

NHS workforce planning – part 2

The clinical workforce in general practice



AUDITOR GENERAL 

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Audit team

The core audit team consisted of: Mark Ferris, Dharshi Santhakumaran, Nichola Williams and Erin McGinley, with support from other colleagues and under the direction of Claire Sweeney.

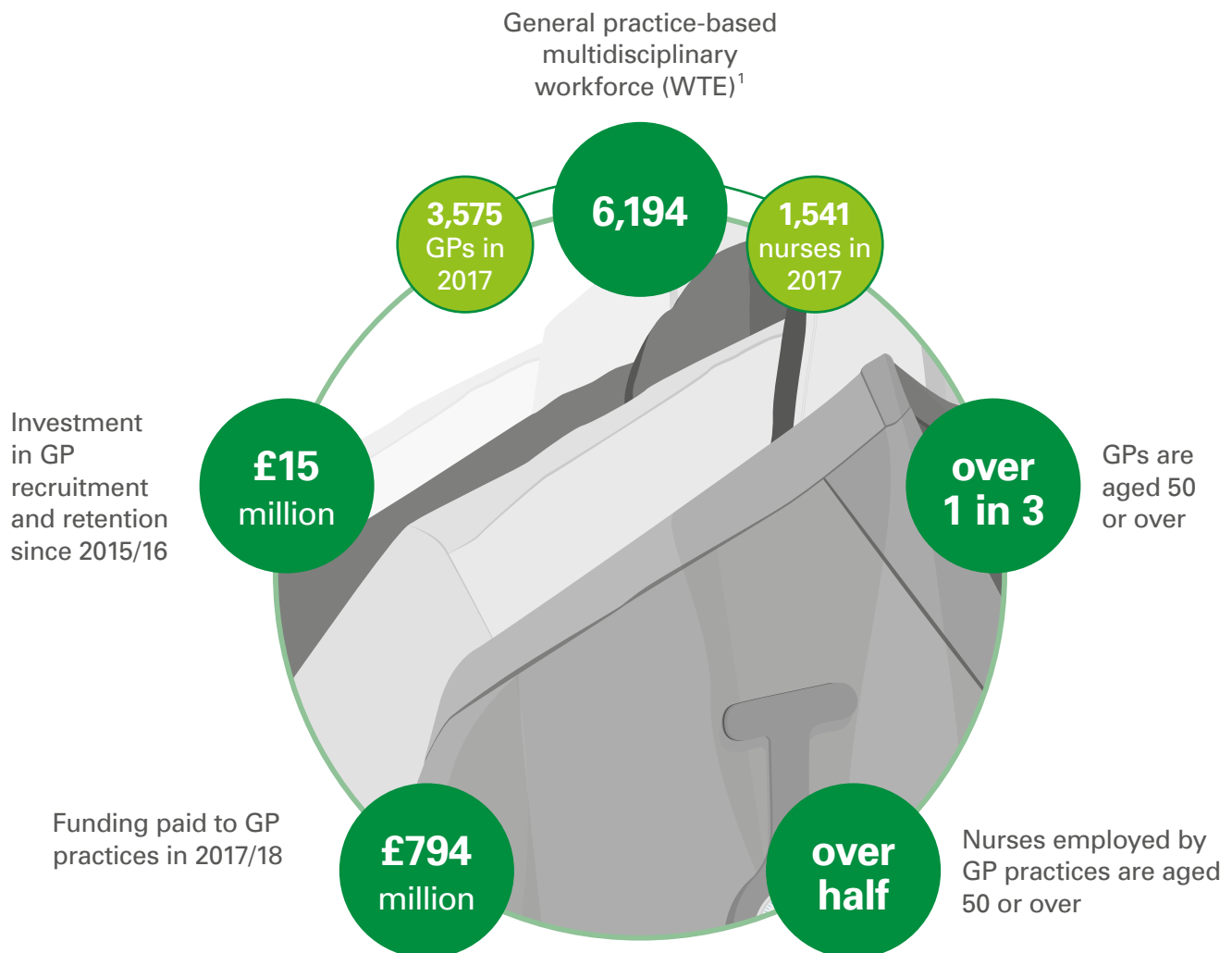
Links

-  PDF download
-  Web link
-  Interactive Tableau exhibit, where further information can be viewed online

Exhibit data

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

Key facts



Notes:

1. Based on survey data.

Summary



Key messages

- 1** Expanding the primary care workforce is central to the government's 2020 vision of delivering more care at home and in the community. Primary care services face growing demand from an ageing population and an increase in the number of people with multiple chronic conditions. There are also pressures on workforce supply, including an ageing workforce and problems with recruitment and retention. The Scottish Government acknowledges these workforce pressures but has not estimated the impact they will have on primary care services.
 - 2** The Scottish Government is working to improve primary care workforce data, but progress has been slow. There is a lack of national data on the current numbers in the workforce, workforce costs, activity and demand. This makes it difficult to plan the workforce effectively or to monitor the impact of major policy changes, such as the new General Medical Services contract.
 - 3** The Scottish Government's commitments to train additional GPs, paramedics, nurses and midwives are on track, but it is not clear how this increase in training will translate into numbers employed in the primary care workforce. The Scottish Government has implemented a range of initiatives to improve recruitment and retention of GPs but these have had limited success to date. UK-wide pressures on the workforce and increasing demand mean the government will find it challenging to meet its GP target of an 800 (headcount) increase over ten years. Meanwhile, similar workforce pressures will make it difficult for integration authorities to increase the multidisciplinary workforce by 2021/22.
 - 4** People are generally positive about their experiences of primary care and would be happy to receive care from professionals other than doctors in a GP practice if they understood more about their roles. However, not enough has been done to engage with the public on a national level about these changes and why they are important.
 - 5** Progress on national workforce planning has been slow, and there has been a series of delays to planned outputs by the Scottish Government. Responsibility for planning the primary care workforce is split across different policy areas, risking duplication of work. This complexity could further slow progress because of a lack of clarity about who is responsible for making decisions.
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Recommendations

The Scottish Government should:

- undertake scenario planning to identify the potential impact of workforce pressures on all staff groups and set out how it plans to address these. This should make use of the NHS Education for Scotland (NES) data platform and include analysis of vacancy rates and the demographics of the workforce
 - work with NHS boards and integration authorities to model how training and recruitment numbers across all healthcare staff groups will meet estimated future demand for primary care
 - provide a clear breakdown of the costs of meeting projected demand through additional training and recruitment across all healthcare staff groups
 - implement plans to collect data from GP practices on workforce numbers, activity, income and expenses. Whole time equivalent (WTE) as well as headcount data should be collected on workforce numbers. This data should be used to:
 - better understand the current workforce
 - underpin workforce planning
 - monitor progress against commitments
 - collect data on the impact of workforce pressures on staff in primary care and set out how any issues will be addressed. This should include:
 - workload
 - sickness absence levels
 - staff morale
 - intention to leave the workforce
 - work with primary care professionals to develop a coordinated national approach to engaging with the public about the changes to how primary care services are delivered
 - monitor the impact of the GMS contract, including:
 - progress towards achieving the aim of changing the role of the GP and reducing GP workload
 - impact on rural and deprived areas
 - impact on staffing of out-of-hours services
 - impact on staff
 - impact on patients, including quality and continuity of care
 - monitor progress towards meeting workforce commitments, including identifying the barriers to meeting the commitments and putting plans in place to meet demand if they are not achieved
 - implement plans to simplify the workforce planning governance structure and clearly identify roles and responsibilities both nationally and locally.
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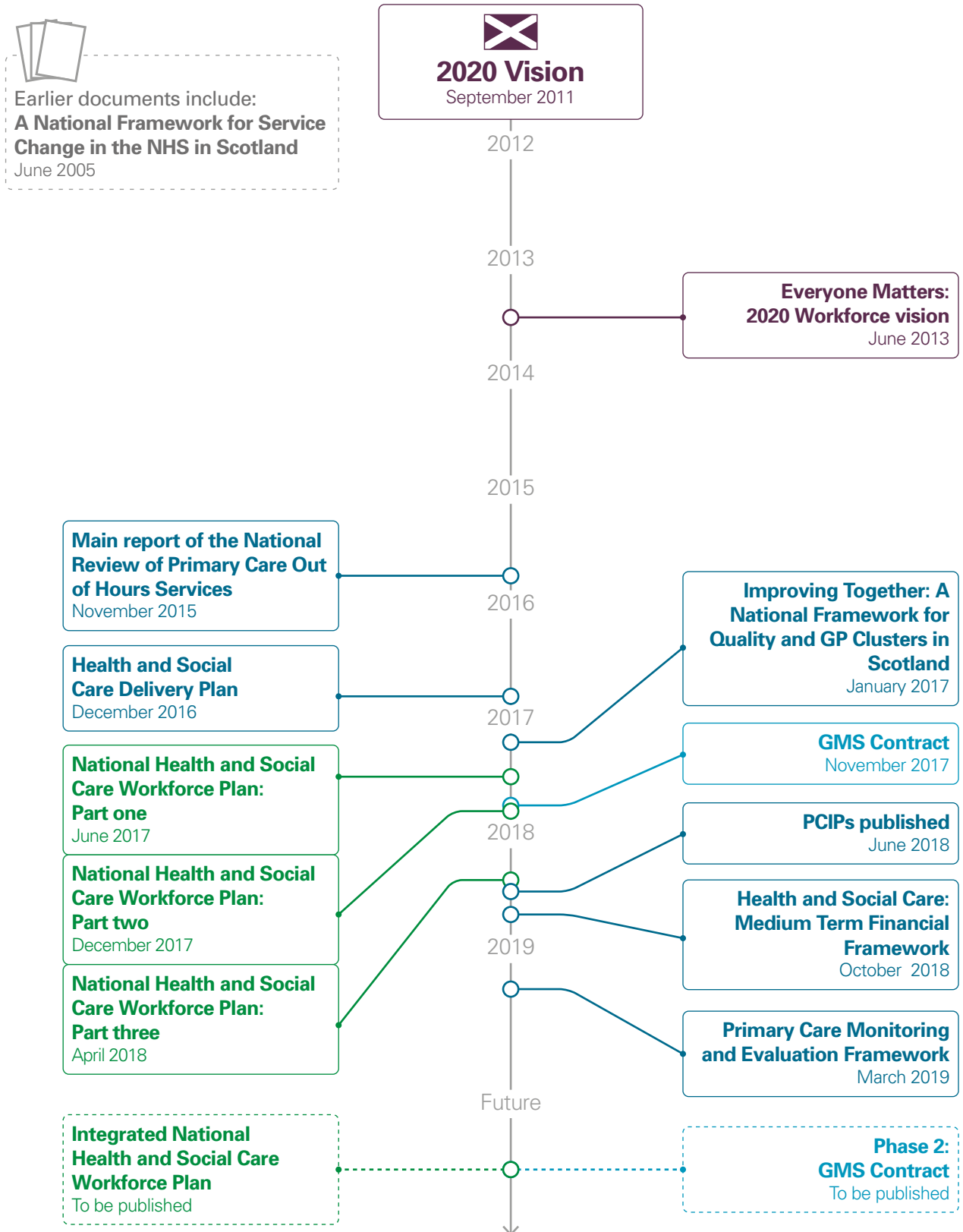
Background

