

There were a number of suggestions as to ways in which GP practice structure could be altered to facilitate more teaching in primary care. One of these were that practice cluster delivery systems could be developed and another was about how to develop an engagement strategy for non-teaching practices, possibly using a buddy scheme and how a personal connection when making university- practice links is helpful in ensuring practices know what teaching involves. There was opinion that practices should be encouraged to make space available for students to consult on their own but concerns about space required for this. A suggestion to address the space issue was to use empty rooms if GP staff not there at that time and others were about utilising community hospital facilities, for example using rooms when staff were out and using meeting rooms to take patient histories (with an acknowledgement that there may be a cost involved in using these spaces).

Advantages to practices of teaching were also discussed: There was an argument that teaching is seen as a discrete activity and somewhat of a badge of honour and also a presentation of anecdotal evidence that GPs are more likely to want to work in teaching practices as there is an indication that this is better for their career development and progression.

Alterations to curriculum or placement structure

There were general comments about the importance of GPs delivering lectures and being involved in central teaching and teaching of clinical skills, in part to act as role models but also to highlight the GP as a scholar, with broad knowledge. One GP tutor argued that “primary care issues” or “fluffy stuff” should be removed from the GP curriculum, which should instead be about managing complexity/ the day job of GPs. There was also an argument that the medical curriculum should move away from a reductionist model to teach Realistic Medicine. There were some warnings or provisos related to the curriculum. These included a concern students need to get

appropriate exposure to general practice (but there was no expansion as to what this would entail), a warning that there were explicit contradictions in teaching that need to be removed and that exams must be set by a diverse group, including GPs. One person was concerned that the GMC's MLA was becoming increasingly reductionist and that a generalist curricular may be at odds with it and another spoke about GPs being reticent to teach as it may not be aligned to the exams faced by students but that this is a shame as GPs have important, realistic perceptions managing asthma, CVD and diabetes. There was a suggestion that attempts should be made to influence the curriculum at year three as this is when undergraduate students are making choices.

Another general line of comment was that there should be an increase in undergraduate placements in primary care and/ or that placements should be longer and immersive so as to develop a sense of ownership ("my practice"). With regards to generalism, there was an argument that case based learning encouraged generalism, ahead of specialisation, and that exposure to patients' stories of multimorbidity at undergraduate level is key to developing generalist skills. One person commented that understanding multimorbidity and not viewing disease in silos is at the core of generalism, while others warned that there is not a universal, shared understanding of generalism and that medical schools should lead on defining it.

Some argued that all FY2s should spend time in primary care and accident and emergency so they can learn about unscheduled care and related decision making. Another that developing medical training within speciality training should include mentorship skills and there was also a suggestion that GP training should be extended to 4 years and that the extra year could be spent teaching.

Changing perceptions of general practice

There were several comments about how GP is perceived, what needs to be done, some suggestions of how to do that and some comments on the selling points of GP which should communicated to improve perceptions.

There was some discussion on GP being seen as a back-up or ineffective and that clinicians in the acute sector were disparaging about primary care. There was a suggestion that the media should be used to combat negativity about GP and that medical school societies can be used to increase interest. Some called for general practice to develop a sense of uniqueness and that GP needs a strong set of principles and identity to raise its status. It was reported that Denis Pereira Gray has written about the unique aspects of general practice, including skills, theory and principles.

Of the comments that appeared to be various "selling points" of GP, these seem to be largely about the advantages to students. They included:

- That in GP, students see a wide range of things including paediatrics, cardiology and dermatology
- That GP encourages self-directed learning
- That students have a safe space to make mistakes
- That there is power in a 1:1 relationship

- Students can see a “bigger picture” by working with families
- That community centric education is patients centric and therefore promotes generalism
- That in general practice there is an opportunity for independence, too see the patient by themselves and that students’ knowledge can be applied to real world settings
- That general practice teaches about complexity, uncertainty and risk

There was some discussion about GP academia and academic careers with some pushing for the option of portfolio careers to be promoted and others concerned about the separation of teaching and research in medical schools, particularly in light of REF funding.