- 1.** The Scottish Government's long-term vision for health and social care is to shift the balance of care so that there is a greater focus on keeping people well in their own homes and the community. This vision is set out in a range of policy documents and plans, going back to 2005, and is central to the government's 2020 Vision, published in 2011 ([Exhibit 1, page 8](#)). Primary care plays a major role in achieving this vision, as primary care professionals can identify issues early and support people to manage their own health as far as possible.
- 2.** The Scottish Government intends to support the shift in the balance of care by increasing funding for primary care. In *Health and Social Care: medium term financial framework*, it committed to increasing primary care funding by £500 million over five years, so that, by 2021, 11 per cent of the frontline NHS Scotland budget should be spent on primary care.¹ The financial framework did not set out how the Scottish Government defines primary care spending, or what proportion of this increase will be spent on the workforce.
- 3.** As well as increasing funding for primary care, the Scottish Government also aims to change the way primary care services are delivered. It plans to expand the primary care workforce, so that care will be provided by a range of professionals working together in multidisciplinary teams (MDTs). The Scottish Government wants people to receive care from the most appropriate member of the MDT. The size and make-up of these MDTs will vary according to local need, but MDTs may include nurses, advanced nurse practitioners (ANPs), physiotherapists, pharmacists and paramedics. MDTs may also include non-clinical staff, such as community link workers, who can support patients to access wider services.
- 4.** MDTs may be based in individual GP practices or work across a cluster of practices. These teams are the focus of this audit, but they do not work in isolation. To carry out their role, they need to work closely with other primary care professionals, for example, district nurses and the wider community nursing team, and colleagues working in hospitals and in social care. Any changes to the way that professionals work in the MDT has an impact on those working in the rest of the system. The Primary Care Clinical Professions Group have set out a joint statement on their vision for the future of primary care, and how the different professions will work together, based on 21 principles.²
- 5.** Reform of primary care is complex and challenging. It is not solely the responsibility of the Scottish Government; NHS boards and integration authorities (IAs), which are partnerships between NHS boards and councils, have a crucial role. The voluntary sector also has a role to play, particularly in the development of the community link worker workforce. Locally, IAs are responsible for planning and resourcing primary care services. As the multidisciplinary workforce grows, the aim is that members of MDTs will be employed by NHS boards rather than GP practices. In the longer term, NHS boards will also take on more responsibility for owning practice premises.

Exhibit 1


Policy timeline

The Scottish Government's vision to shift the balance of care has been in place since 2011.



Note: PCIPs – primary care improvement plans, produced by integration authorities.

Source: Audit Scotland

6. These changes to primary care will require effective national and local workforce planning to make sure the right workforce is in place to meet the needs of Scotland's population. In our 2013 report, [Scotland's public sector workforce](#) , we define workforce planning as 'the process that organisations use to make sure they have the right people with the right skills in the right place at the right time'. For primary care, this means that the Scottish Government, NHS boards and IAs have to understand the needs of the population, both now and in the future, and plan the workforce to meet demand. We have previously highlighted the risk that the NHS workforce is being planned in response to budget pressures rather than strategic needs.³

7. Primary care is usually a person's first point of contact with the NHS. It is provided in the community by generalist health professionals, and includes general practice, community pharmacy, dentistry and optometry services. It covers both physical and mental health, and all age groups and health conditions.

8. Most GPs are self-employed. GP partners are GPs who own and run practices, usually in partnership. Historically, they have been responsible for employing their own staff, including other salaried GPs. Practices are contracted by NHS boards to provide primary care services.

9. Data on the size and make-up of the primary care workforce is limited ([paragraphs 57–58](#)), so workforce estimates are based on available survey data ([Exhibit 2, page 10](#)).

10. In April 2018, the new General Medical Services (GMS) contract came into effect. This contract aims to:

- refocus the role of GPs as expert medical generalists
- reduce GP workload and allow them to concentrate on patients with more complex care needs
- provide better care and improved access for patients
- improve infrastructure and reduce risk.


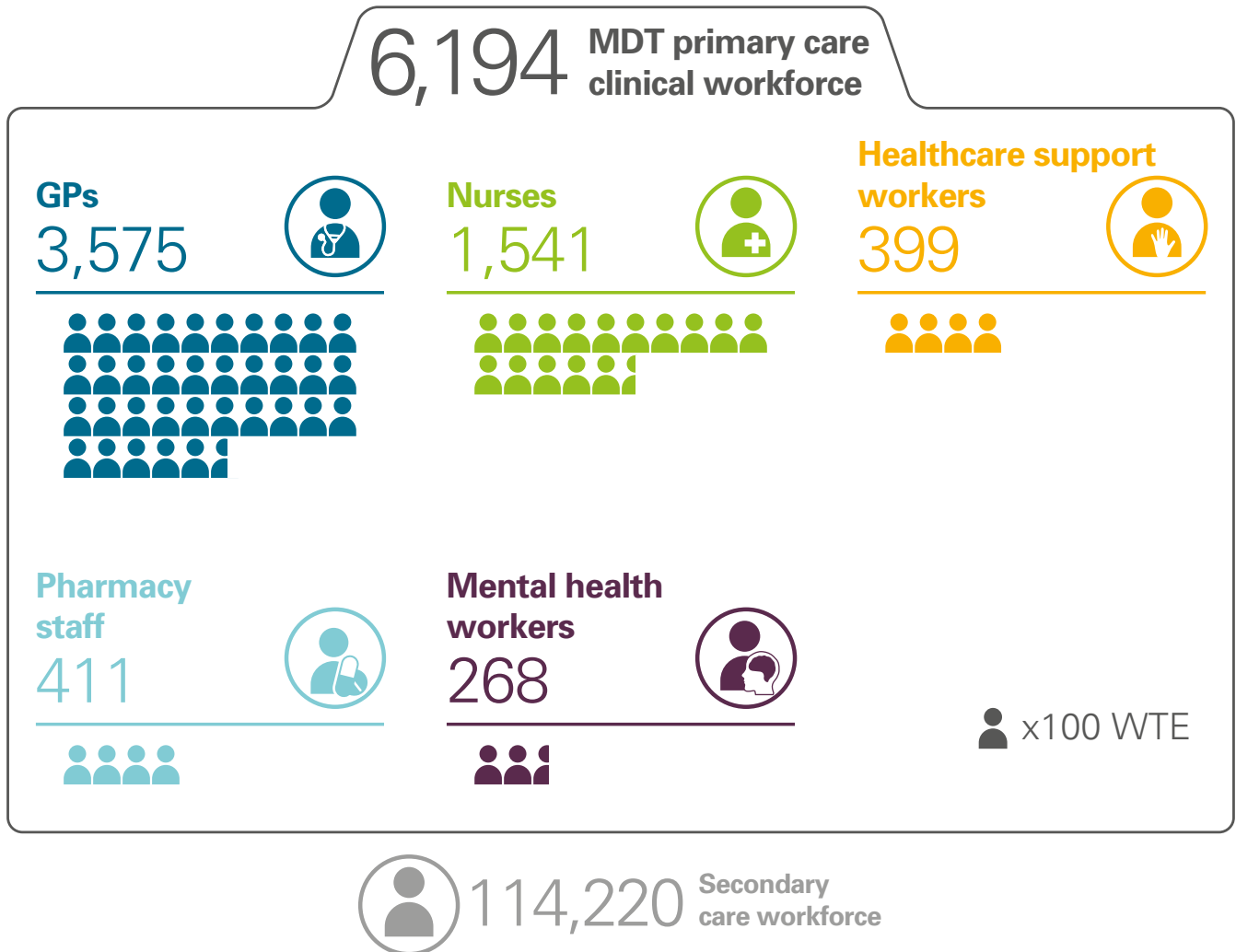
11. The contract is accompanied by a memorandum of understanding (MOU), which sets out the role of the GP as the senior clinical decision-maker at the head of the MDT. The increased role of other professional groups in the practice is intended to free up GP time and make it easier for patients to access the most appropriate care. The MOU also sets out priorities for reform to support the implementation of Phase 1 of the contract, from 1 April 2018 to 31 March 2021. As part of the contract, all IAs were required to work with NHS boards and GPs to develop primary care improvement plans (PCIPs). These plans should explain how the priorities set out in the MOU will be implemented locally. More information on the background and aims of the GMS contract is provided in our [General Medical Services contract in Scotland: a short guide](#) .⁴

Exhibit 2

The multidisciplinary primary care workforce in Scotland

A number of professional groups make up the MDTs based in GP practices.



Notes:

1. Figures given are whole time equivalent.
2. The figures for GPs, nurses and healthcare support workers are estimates made as part of the 2017 National Primary Care Workforce Survey carried out by ISD Scotland. These figures will only include staff members employed by the GP practice. Allied health professional data is not available.
3. The secondary care WTE figure excludes administrative staff and may include some staff employed by the NHS board but working in a GP practice, as it is not possible to separately identify these staff members.

Sources: Secondary care, ISD Scotland workforce trend data for March 2017 (2017 data used to be consistent with the latest primary care workforce survey); Pharmacy staff data provided by the Scottish Government, as at March 2019; Mental health workers, Mental health worker quarterly performance report, as at July 2019 (2019 data used for pharmacists and mental health workers, as 2017 data not available); Other staff groups, ISD Scotland National Primary Care Workforce Survey 2017.

About this audit

12. In July 2017, the Auditor General published the first in a series of audit reports on NHS workforce planning.⁵ That report focused on clinical staff in a hospital setting and concluded that:

- the Scottish Government and NHS boards had not planned effectively for the long term
- responsibility for NHS workforce planning was confused
- there was a risk of further fragmentation as health and social care planning and planning for specialist medical centres developed.

It found that NHS staff were raising concerns about workload, and that NHS services were under increasing pressure. The Scottish Government expects demand for health and social care to increase but is yet to provide a clear analysis of the skills and workforce numbers needed to meet this demand. A summary of progress against the recommendations made in the first report is set out in [Appendix 1 \(page 33\)](#).

13. The aim of this audit was to establish how effectively the Scottish Government is planning and developing the primary care clinical workforce to meet the needs of the Scottish population. We set out to answer four key questions:

- How effectively is national workforce planning for the primary care clinical workforce addressing current pressures on staff and patient care?
- How well are national primary care clinical workforce planning arrangements considering the future needs of the Scottish population?
- What are the anticipated workforce costs to meet demand for primary care services and how effectively are these being planned for?
- What impact will the new GMS contract have on the Scottish Government's ability to deliver its vision of primary care?

14. This audit looked mainly at the national approach to workforce planning and how well it supports planning at regional and local levels. It focused on the general practice-based workforce of GPs and the wider clinical MDT, including nurses, allied health professionals (AHPs), pharmacists and others, as they are central to the implementation of the new GMS contract. AHP is a term which covers a range of healthcare professionals including paramedics, physiotherapists, occupational therapists and podiatrists. For the purposes of this report, when we refer to the primary care workforce, we mean the general practice-based clinical workforce. Although the dentistry, optometry, community nursing and care home workforce fell outwith the scope of this audit, they are an important part of the overall primary care workforce, and many of the issues highlighted in this report are also relevant to planning for the wider workforce.

15. This report is in two parts:

- [Part 1](#) examines current pressures on the primary care workforce.
- [Part 2](#) focuses on planning the future workforce to meet the needs of the Scottish population.

Part 1

The primary care landscape



There are significant pressures facing the primary care workforce

Demographic issues put increasing pressure on primary care services

16. Scotland's population is ageing. People aged over 75 are projected to be the fastest-growing age group in Scotland, expected to grow by 27 per cent between 2016 and 2026. The average number of patients registered at a GP practice is increasing. Between 2013 and 2018, the average practice list size across Scotland increased by eight per cent, from 5,602 to 6,073 patients.⁶ Scotland's ageing population means that more people will be living longer with multiple long-term conditions, putting increasing pressure on the NHS.⁷ This places pressure on general practice as GPs manage growing numbers of patients with multiple and complex health needs.

17. There are significant health inequalities across Scotland. People living in the most deprived areas have a lower life expectancy than those living in more affluent areas. They are also likely to spend more years living with ill health. From 2015 to 2017, the difference in healthy life expectancy between the ten per cent most deprived and ten per cent least deprived areas was 22.5 years for males and 23 years for females.⁸ Primary care services in deprived areas face particular issues in meeting the complex needs of their patients, who are more likely to have multiple chronic conditions linked with poverty.

Recruitment and retention issues create pressures on the workforce

18. Recruitment and retention difficulties are one of the key issues facing the primary care workforce ([Exhibit 3, page 13](#)). Although there has been a slight increase in the overall headcount of GPs, the number of GPs who are partners has decreased, from 3,721 in 2013 to 3,396 in 2018. The number of practices being taken over by NHS boards has been rising.⁹ This means that the practice is run by the NHS board instead of by GP partners as independent contractors, often because of difficulties recruiting new partners or retaining existing ones. The Royal College of General Practitioners (RCGP) Scotland recently reported that 26 per cent of GPs think they are unlikely to be working in general practice in five years' time.¹⁰

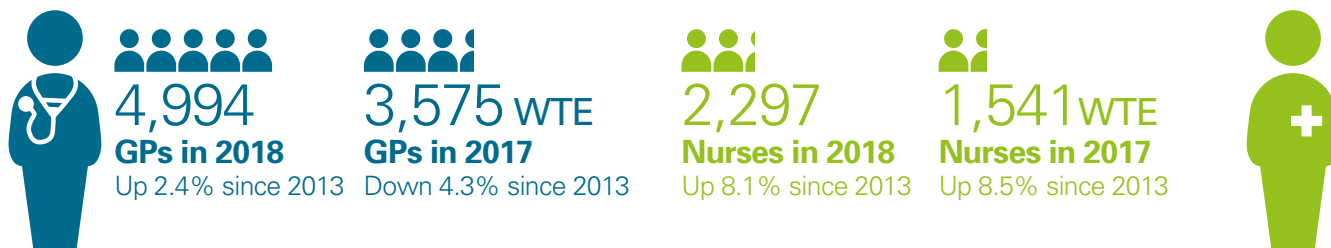
19. Until 2017, the main source of data on staff and vacancies in GP practices was a primary care workforce survey, run by ISD Scotland, on behalf of the Scottish Government. This was completed by GP practices and run every two years. The survey was voluntary and had a response rate of 82 per cent in 2017, up from 58 per cent in the previous survey, run in 2015. Fifty-nine per cent of GP vacancies that occurred in 2017 were filled, but 27 per cent of those took more than six months to fill. Commonly reported challenges in filling GP vacancies in 2017 included a shortage of applicants and the fact that the practice was in a rural area. The most commonly reported reasons for difficulty in filling nursing positions were a lack of candidates and the quality of the candidates applying.

Exhibit 3

Pressures on the primary care workforce

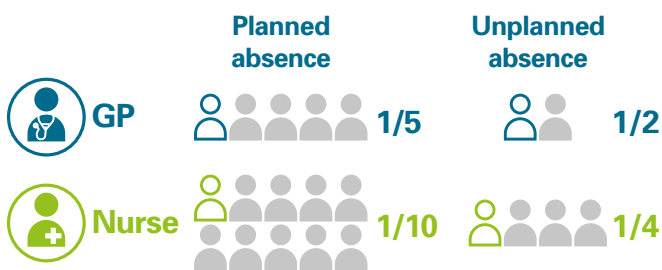
The available data shows workforce numbers increasing, but there is wide variation in vacancy rates across the country.

Workforce in post



Absences

Practices that said they often could not fill absences, 2017



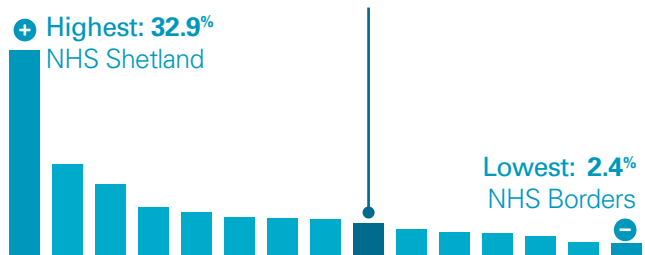
Age of workforce

(50 years or over in 2017)



Vacancies

5.6% vacancy rate for GPs across Scotland



2.4% vacancy rate for nurses in GP practices across Scotland



1 in 4 practices reported a GP vacancy in 2017



Notes:

- The GP total includes 564 third-year trainees in 2018 and 490 third-year trainees in 2013. The figure for nurses includes only those employed by a GP practice, and not those employed by an NHS board.
- WTE – Whole-time equivalent.
- Trend data not used for vacancies and age of workforce, as these figures are based on a survey with large differences in response rates between years.
- This level of detail is only available for GPs and nurses.

Source: Audit Scotland using ISD Scotland data



20. Out-of-hours services are a fundamental part of the health system, providing primary care services outwith GP practice opening times. Pressures on the primary care workforce are also reflected in the delivery of out-of-hours services. NHS boards completed the part of the primary care workforce survey that asked about out-of-hours care. Boards reported that 90 per cent of out-of-hours shifts were filled but noted the amount of effort this took. The most commonly reported actions taken to fill shifts were the use of financial incentives such as increased rates and staff working longer shifts. Other issues reported included:

- instances of both nurses covering GPs' shifts and GPs covering nurses' shifts
- out-of-hours services being delivered through NHS 24 and a hospital ward because of difficulties in filling shifts
- a reduction in the number of locations where out-of-hours services were provided.¹¹

The primary care workforce is changing

21. The primary care workforce survey data is used to estimate the whole-time equivalent (WTE) GP workforce across the country. The data shows a fall in the WTE GP workforce from 3,645 in 2015 to 3,575 in 2017. This suggests that, although the overall number of GPs may be increasing, more are choosing not to work full-time. A GP session is about five hours, and one WTE represents eight sessions a week. The demographics and changing working patterns of the primary care workforce pose a challenge to future supply:

- A higher proportion of GPs aged between 50 and 59 are working eight or more sessions a week.
- Those aged 25-49 years are more likely to be working four to seven sessions a week.
- Partners are often working more sessions a week than salaried GPs.

The increase in the proportion of GPs who are salaried rather than partners, and the pattern of younger GPs increasingly working part-time, is likely to mean that for every GP that retires more than one will need to be trained and recruited to replace them.

22. Recent changes to pension and tax arrangements may have an impact on GP recruitment and retention. The British Medical Association (BMA) has raised concerns that limits on annual and lifetime allowances, which govern how much GPs can contribute to their pension funds before incurring a tax charge, will lead to GPs retiring early or reducing their workloads. The BMA has also expressed concerns about the impact of UK Government changes to increase employer pension contributions by six percentage points, from 14.9 per cent to 20.9 per cent, from April 2019. The UK Government has committed to provide funding to cover some of the cost of increased pension contributions to the NHS. In June 2019, the Scottish Government confirmed that it would provide additional funding to cover the remaining £48.4 million for 2019/20.

23. The Scottish Government has identified EU withdrawal as having a major impact on the health and social care workforce, but it has not set out potential scenarios or how it plans to respond. Although data on the nationality of doctors

is available only for those who took up a licence to practice in the UK from June 2017, the General Medical Council (GMC) holds data on country of qualification for all doctors. This data shows that, in 2018, 3.7 per cent of Scottish GPs had graduated in a European Economic Area (EEA) member country. Remote and rural areas of Scotland, including Argyll and Bute, Orkney, Shetland and the Western Isles are more reliant than other areas on non-UK-licensed doctors.¹² The GMC has looked at the relationship between where medical students qualified and their nationality. It concluded that using place of qualification as a proxy for nationality is likely to result in an underestimate of the number of doctors who were EU nationals working in the UK.¹³

24. As at March 2018, five per cent of nurses and midwives in the UK had first registered in the EEA. Between 2016/17 and 2017/18, there was a drop of 87 per cent in the number of EEA-qualified nurses and midwives joining the UK register, and an increase of 29 per cent in those leaving it.¹⁴ This suggests that EU withdrawal will exacerbate existing workforce pressures.

The Scottish Government does not collect enough information on the impact that primary care workforce pressures are having on staff

25. There is a lack of data on the impact of workload pressures on staff in primary care. The Scottish Government's national staff survey is completed only by staff employed by NHS boards, and not those employed by GP practices, or most GPs themselves.

26. The GMC runs an annual survey of trainees and their trainers, including those in general practice, which includes questions about workloads.¹⁵ Those delivering training were more likely to report a heavy or very heavy workload than those training in other specialties, 78 per cent compared with an average of 59 per cent across all other specialties. They were also more likely to work beyond normal working hours, with 59 per cent doing so daily. Among doctors in GP training posts, although overall satisfaction was high, responses to questions on workload indicate this is an area of concern. Thirty-five per cent rated their workload during the day as heavy or very heavy, and 46 per cent were working beyond scheduled hours at least weekly.

27. A recent RCGP survey of Scottish GPs found that 37 per cent feel so overwhelmed by their daily tasks that they cannot cope at least once a week. Workload pressures may have an impact on patient experience as well as staff morale; 35 per cent said that their stress levels have an impact on their ability to make decisions.¹⁶

28. Without national data on, for example, staff morale or sickness absence levels for all staff groups, the Scottish Government cannot identify and monitor the impact that workload pressures may be having on the primary care workforce. When making major changes to the workforce, the Scottish Government needs to understand the challenges facing the workforce and monitor the impact of policy changes on the people delivering those changes.