Contractual changes

The idea that teaching should be part of the core business of general practice was expressed by several people, with some offering that this should be an integral part of new GP contracts and primary care improvement plans. There were calls for clarity over funding for teaching (with some simply saying more funding was required, particularly to pay for “backfill”) and several comments about the need for changes to ACT funding. In discussion about multidisciplinary learning, some were concerned about contractual issues and funding silos acting a barrier. One person suggested that perhaps 10 minute appointment times in GP were simply not long enough. In terms of solutions to issues of capacity, it was suggested that sometimes institutes have underspends even when there is no operational money; that there may be untapped capacity at individual level as well as at practice level, that some GPs working LTFT may want to teach, rather than have more sessions in GP and that possibly NES could play a part in out of programme experiences.

Appendix C

Medical ACT Primary Care Re view: Draft Recommendations

NES' Medical ACT Governance Group triggered a review of the costs of delivering undergraduate medical teaching in primary care with the aim of describing the following areas:

1. An understanding of the provision of undergraduate medical teaching in GP-Primary Care for each of Scotland's medical programmes, including ScotGEM, to create a baseline snapshot of what is being provided currently.
2. An understanding of the costs associated with delivering undergraduate medical teaching in GP-Primary Care for each programme, including ScotGEM.
3. An analysis of whether the existing approach to measurement and reimbursement from Medical ACT funding of the costs of undergraduate teaching in secondary care using the Measurement of Teaching (MoT) Tool could be adapted to support, prospectively, the measurement and reimbursement of the costs of undergraduate teaching in GP - Primary Care.

The NES review describes the current vital and varied contributions of GPs and the wider Primary Care team to undergraduate medical curriculum delivery for all Scotland's Undergraduate Medical Programmes**.** The group has had input from a number of stakeholders including representatives from all Scottish Medical Programmes and from Prof John Gillies, Chair of the Scottish Government/ Board for Academic Medicine Primary Care Review Group. Outputs from all NES review meetings have been shared with the SG/BfAM group as will the final report on completion of the NES review.

The following draft recommendations have been made based on discussions at the final NES Medical ACT Primary Care Review meeting in February 2019 and following feedback from the SG/BfAM Increasing Undergraduate Education in Primary Care Group.

Measurement of Teaching Activity and Accountability Reporting

- It is clear there is considerable heterogeneity around the detail within the annual accountability reports for undergraduate teaching delivered in primary care that is supported through Medical ACT funding.
- Consistency of information provided from all Boards, including clear headings for all categories relevant to primary and secondary care is required.
- For GP-Primary Care costs, information should provide explicit detail of all GP-related teaching activities including placements, lectures/tutorials, support costs and information on costs associated with student travel and subsistence for all programmes.
- The contribution made by GPs and Primary Care teams to the delivery of SSCs, electives, and other non-core activities for some programmes is not ACT funded and therefore not currently captured within the MoT exercise or annual Medical ACT Accountability process.

- It is apparent that some educational activities within the GP-Primary Care curriculum are being provided *pro bono*. It would be important to understand how changes to student numbers and percentage of curriculum devoted to Primary Care teaching influence that amount
- The current funding models and accountability processes do not reflect the heterogeneity around which healthcare professionals contribute to the delivery of medical education and training in GP-Primary care. In reality, this is likely to be difficult to quantify on an ongoing basis.

Recommendation 1
Revision of the processes of accounting for ACT funding received and reporting of activities funded by ACT must be implemented to ensure a consistent and comprehensive understanding of the contributions to undergraduate medical education and training by GPs and other healthcare professionals in Primary Care, across all undergraduate Medical Programmes.

Recommendation 2
All Medical Programmes should have an understanding of the costs associated with Primary Care teaching, including any elements that are not funded via Medical ACT and those which are currently being provided *pro bono*.

Recommendation 3
The current ACT allocation model is based on use of retrospective data. While the merits or otherwise of this approach were not considered by this review, there is some appetite for exploring whether there may be benefit in moving to a prospective model in the future. The recommendation is therefore to engage with all relevant stakeholders to consider jointly the risks and benefits of adopting a prospective versus retrospective allocation model.