Patients are generally happy with the quality of care from their GP practice

29. The Scottish Government carries out a health and care experience survey every two years. This asks the public about their experience of health and care services; it covers GP practices and out-of-hours care. The latest survey, in 2017/18, reported a mixed picture regarding patient experience. There is a national target that 90 per cent of people should be able to access a GP, or an

appropriate healthcare professional, within 48 hours if they need to. The survey found that this target was met, with 93 per cent of people able to see a GP within two days. All NHS boards, and all except two IAs, met this target. North Lanarkshire and Aberdeenshire each missed it by one percentage point.

30. Although the responses to some questions in the survey indicated a decline in patient satisfaction, satisfaction remains high overall ([Exhibit 4, page 17](#)). Eighty-three per cent of people rated the overall care provided by their GP practice as good or excellent in 2017/18, a slight fall from 87 per cent in 2011/12.

31. When asked about recent experiences with a health professional at their GP practice, 93 per cent of people were positive about feeling listened to and 95 per cent understood the information they had been given. However, there was a lower percentage of positive responses when people were asked if they felt their treatment had been well coordinated (78 per cent) and if they knew the health professional well (50 per cent).

More engagement with the public is needed on changes to primary care

32. The Scottish Government's vision for primary care represents a significant change to how services will be delivered. It intends to expand GP-led MDTs to enable people to receive care from the most appropriate member of the MDT ([Case study 1, page 18](#)). The various professional groups believe a national campaign is needed to ensure that members of the public understand why they may be asked more questions than before when they want to make an appointment, and why they will not necessarily see a GP. We have previously reported on the need for greater public engagement by the Scottish Government, NHS boards and IAs to build support for change by increasing understanding.¹⁷ Following discussions between the primary care professions and the Cabinet Secretary for Health and Sport, the Scottish Government is currently developing its approach to public engagement on this issue.

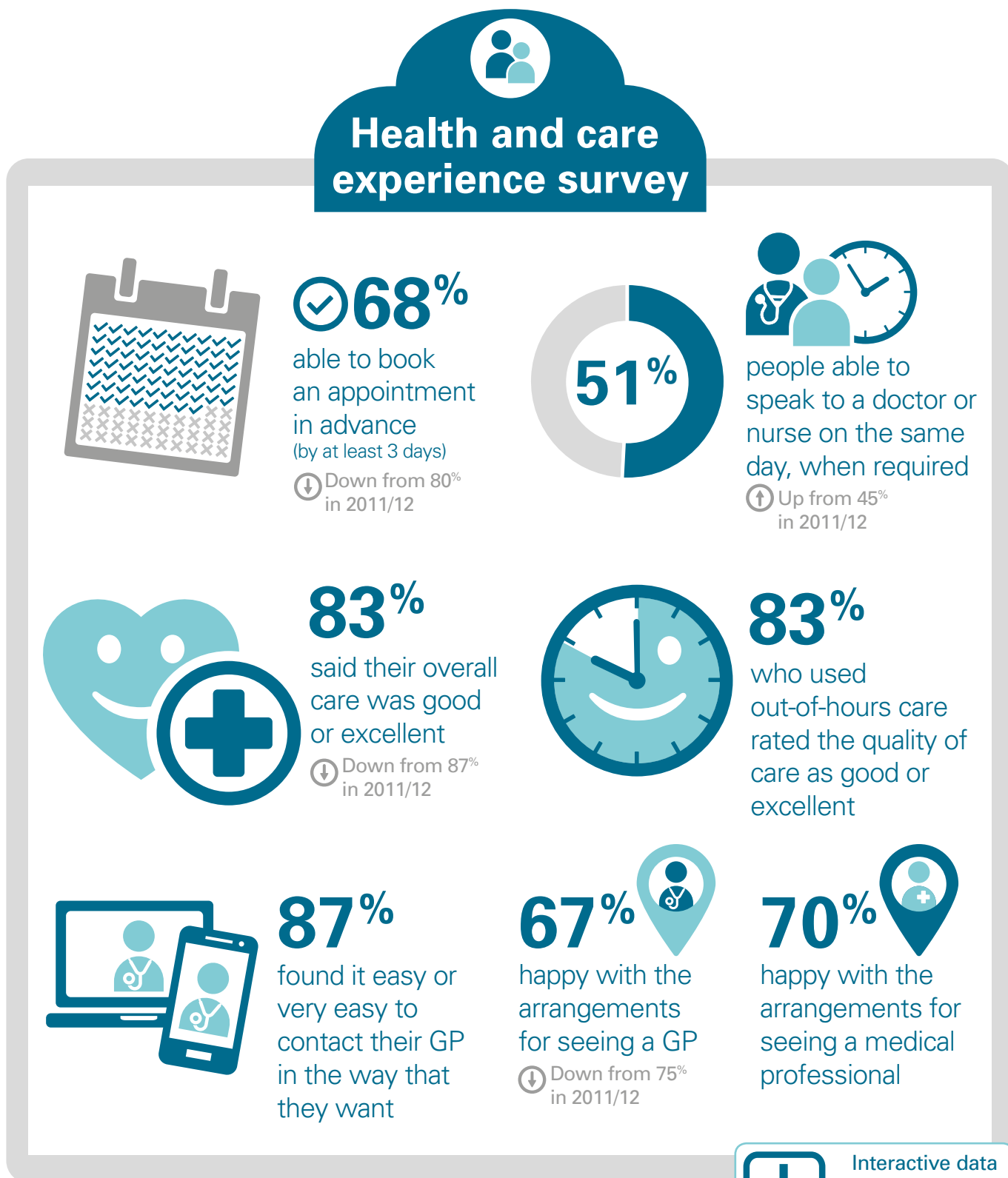
33. Some public engagement has suggested that people may be happy to see other staff members within a GP practice when they understand more about the roles of these staff members and are confident in the quality of care. A survey was carried out by Our Voice Citizens' Panel to ask people about primary healthcare and their views on seeing non-GP medical professionals.¹⁸ Seventy-eight per cent of respondents said that they would consider going directly to non-GP healthcare professionals if they were happy with the treatment that they had received from them previously. Three-quarters would be more likely to accept an appointment with a health or social care professional who was not a GP if they understood more about their role.¹⁹

34. The Scottish Government commissioned a study on pharmacists working in GP practices, carried out through surveys and interviews with patients and the other members of the MDTs in the practices. Both the patients and the teams had positive feedback about the quality of the care, and the knowledge and ability of the pharmacists. Eighty-four per cent of patients surveyed said that they were confident that the pharmacist would prescribe as safely as a GP and 83 per cent said that they were more interested in the quality of the care they received than in who delivered it. However, 43 per cent still said that, given the choice, they would prefer to see a GP rather than a pharmacist.²⁰

Exhibit 4

Health and care experience survey

The results of the survey show that patients are mostly satisfied with their care, although in some areas there has been a drop in satisfaction.



Note: Trend data not available for all questions.

Source: Audit Scotland using the Scottish Government's health and care experience survey



Case study 1



Musculoskeletal (MSK) physiotherapists

MSK conditions are estimated to account for about one in five GP appointments, and are the second biggest cause of sickness absence in the UK. MSK advanced practitioner physiotherapists as a first point of contact in primary care MDTs have the potential to:

- improve access for patients
- support greater self-management
- reduce GP workload
- reduce referrals to orthopaedic specialists.

Several areas around Scotland have introduced MSK physiotherapist pilots to show the impact that this can have on general practice. For example:



NHS Forth Valley recruited 2.4 WTE MSK advanced practitioner physiotherapists to work across two GP practices.

Over the first two years, 8,417 patients accessed the service, with 60 per cent of people able to self-manage following the appointment. Orthopaedic referrals decreased across both practices by approximately 212 referrals a year.



Inverclyde appointed an MSK advanced practitioner physiotherapist (0.88 WTE) to work across three GP practices.

The pilot concluded in June 2017. During the pilot, the physiotherapist saw 55 per cent of MSK consultations across the three practices and 56 per cent of referrals were made directly by receptionists to the physiotherapist. It was reported that the proportion of consultations where people needed to be prescribed medication decreased from 80 per cent to 20 per cent for patients presenting with an MSK problem. The evaluation highlighted the need for better routine data collection to enable monitoring of the impact on GP time and on referrals to secondary care services.

Source: Audit Scotland using *Evaluation of New Models of Primary Care: Inverclyde Case Study*, Scottish School of Primary Care, January 2018 and information provided by NHS Forth Valley

The new GMS contract will affect the primary care workforce

The new GMS contract is accompanied by a new funding formula that may affect rural areas

35. The new contract is accompanied by a new funding formula for GP practices. The aim of the new formula is to better reflect the workload of GPs. The practices that stand to lose funding because of this new formula have received a guarantee from the Scottish Government that their funding will be protected. Some rural GPs

have expressed concerns that the formula will have a disproportionate impact on rural GP practices, as under the new workload calculation they are less likely to receive an increase in funding than urban practices.

36. Under the previous formula, rural practices received more funding per patient than practices in urban areas, an average of £264.1 per patient in the most rural areas in 2017/18, compared with £101.2 per patient in the most urban areas.²¹ Although funding has been protected so that no practice will see its funding drop, difficulties in recruiting and retaining staff may increase when these practices have to compete for staff with practices with increased funding. This could also have an impact on the morale of staff. These concerns have been raised in response to a petition to the Scottish Parliament on medical care in rural areas.²²

37. The Rural GP Association of Scotland carried out a survey with a small sample of 66 rural GPs on the new contract, in March 2018. Sixty-eight per cent felt less confident that the changes would benefit rural practices and about 70 per cent felt less confident about the sustainability of their practice. Concerns were specifically expressed about the funding formula, recruitment and retention issues, and out-of-hours service delivery.

The Scottish Government should do more to measure the impact of the GMS contract on patients and staff

38. The Scottish Government carried out an equality impact assessment on the GMS contract, in which it considered the impact that the contract could have on specific groups, including certain age groups, different genders and those from deprived areas and rural areas.²³ The GP contract impact assessment split this into:

- the impact on GPs
- the impact on the rest of the primary care team
- the impact on patients.

39. The impact assessment does not fully consider the concerns expressed about some aspects of the new contract. For example, the assessment concludes that there will be a positive impact on rural practices because protected funding mitigates the potential negative impact of the funding formula. As the impact assessment does not fully acknowledge potential risks it does not set out how any negative impact could be monitored, or concerns addressed.

40. The Scottish Government published a primary care monitoring and evaluation strategy in March 2019.²⁴ This includes indicators on the size of the workforce and involves the use of the health and care experience survey to measure patients' views. There are no measures that would allow the Scottish Government to monitor the direct impact of the GMS contract, including the intended effects on the role of the GP, recruitment and retention, and any impact on staff or patient care. The Scottish Government is due to publish an evaluation work plan to provide more detail on how it will monitor the priority areas set out in the strategy. Health Scotland is also due to produce a report on primary care in Scotland later in 2019, which is planned to include data across a wider range of indicators.