Quality Assurance of UG Teaching in Primary Care
- The approach to quality assurance of UG GP teaching is also heterogeneous across the programmes
- All programmes invite student feedback at least annually and are involved in an annual national Undergraduate Quality Review Panel which includes representation from the NES Quality team.

Recommendation 4
If the amount of undergraduate medical education and teaching increases as seems likely, resulting in an increase to the associated costs – the activities provided must continue to be subject to quality management by the Medical Schools responsible for the curricula. This process should adhere to common principles and have a consistent approach.

Revision of the tariff for GP remuneration (Category A teaching)
- the current rate of remuneration of £40 per placement session for medical undergraduate teaching in GP-Primary Care has been in operation since 2010 and has not altered with inflation over that time
- The group recognizes why the payment rate needs to be increased and the potentially deleterious effects that have occurred already and are likely to persist

if action is not taken. However, any upward revision of the tariff needs to take into account the knock-on effects for funding to Health Boards for undergraduate teaching in secondary care, within the overall Medical ACT funding arrangement.

Recommendation 5

This will be made to Scottish Government based on modelling an uplift to the tariff for clinical placement (Category A) teaching and the amount of GP/Primary Care teaching delivered in line with SG/SFC advice.

If the Medical ACT budget remains the same and the current provision of undergraduate medical education and training in GP and primary care remains the same – we will model the impact of changing the tariff for remuneration, on the distribution of the medical ACT budget across primary and secondary care.

Thereafter if required, we will also assess the impact of any increase to the proportion of undergraduate medical curricula devoted to GP and primary care teaching as advised by SG and SFC – by modelling the impact of that change on the distribution of the Medical ACT budget across primary and secondary care.

Revision of the tariff for GP remuneration (Category B teaching)

Category B teaching refers to formal teaching or other teaching-related activity which occurs outwith clinical placements. This can be delivered on campus and within other settings including in a General Practice setting, by staff employed by a variety of contracts. The review identified significant variation between the type of activity and rates of remuneration provided by each of the medical programmes. As such it was not possible to make meaningful comparisons between programmes or to make recommendations for any changes to the current rate of Category B payments. Further work will be required to investigate the feasibility of doing so.

Recommendation 6

Following feedback received from stakeholders as part of the Scottish Government/Board for Academic Medicine (SG/BfAM) Primary Care review process, the NES Medical ACT team will lead further work on the feasibility of revising Category B payments in collaboration with relevant stakeholders. The remit will be to attempt to streamline the existing diverse range of Category B tariffs in Primary Care ACT, with an aim of agreeing a simplified range of tariffs that are applicable to all medical programmes.

Appendix D

Revised Tariff Implications

Amount of Primary Care Teaching Unchanged

2017/18 GP costs data derived from MoT/actual costs submitted to NES

Total ACT Budget: £77,161,744

(£75 536 744 baseline + £1,625,000 uplift due to "widening access payment" made 2018/19 – see below):

TOTAL ACT BUDGET			
Secondary Care		GP-Primary Care	
Costs	£68,309,094	GP Placement costs (Cat A)	£2,244,044
Travel & Subsistence	£442,113	GP Teaching costs (Cat B + prep)	£2,135,574
		GP Support costs	£2,380,539
		GP Travel & Subsistence	£340,686
Total	**£68,751,207**	**£7,100,843**	

Note: The overall total for the two columns is £75,852,050. This may be due to some health boards being unable to use the widening access payment they received at end of 2017/18 financial year. In this context, "widening access payment" refers to 10 contextualised admissions for 5 undergraduate medical programmes per annum currently supported by Scottish Government.

Scenario A - Tariff Increased/ Curriculum unchanged

New Primary Care Amounts	
GP Placement costs (Cat A)	(£2,244,044 x 85/40) = £4,768,593.50
GP Teaching costs (Cat B + prep)	Unchanged = £2,135,574
GP Support costs	Unchanged = £2,380,539
GP Travel & Subsistence	Unchanged = £340,686
Total	£9,625,392.50

Total cost of increasing tariff from £40 to £85 (curriculum unchanged) = £2.5 million

Appendix E

Measuring GP teaching

Scottish GP Heads of Teaching

Nov 2018

Background

Drivers

- Recruitment to GP
- *By Choice - Not by Chance*[1]
- Scottish Government aim to increase GP based teaching to 25% of the undergraduate curriculum

Issues

- 6 different curricula some with additional GP enhanced programmes
- No existing standard method for measuring and recording of GP involvement
- Not all GP involvement is easily quantifiable (goodwill, part of infrastructure rather than 'itemisable' tasks)
- Multiple requests for data

Risks

- Counting what can be counted rather than what accurately reflects the value and extent of GP involvement
- Multiple data sets from different perspectives lead to lack of credibility and utility of data overall

Proposal

- To agree a standard data set for use by all 5 Medical Schools as baseline and to measure progress
- Use of a dataset mapped to *By Choice-Not by Chance*[1]

GP Heads of Teaching – Proposed measurements

These are based on areas proposed in the literature with each measure (in bold) proposed linking to relevant recommendations underneath from '*By Choice – Not by Chance*[1]

- **Actual GP placement time - both absolute (number of sessions/days) and as a proportion of all clinical placement time**

- Recommendation 8: An increase in UG GP placements must address improved quality, content, timing and variety. This should include exposure to a variety of practices.
- Recommendation 9: Positive and enthusiastic role models should be identified and made visible across all medical schools.
- Recommendation 15: Existing GPs should champion the vision of the profession as an exciting intellectually challenging and rewarding career.

- **Curriculum time specifically badged as GP led/managed/designed – both absolute and as a proportion of the whole curriculum**

- Recommendation 6: Students should recognise the breadth and complexity of general practice care and be stimulated by the complex intellectual challenge.
- Recommendation 15: Existing GPs should champion the vision of the profession as an exciting intellectually challenging and rewarding career.

- **Joint primary /secondary care teaching**

- Recommendation 5: All medical schools must revise their undergraduate curricula to ensure they develop to reflect the patient journey through different healthcare settings and offer a more integrated less specialty organised approach.
- Recommendation 6: The formal curriculum must better inform students on NHS management and delivery at the primary-secondary care interface.

- **GP based SSC/elective availability and uptake**

- Recommendation 8: An increase in UG GP placements must address improved quality, content, timing and variety. This should include exposure to a variety of practices.
- Recommendation 9: Positive and enthusiastic role models should be identified and made visible across all medical schools.

- **Admissions interviewers who are GPs – both proportion of slots and proportion of overall interviewers**

- Recommendation 4: All medical schools must ensure that GPs contribute significantly in all selection processes.

- **GP based vacation scholarship availability and uptake**

- Recommendation 8: An increase in UG GP placements must address improved quality, content, timing and variety. This should include exposure to a variety of practices.
- Recommendation 9: Positive and enthusiastic role models should be identified and made visible across all medical schools.

- **Evidence of involvement of GPSTs in teaching and assessment**

- Recommendation 9: Positive and enthusiastic role models should be identified and made visible across all medical schools. This includes enhancing and supporting the role of GPSTs as educators and assessors and interaction in primary care between medical students and near peers.

- **GP contribution to careers events – both as absolute and proportion of overall medical school delivered careers sessions**

- Recommendation 6: The business elements of, and career option within, GP (e.g. partnership v salaried v locum roles) need to be clear to students.
- Recommendation 14: The range of opportunities within GP should be actively promoted within medical schools and students should be offered a far better understanding of what being a GP can offer.
- Recommendation 15: Promotion of GP careers should be carefully considered to ensure students have the ability and flexibility to make informed career decisions without feeling pressurised by market forces.

- **Evidence in curriculum of efforts to tackle undermining of general practice (e.g. teaching about hidden curriculum, improved feedback mechanisms to enable students to report any serious undermining on placement.)**

- Recommendation 11: Work should take place to tackle undermining of GP as a career across all medical school settings including primary care.)

Reference

[1] Health Education England/ Medical Schools Council. By Choice - Not By Chance. 2016.

Acknowledgements

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Scottish Rural Medicine Collaborative

https://www.srmc.scot.nhs.uk

Rural GPs Association of Scotland

https://ruralgp.scot

The Scottish Deep End Project

https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

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