Part 2

Planning the future workforce

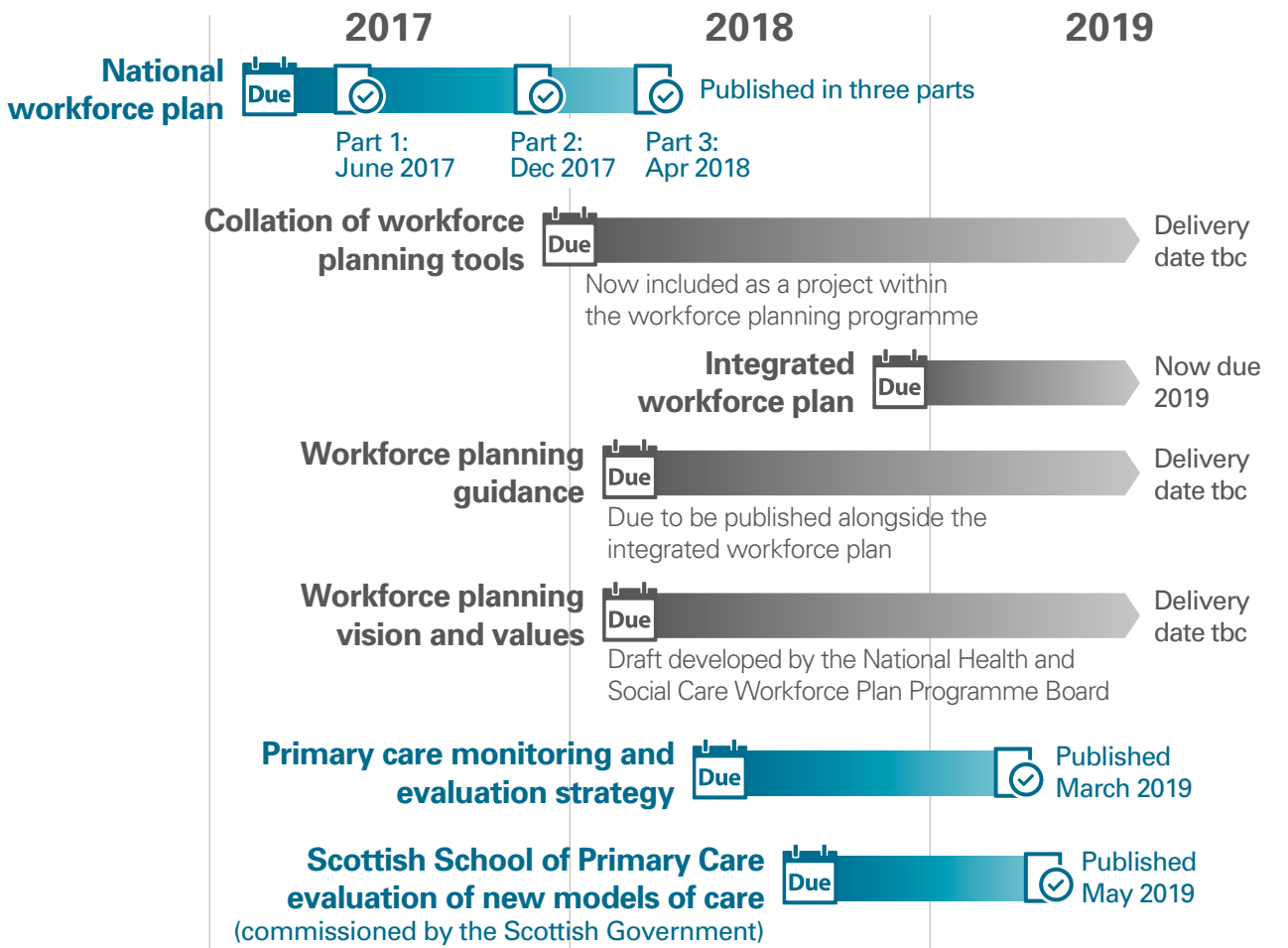


The Scottish Government is developing its approach to workforce planning but progress has been slow


41. The Scottish Government initially planned to publish a national workforce plan in spring 2017, covering the entire health and social care workforce. It then revised its approach, publishing the plan in three parts, covering the NHS workforce, the social care workforce and the primary care workforce. This was to be followed by an integrated national health and social care workforce plan, a joint publication with the Convention of Scottish Local Authorities (COSLA), in 2018. This is now due to be published in 2019 ([Exhibit 5](#)).

Exhibit 5

Workforce planning and primary care outputs have been delayed



42. The third part of the plan, published in April 2018, considers how primary care workforce arrangements will change.²⁵ The plan sets out the intention to reform primary care in Scotland by building and expanding primary care MDTs. The plan recognises the challenges facing primary care, including that demand for primary care services is increasing, because of the ageing population and a rise in people suffering from two or more chronic conditions. It also notes the pressures arising from an ageing workforce, but it does not include projections of what this might mean in terms of numbers leaving the workforce.

43. The Scottish Government acknowledges that it needs to develop a more sophisticated approach to workforce modelling. It also recognises that more needs to be done to improve primary care data to inform workforce planning. In *NHS workforce planning: The clinical workforce in secondary care* , we recommended that the Scottish Government should:

- improve understanding of future demand
- demonstrate how training and recruitment numbers will meet estimated demand
- provide a clear breakdown of the costs of meeting projected demand through additional recruitment.

44. In April 2019, NHS Education for Scotland launched a data platform to bring together data on workforce supply. The platform includes data on different stages of the GP training pipeline and will give a better picture of how the numbers entering training will translate into the number entering employment in NHS Scotland, as well as the numbers of trainees leaving Scotland or going to work in other areas of the health service. The platform is available to both national and local workforce planners and should enable a more joined-up approach to workforce planning across the health service. The extent to which it can be used for primary care workforce planning will be limited until better data on the primary care workforce is available.

Workforce planning is fragmented

45. Nationally, responsibility for health and social care workforce planning sits in one division of the Scottish Government and responsibility for primary care sits in another (**Exhibit 6, page 22**). This creates a risk that workforce planning for different elements of the workforce is carried out separately, without a coordinated, strategic approach to planning the whole primary care workforce. The Scottish Government intends to create a revised structure to move towards a more strategic approach. This is due to be in place by November 2019.

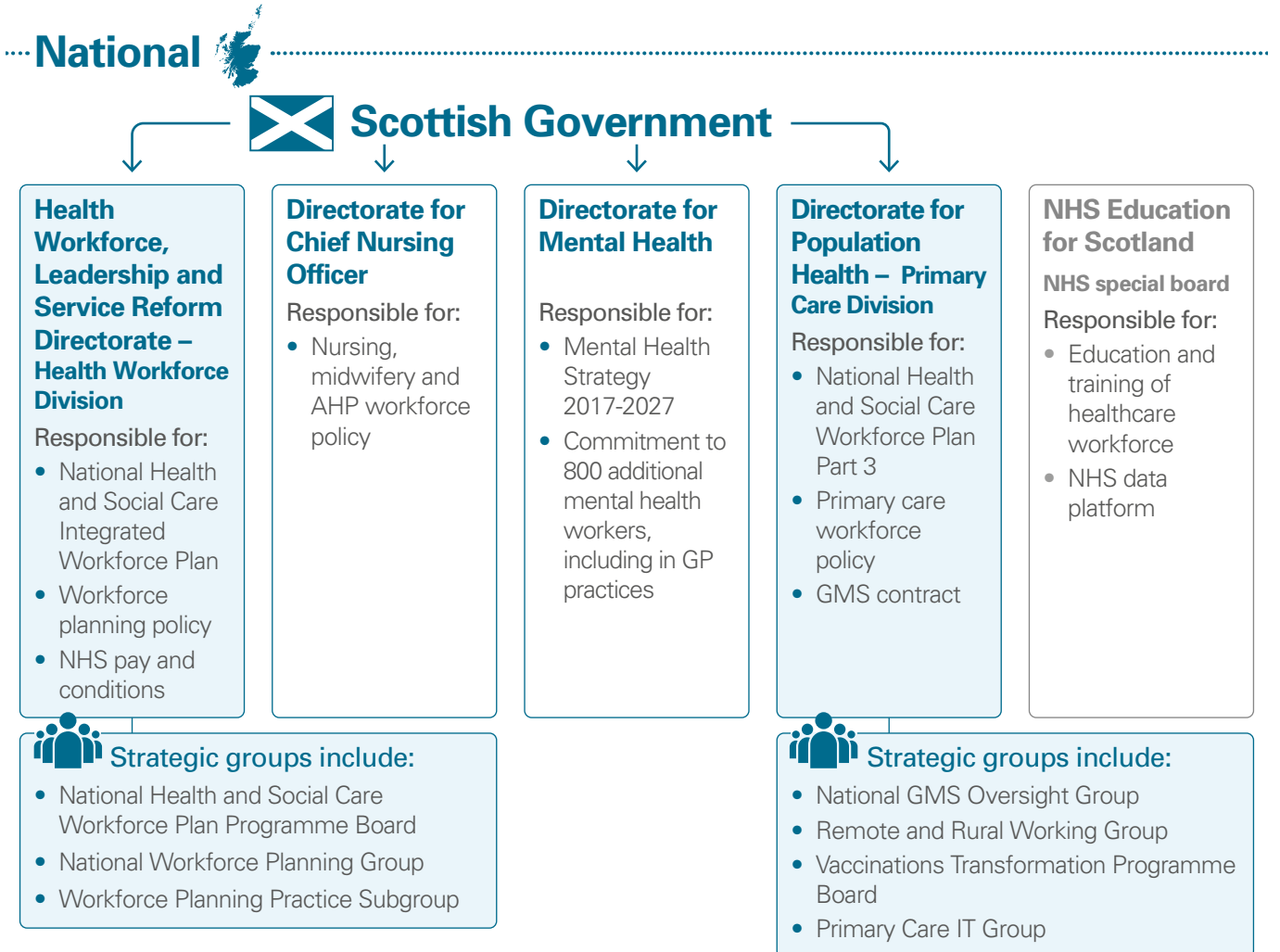
46. Locally, NHS boards and integration authorities need to work together to plan the primary care workforce.

- NHS boards are responsible for contracting with GP practices to provide general medical services in their area. They are required to submit annual workforce plans and workforce projections, but most of their plans do not specifically mention primary care.
- IAs are responsible for planning, designing and commissioning primary care services. IAs are supposed to produce workforce plans, but not all have done so. They are also responsible for the development of primary care improvement plans, in collaboration with NHS boards and local GP subcommittees.

Exhibit 6

Workforce planning roles and responsibilities

Responsibility for planning the primary care workforce is fragmented.



Regional

- Three planning groups for North Scotland, West of Scotland, and South-East and Tayside
- The regional groups have not produced workforce plans and are not required to do so
- Regional delivery plans were due to be published by autumn 2018. These were to include consideration of workforce but it is not clear when these will be published


Local

- 14 territorial NHS boards**
- All NHS boards (except NHS Orkney) have workforce plans
 - Contract for provision of primary medical services in their area
 - As part of new GMS contract will be responsible for employing wider MDT members

- 31 integration authorities**
- Responsible for planning and resourcing primary care services
 - Development and implementation of PCIPs

47. The National Health and Social Care Workforce Plan Programme Board was set up in November 2018. This is a group of representatives from the Scottish Government, COSLA and the Scottish Social Services Council. It was set up to oversee the development and delivery of the whole health and social care workforce planning programme and to provide clearer governance. Progress against the workforce commitments in the plans is the responsibility of the relevant policy teams in the Scottish Government.

48. The National GMS Oversight Group is responsible for overseeing implementation of the new GMS contract across Scotland. This group includes representatives from the Scottish Government, NHS boards, IAs and the Scottish General Practitioners Committee (SGPC). It does not include the professional organisations which represent the different healthcare staff groups which make up MDTs. In addition, there are several groups that provide advice and support on a range of issues such as remote and rural, IT and premises.

49. In [NHS workforce planning: The clinical workforce in secondary care](#) , we reported on the risk that the number of workforce plans and workforce groups could become a barrier to effective working. It is important that NHS boards and IAs work together with the Scottish Government to ensure their different plans align and that their respective roles are clear.

It is not clear how the Scottish Government's workforce commitments will contribute to the wider ambitions for primary care

50. The Scottish Government has made several commitments to train and recruit a range of primary care professionals ([Exhibit 7, page 24](#)). Planning the primary care workforce at a national level has been complex and challenging because most practices are run by self-employed GP partners who have been responsible for employing other practice staff. This has made it difficult to both understand the size and make-up of the existing workforce and also to plan for changes to the future workforce.

51. The commitments to train additional staff are either on track or have already been achieved. For the commitments relating to staff groups who work across the health service, such as nurses and paramedics, it is difficult to assess what the impact will be on the primary care workforce specifically, as those trained may go on to work outwith Scotland or in other parts of the health system. The Scottish Government's intention to increase the primary care workforce and expand the role of MDTs is clear, but it has not set out in detail how it anticipates that its workforce commitments will:





















- reduce GP workload
- improve patient care and access
- meet future demand.

52. It is also unclear how these commitments link to workforce decisions being made at a local level. IAs are responsible for specifying the future primary care workforce they need to deliver services in their area. The Scottish Government did not use information from IAs about their requirements to inform its commitments and such information is not being used to monitor progress towards achieving them.

Exhibit 7

NHS workforce commitments

The Scottish Government has made a number of commitments to increase the NHS workforce.

Primary care commitments	Status	Progress	
 800 more GPs (headcount) over next 10 years		Further information in paragraphs 53-54	
 100 more GP specialist training places from 300 to 400		This was achieved in 2016 and 2017. There was a change in the way GP training was delivered in 2018, moving from a mixture of three- and four-year courses to only three-year courses. As a result, the number of new places advertised fell, but the overall number of training posts increased.	
 500 more health visitors by 2018	 (late)	There was an increase of between 509.1 and 575.9 WTE, between March 2014 and March 2019. This is based on estimated 2014 data.	
 All GP practices to have access to pharmacist support by the end of 2021		Funding for this has been provided by the Primary Care Transformation Fund. This had funded pharmacy support for about 68 per cent of GP practices as at December 2018. There is no information on how many of the remaining 32 per cent have pharmacy support funded through other means.	
 Up to 250 community link workers to work in GP surgeries by 2021 at least 40 being recruited in the coming year		It is difficult to assess whether this commitment is on track because there is a lack of complete data on the current number of these workers, and on trends. Primary Care Improvement Plans report 120 community link workers in post in 2018/19.	
Wider commitments with primary care impact			
 2,600 more nursing and midwifery training places by 2021		The Scottish Government sets the number of nursing university places for Scottish students. This increased to 4,006 for 2019/20. If current trends continue, it looks likely that an additional 2,600 places cumulatively will be achieved by 2021.	
 500 additional ANPs trained by 2021		1,023 nurses received funding to undertake training, 425 from a primary or community care background, during 2017/18 and 2018/19. As at December 2018, 60 nurses had completed ANP education, with the Scottish Government expecting an additional 95 to have completed it by September 2019.	
 1,000 more paramedics training in the community over five years including 50 with enhanced skills to work in the community		518 paramedics trained, and 57 more recruited between 2016/17 and 2018/19.	
 800 additional mental health workers over 5 years in A&Es, GP practices, police custody suites and prisons		An additional 268 mental health workers were appointed as of 1 July 2019; 99 were in GP surgeries.	
 Incomplete data	 Not on track	 On track	 Achieved

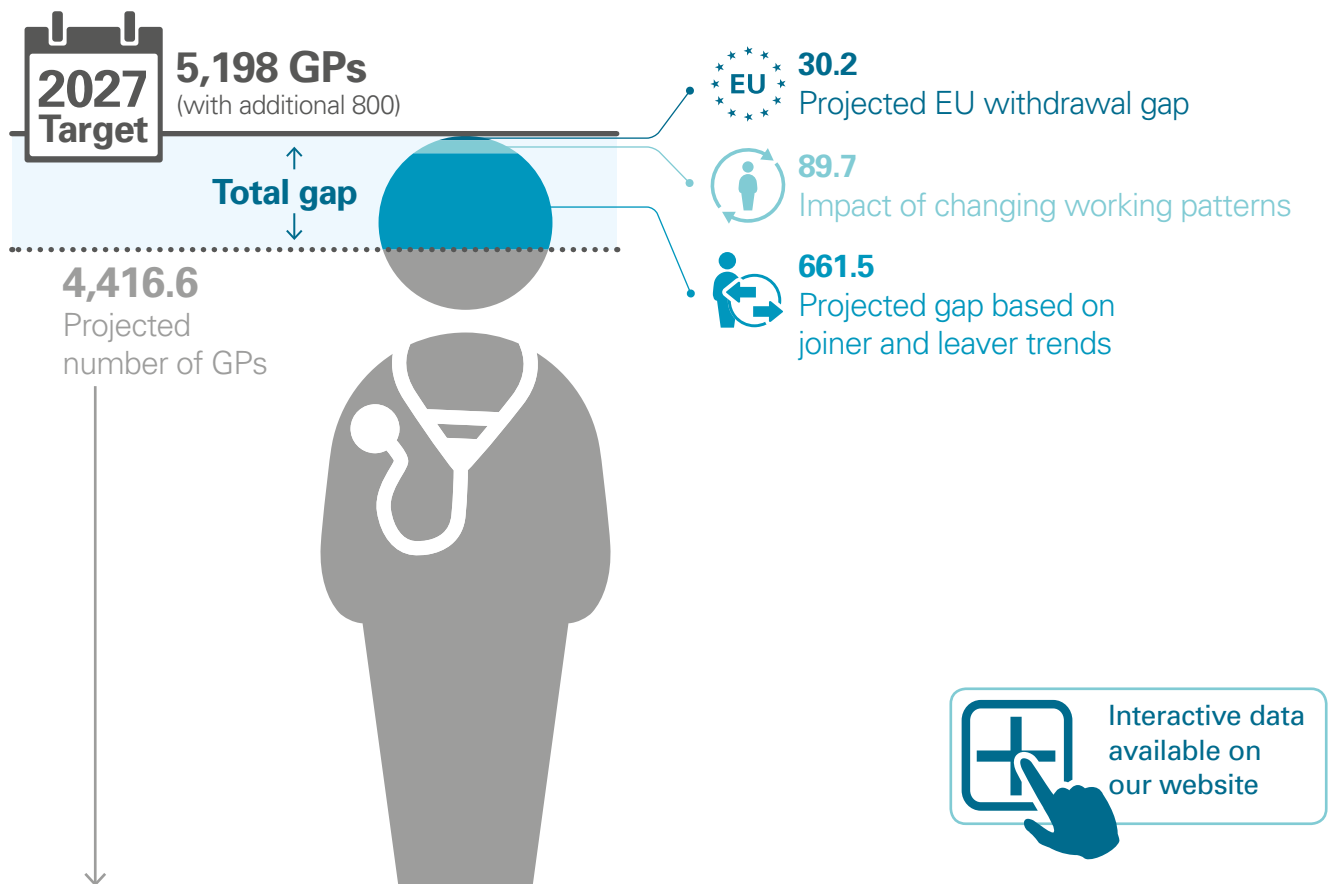
53. One of the most ambitious workforce commitments is the plan to have an additional 800 GPs over a ten-year period. Taking 2017 as the baseline, an additional 800 GPs would represent an 18 per cent increase, from 4,398 to 5,198. The Scottish Government has not set out what impact these additional GPs will have or how the target reflects retirement rates or changes in working patterns. It has not provided an assessment of how policy initiatives will contribute to reaching the target, or identified what the risks are if it is not achieved.

54. We have analysed the trend in GPs joining and leaving the NHS workforce in Scotland over the last ten years, the potential impact if ten per cent of GPs from the EU were to leave the workforce and the impact of changing working patterns. Our analysis indicates that GP numbers will remain broadly stable over the period 2017–27. **Exhibit 8** shows the potential gap between the Scottish Government's commitment and the likely number of GPs, taking account of past trends and future pressures.

Exhibit 8

Potential shortfall in the number of GPs, 2027

Factors such as changing working patterns and past trends in GP joiners and leavers indicate that GP numbers are likely to remain fairly stable, which will make achieving the Scottish Government's commitment challenging.



Note: See [Appendix 2](#) for methodology.

Source: Audit Scotland using ISD Scotland data



55. The target is based on a headcount of GPs, rather than WTE. With more GPs working part-time, this is likely to translate into considerably less than 800 additional WTE GPs ([paragraph 21](#)). This makes it difficult to assess:

- what impact achieving this commitment would have on the primary care workforce and pressures in primary care
- how it would contribute to the Scottish Government's aim to change the way primary care is delivered through the use of MDTs.

56. Some individual boards have considered these issues as part of local workforce planning. For example, in 2017, before the new GMS contract came into effect, the IAs in Ayrshire and Arran looked at the age profile of their GP population and at trends in recruitment and working patterns. On this basis, they calculated that for every GP leaving the workforce they would need to recruit an additional 1.6 GPs to maintain workforce capacity. Based on trends in retirement, they projected that they were likely to need an additional 80 GPs by 2022, without factoring in any additional recruitment needed to increase the workforce. This level of GP recruitment was assessed as being difficult to achieve. To address this the IAs developed a primary care programme to focus on implementing multidisciplinary working in practices and to divert activity away from GP practices where appropriate.

A lack of data on the primary care workforce will make it difficult to assess whether the GMS contract is achieving its aims

57. In 2008, in our report on the previous GMS contract, we highlighted that there was a lack of basic data on general practice, making it difficult to plan the workforce effectively. We recommended that:

- the Scottish Government collect robust data before implementing major schemes so that it could base decisions on accurate information
- the Scottish Government and NHS boards collect comprehensive data on GP numbers and GP practice staff numbers to support workforce planning at national and local levels.²⁶

58. Between 2004 and 2018, GP practices were not obliged to provide data on staff employed by the practice. Lack of data on practice-employed staff means that there are no accurate figures on the size and make-up of the primary care workforce.

59. In 2018/19, £870.5 million was spent on GMS funding, making up 6.4 per cent of the total health budget. This is a real terms increase of 13 per cent since 2013/14, when GMS funding made up six per cent of the health budget.²⁷ The latest published data on GP practice funding is for 2017/18. About £794 million was paid to GP practices. This covers the cost of delivering core primary care services, including payments to GP partners and staff salaries for those employed directly by the practice. It also includes additional payments for premises, seniority payments for staff and payments for some additional services commissioned by NHS boards. There is no data available on how much of this is spent on staff, so primary care workforce costs cannot be separately identified.

60. Accurate workforce data is essential for effective workforce planning both nationally and locally. Without a clear picture of the size and make-up of the primary care workforce, WTE as well as headcount, it is difficult to plan the workforce to meet future need and to assess progress against plans to increase the workforce. Similarly, without accurate information on the costs of the primary care workforce, it is difficult to project what the cost of expanding the workforce will be. Some work has been done to assess the pharmacy workforce needed to meet future demand ([Case study 2](#)).

Case study 2

Pharmacy modelling



The Scottish Government commissioned the University of Strathclyde and Robert Gordon University to carry out some work on the involvement of pharmacists in GP practices. The results were published in November 2018. The universities looked at the pharmacy workforce across Scotland to get an understanding of the workforce and to model future demand.

They wanted to calculate the potential workforce needed to take on two areas of work: polypharmacy clinics, for patients receiving prescriptions for four or more medications, and requests for non-repeat medication. To do this, they carried out case studies in NHS Greater Glasgow and Clyde and NHS Lothian. As both NHS boards already collect data on pharmacy activity and demand, it was possible to project the number of WTE pharmacists required to meet demand in these areas and model this nationally.

For example, for acute medication requests they calculated the time taken and corresponding WTE figure using both the NHS Greater Glasgow and Clyde model, and the NHS Lothian model.

	Process two acute prescriptions for all patients	
	Estimated hours	Estimated WTE staff
Scotland (NHS GGC 3 mins per acute prescription)	196,702 hrs	114.0 WTE
Scotland (NHS Lothian 8.6 mins per acute prescription)	563,880 hrs	326.9 WTE

As part of this work, they recommended that NHS boards follow a consistent approach to collecting and reporting data on pharmacy activity.

Source: Audit Scotland using *Evaluation of pharmacy teams in GP practice report*, Robert Gordon University and the University of Strathclyde

61. As part of the new GMS contract, GP practices will be required to provide data on income and expenses and on practice-employed staff. Arrangements for the collection of this data were not in place when the contract came into effect in April 2018. The contract document states that data collection to inform phase 2 would start in 2018/19. This data collection was piloted in April 2019 and is due to be rolled out to all GP practices over the summer of 2019. This data will be used to inform the development of Phase 2 of the contract. It is expected to include the data previously collected through the primary care workforce survey.

62. As part of Phase 2, the Scottish Government plans to introduce a guaranteed income range for GPs, similar to that currently in place for consultants, and to directly reimburse practice expenses. This is due to come into effect from 2020/21, but there is a risk that Phase 2 will be delayed or based on limited data.

National data on activity and demand has not been available since 2012

63. Since 2012, the Scottish Government has been working with NHS National Services Scotland to improve the extraction of data from GP practice records by developing the Scottish Primary Care Information Resource (SPIRE). In December 2018, SPIRE had been deployed in 93 per cent of Scottish GP practices.

64. Until 2013, data on consultations with GPs and other members of practice teams was collected from a sample of six per cent of practices. This was used as the basis for estimates for Scotland. SPIRE is intended to provide an improved source of activity data and was originally due to be operational in 2016. As implementation has taken longer than planned, estimates of practice workload are considerably out of date, including those used as the basis for the funding allocation formula for the new GMS contract.

65. As part of the GMS contract, the Scottish Government intends to collect information on hours worked by GPs, but there is no clear timetable in place for when this data collection will begin. To fully understand primary care activity and demand, data is needed on the number of consultations with all staff groups. The Scottish Government is in the early stages of modelling work intended to give it a better understanding of demand and to assess the potential impact of the range of commitments included in its Health and Social Care Delivery Plan. This work is currently limited in its ability to model the impact of primary care commitments by the lack of robust data. However, the Scottish Government hopes that in the longer term it will have an analytical model in place that can be used to model workforce capacity across health and social care.

66. As SPIRE is not yet fully deployed, there is no up-to-date information at a national level on what activity is being moved to other MDT members and the impact that this is having on GP workload. Without this data, the Scottish Government will not be able to assess whether the new contract is achieving the aim to change the role of the GP and reduce GP workload.

67. The development of MDTs depends on having the digital and physical infrastructure in place to enable joint working. Different professional groups currently use different records management systems. This makes it difficult for MDT members to share information. MDTs will operate differently in different local contexts, but for those based in GP practices there can be challenges in accommodating an expanded MDT on the existing premises. The Scottish Government has asked IAs to clearly set out in the second iteration of the PCIPs how they are identifying the digital and physical infrastructure needed locally to

deliver the priorities set out in the MOU accompanying the GMS contract. The costs of digital infrastructure to support additional staff are to be included in the PCIPs as core workforce costs.

Putting the workforce in place to deliver the planned primary care changes will be challenging

68. The Scottish Government has implemented a range of initiatives to increase recruitment and retention of GPs. Between 2015/16 and 2016/17, it invested £2.5 million on recruitment and retention. In 2017/18, it increased this funding to £5 million and provided a further £7.5 million in 2018/19, bringing the total investment to £15 million. Initiatives include:

- ScotGEM: a four-year graduate entry medical course, open to students who have graduated with a degree other than medicine. The course has a focus on general practice and rural working. Students can also apply for a bursary of £4,000 per year if they agree to work in Scotland's NHS for at least one year for every year they received the bursary, after graduating. There are currently 55 students enrolled on the course.
- Pre-medical entry courses at Glasgow and Edinburgh universities: these courses are designed to widen access to medical training by providing 40 places for students from disadvantaged backgrounds to prepare for undergraduate medical training.
- The Scottish Rural Medicine Collaborative: this is a programme to develop ways to improve recruitment and retention in rural areas.
- A relocation package and 'golden hello' scheme: these measures are intended to encourage GPs to work in 160 eligible rural practices.
- A marketing and recruitment campaign: the campaign aims to attract GPs from the rest of the UK and overseas to work in Scotland.
- Mentoring and coaching programmes: the objective is to help retain the existing workforce.
- The Scotland GP returners programme: designed to make it easier for GPs who have taken a break to return to general practice.

69. The Scottish Government has reported that, between 2015/16 and 2017/18, an additional 39 GPs were recruited as a result of this recruitment and retention funding. Despite the additional funding, based on the number of additional GPs recruited to date, and the scale of pressures on the workforce, it will be challenging for the Scottish Government to recruit an additional 800 GPs by 2027.

70. Some areas have implemented local initiatives to improve recruitment and retention of GPs. NHS Ayrshire and Arran runs a 'GPs with enhanced role' programme, which enables GPs to work part time in a practice and part time in an acute specialty.

71. The expansion of the MDT workforce depends on the availability of staff across the various professional groups with the necessary skills and experience. Although the Scottish Government has made commitments to train additional

GPs, nurses, ANPs and paramedics, this increase in supply will take time to result in an increase in the available workforce. The Scottish Government does not currently control the number of training places for AHPs, making it harder to plan for numbers entering the workforce. The National Health and Social Care Workforce Plan Part 3 notes that NHS boards have indicated that there are challenges with recruitment across the AHP workforce and states that the Scottish Government is considering options for taking a more managed approach to training AHPs. There is no published timescale for this work.

More needs to be done locally to plan the future workforce

72. In support of the 2018 GMS contract, all 31 integration authorities were asked to develop the first versions of their primary care improvement plans by 1 July 2018. There was considerable variation in the detail provided in the initial plans, particularly in relation to projected workforce numbers and costs. The Scottish Government provided additional guidance on what the second iteration of PCIPs should cover. These were due as soon as possible after 1 April 2019. IAs are now also required to submit a tracker every six months to report on progress against the PCIPs.

73. PCIPs also provide an opportunity for the Scottish Government to collect local-level information on demand. Some plans use local monitoring data to assess trends in demand. For example:

- The three IAs in Ayrshire and Arran worked together to collect data on the recent increase it has seen in demand on primary care services, including a seven per cent increase in the rate of consultations per 1,000 patients since 2015.
- East Dunbartonshire IA has projected demand in 2025 based on a model using data from practices across Scotland and population estimates for NHS Greater Glasgow and Clyde. It estimates that face-to-face GP consultations across Greater Glasgow and Clyde will increase from 3.77 million to 4.26 million per year. It also projects a rise in district nursing contacts of 25.7 per cent by 2025.

74. Based on an analysis of national trend data, for some staff groups the PCIP projections would require the workforce to grow at a much faster rate than it has in previous years ([Exhibit 9, page 31](#)). This indicates that local projections will be difficult to achieve, regardless of available funding, without a substantial increase in workforce supply across the country over the next three years.

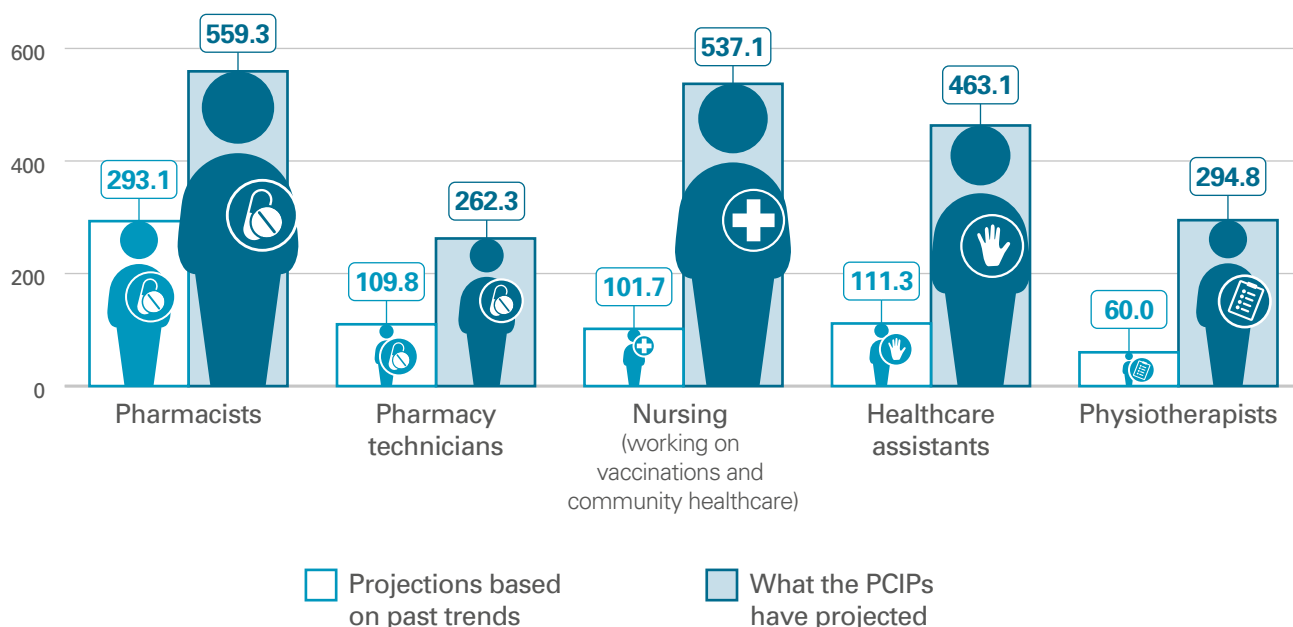
75. Integration authorities have identified issues with the availability of staff as one of the main barriers to implementing their PCIPs. As all IAs are working to expand their primary care workforce during Phase 1 of the GMS contract, there is a significant risk that they will be in competition for the same limited workforce. This may cause additional recruitment challenges in rural areas, where recruitment is already difficult.

76. Locally, some NHS boards and IAs are taking steps to support the expansion of the workforce and development of new roles. For example, to help support the recruitment and training of ANPs, NHS boards in the west of Scotland have come together to establish the West of Scotland Advanced Practice Academy. The academy has developed a coordinated training and development programme for ANPs, working in collaboration with general practice.

Exhibit 9

Workforce projections


The numbers of staff that IAs are projecting that they will need over the next three years represent much larger increases in staff than have been seen in recent years.



Source: Audit Scotland using PCIPs and ISD Scotland workforce data











77. It is likely that the expansion of the primary care practice-based workforce will have unintended consequences for workforce numbers in other parts of the NHS. In some areas, NHS boards are struggling to find staff to work in out-of-hours services. There is a risk that this situation will worsen if staff find working in a practice more attractive. For example, over the period 2017/18 to 2018/19, 12 nurses left the out-of-hours service in NHS Lothian to work in GP practices. Similarly, pharmacists have raised concerns that the increase in pharmacists working in GP practices is leading to staff shortages in community and hospital pharmacies.

78. Part 3 of the national workforce plan does not assess the potential impact of primary care workforce expansion on other parts of the healthcare system. In [Changing models of health and social care](#) , we reported on the benefits of taking a whole-system approach to planning health and social care services, which would assess the impact of changes to the primary care workforce on the NHS more widely.

Endnotes



- 1 *Health and social care: medium term financial framework*, the Scottish Government, October 2018.
- 2 *The future of primary care in Scotland: A view from the professions*, Primary Care Clinical Professions Group, September 2016 (updated May 2017).
- 3 [Health and social care integration](#) , Audit Scotland, December 2015.
- 4 [General Medical Services contract in Scotland: a short guide](#) , Audit Scotland, May 2019.
- 5 [NHS workforce planning: The clinical workforce in secondary care](#) , Audit Scotland, July 2017.
- 6 *General practice – GP workforce and practice list sizes 2008–2018*, ISD Scotland, December 2018.
- 7 [NHS in Scotland 2018](#) , Audit Scotland, October 2018.
- 8 *Healthy life expectancy for Scottish areas, 2015–2017*, National Records of Scotland, 2019.
- 9 *General practice – GP workforce and practice list sizes 2008–2018*, ISD Scotland, December 2018.
- 10 *From the frontline – the changing landscape of Scottish general practice*, Royal College of General Practitioners Scotland, June 2019.
- 11 *Primary care workforce survey Scotland 2017*, ISD Scotland, March 2018.
- 12 *Health select committee inquiry: Impact of a no-deal Brexit on health and social care*, General Medical Council, 2018.
- 13 *The relationship between the primary medical qualification region and nationality at the time of registration, 2017 and 2018*, General Medical Council, November 2018.
- 14 *The NMC register*, Nursing and Midwifery Council, March 2018.
- 15 2018 National training survey, General Medical Council.
- 16 *From the frontline – The changing landscape of Scottish general practice*, Royal College of General Practitioners Scotland, June 2019.
- 17 [NHS in Scotland 2018](#) , Audit Scotland, October 2018.
- 18 Our Voice Citizens' Panel is a large, demographically representative group of citizens selected at random. The panel is used to gather information on the views of the public on health and social care policy and services.
- 19 *Survey on the use of digital technologies for healthcare improvement, using and sharing personal health and social care information and access to healthcare professionals other than doctors*, Our Voice Citizens' Panel, January 2018.
- 20 *Evaluation of pharmacy teams in GP practice*, Robert Gordon University and University of Strathclyde, November 2018.
- 21 *NHS Scotland payments to general practice 2017-18*, ISD Scotland, November 2018, *Practice populations by urban/rural classification*, ISD Scotland, December 2018. Urban/rural classifications are based on the location of the practice, patients may not necessarily live in areas with the same urban/rural classification as the practice itself.
- 22 [Rural GP Association of Scotland submission of 14 October 2018](#) , The Scottish Parliament, October 2018.
- 23 [Equality impact assessment on the new GMS contract](#) , Scottish Government, 2018.
- 24 *Primary care: National monitoring and evaluation strategy*, Scottish Government, March 2019.
- 25 *National Health and Social Care Workforce Plan Part 3 – Improving workforce planning for primary care in Scotland*, Scottish Government, April 2018.
- 26 [Review of the new General Medical Services contract](#) , Audit Scotland, July 2008.
- 27 *Scottish Budget: draft budget 2018-19*, Scottish Government, December 2018.

Appendix 1

Progress on implementing the recommendations made in *NHS workforce planning: The clinical workforce in secondary care*



Recommendation



Progress

The Scottish Government should:

Improve understanding of future demand to inform workforce decisions, including:

- collating, comparing and monitoring NHS boards' assessments of demand and supply to help form a national picture and manage risks
- carrying out scenario planning on the future population health demand and workforce supply changes (such as staff retiring), including how this will affect the types of treatments provided
- considering and clarifying potential future skills mix with NHS boards and stakeholders to determine how a future team can work to meet this demand.

The medium-term financial framework was published in 2018, and includes estimates of increases in demand, as a percentage per year.

NHS NES launched a data platform in April 2019, bringing together a wide variety of NHS and social care workforce data. It includes both training and employment data. The platform is being tested and developed in collaboration with stakeholders. Once further developed, this will give workforce planners a better picture of supply and allow scenario planning on future workforce numbers.

Still in development:

- the publication of the integrated health and social care workforce plan, originally expected in 2018. This may address some of these issues, including scenario planning for future demand
- updated workforce planning guidance for boards, originally due in 2018
- further development and implementation of the modelling tool that could be used to look at demand, workforce and cost.

Demonstrate how training and recruitment numbers will meet estimated demand for healthcare – if it does not, document and cost how the gap between demand and supply in the future will be covered.



The NHS NES data platform will give a better picture of numbers coming through training and into employment from the supply side.

We would hope to see more on this in the upcoming workforce plan.

Provide a clear breakdown of the costs of meeting projected demand through additional recruitment across all healthcare staff groups.

We would hope to see this in the upcoming workforce plan.

Cont.


 Recommendation	 Progress
<p>Demonstrate how policy initiatives, such as safe staffing levels and elective centres, are expected to affect staffing requirements in NHS boards.</p>	<p>We would hope to see this in the upcoming workforce plan.</p>
<p>Set out the expected transitional workforce costs and expected savings associated with implementing NHS reform. This includes collating transitional costs in relation to moving staff into elective centres and into the community, and savings through increased efficiencies.</p>	<p>We would hope to see this in the upcoming workforce plan.</p>
<p>Determine the data required for decisions on the workforce. This will include data on the training pipeline for medical and AHP staff, data on EU citizens working in the NHS in Scotland, and agency spending by professional group.</p>	<p>NHS Education for Scotland work on the data platform will bring together the workforce data sources available, to be used for workforce planning. This went live in April 2019.</p>
<p>Progress arrangements to create national and regional staff banks.</p>	<p>A national service model for radiology is due to be launched in summer 2019. For most other specialties, the Scottish Government has decided against the creation of a national staff bank because evidence suggests staff are only likely to accept shifts within a 15-mile radius of their home.</p>
<p>NHS boards should:</p>	
<p>Produce future plans as well as supply criteria. This would include:</p> <ul style="list-style-type: none"> projecting their future workforce against estimated changes in population demography and health factors producing plans which detail the expected workforce required, supported by analysis of workforce supply and demand trends. 	<p>Not in the scope of this audit.</p>
<p>Fully cost the workforce changes needed to meet policy directives, such as the shift to community-based care, proposed elective centres, safe staffing levels and more regional working.</p>	<p>Not in the scope of this audit.</p>
<p>Improve the accuracy of budgeting for agency spending.</p>	<p>An analysis of financial performance report data for the NHS in Scotland in 2018 found that 12 of 14 boards overspent against their pay budget.</p>

Appendix 2

Methodology



Methodology for GP projections ([Exhibit 8, page 25](#))

- Total number of current and historic GPs is based on the GP headcount, excluding trainees, published by ISD Scotland. The number of GPs needed in the future has been calculated by taking the headcount in 2017 and adding 800.
- Leaver and joiner projections are calculated by forecasting forward based on trends over the previous ten years, using data on GPs starting or leaving the NHS in Scotland provided by ISD Scotland. Alternative scenarios used factored in the number of ScotGEM graduate training places and the impact of increasing numbers of retirements.
- Potential gap due to EU withdrawal has been calculated by assuming 3.7 per cent of GPs are from the EU (based on GMC data for all doctors). Surveys have shown as many as 40 per cent of doctors from the EU are intending to leave, so we have assumed ten per cent may genuinely leave. These potential leavers due to EU withdrawal have been removed from the overall GP number, as well as future GP new starts.
- Given that the GP workforce demographics show a decreasing number of GP partners, an increasing number of women and that about one in three are over 50, it is likely that an increasing number of new GPs will be needed to replace those who leave, due to changing working patterns. To demonstrate the impact that this could have we have assumed that the current ratio of about 1.2 GPs for every 1 WTE will increase to about 1.4.
- For each of these factors a range of scenarios was produced, and those that may be most likely, based on the available evidence, were selected. Further data on the alternative scenarios is presented in the linked [background data](#) .

Methodology for cost per patient ([paragraph 36, page 19](#))

- The cost per patient for the most rural and most urban practices uses data from the ISD Scotland GP payments publication and published data on the urban/rural categorisation of GP practices.
- Cost per patient for each practice was calculated by dividing the global sum plus correction factor by the number of people on the practice list. Then the average was calculated for the most and least rural practices, for comparison.

Appendix 3

Advisory group members



Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit. Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Member	Organisation
Richard Foggo	Scottish Government
Miles Mack	Rural GP
Moya Kelly	NHS Education for Scotland
Lorna Greene	Royal College of Nursing Scotland
Robert Peat	Allied Health Professions Federation for Scotland
Carey Lunan	Royal College of General Practitioners
David Prince	British Medical Association
Aileen Bryson	Royal Pharmaceutical Society Scotland
David Leese	Renfrewshire Health and Social Care Partnership

NHS workforce planning – part 2

The clinical workforce in general practice

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