Dear Colleague

SUPPLEMENTARY MEDICAL STAFFING – GUIDANCE TO BOARDS

Purpose
1. This guidance sets out the best practice framework for addressing supplementary medical staffing issues and should be used by all Boards. The aims of these measures are to enhance patient care and safety and reduce expenditure on supplementary medical staff, including agency staff where costs have risen from £19m to £36m per annum.

Background
2. In light of the benefits from the creation and development of Nurse Banks, Health Management Board (HMB), with the agreement of NHSS Board Chief Executives asked for further work to be done in respect of supplementary medical staff.

3. The Audit Scotland report Using Locum Doctors in Hospitals, published in June 2010, indicates that all Boards should take action to ensure patient safety when using supplementary medical staff. It also indicates that Boards should be capable of making savings on expenditure on locum doctors by improving procurement procedures and, more generally, managing their workforce to minimise demand for locum doctors. The report suggests that using locum doctors more efficiently alone could potentially release about £6m per year.

4. A Short Life Working Group (SLWG) was established to take account of best practice currently underway across NHSScotland and produce this guidance for Boards.

Summary
5. This guidance sets out the measures Boards should take to reduce the need for supplementary medical staff and, where there use is unavoidable, to ensure a high quality and affordable supply. NHS boards will determine their own local processes in managing supplementary medical staffing, against the parameters set out in this guidance.

6. An Implementation Group, chaired by an NHSS Chief Executive is being established to support Boards with the practicalities of implementation, including the establishment of a medical staff bank, and importantly to agree the solutions and approaches to HR issues.
Action

7. NHSS Board Chief Executives and Human Resource Directors are asked to ensure that the measures outlined in this CEL are taken forward within their Board, in consultation with and supported by the Implementation Group.

Yours sincerely

[Signature]

John Nicholls
Deputy Director, Health Workforce
Background

1. As a first step in taking this work forward, the Scottish Government’s Health Workforce Directorate convened a scoping workshop with key service stakeholders including medical staffing managers, HR, National Procurement and SAMD. The outcome of that discussion was agreement that the overall objective should be:

(i) to reduce demand for supplementary medical staff by the use of effective workforce planning tools and staff management practices;

(ii) where it is necessary to use supplementary medical staff, to ensure that they provide high quality care at an affordable cost;

(iii) to secure an adequate supply of supplementary medical staff, which is easy for Boards to access and attractive to doctors wishing to undertake temporary work.

2. A number of key issues were identified, including the need to reduce demand for supplementary staff where possible, HR and performance management issues raised by cross-Board working, the need for Boards to act in concert when dealing with agencies, and the importance of national leadership by SGHD.

Audit Scotland Report “Using Locum Doctors in Hospitals”

3. The recommendations in the June 2010 Audit Scotland report “Using Locum Doctors in Hospitals”, which the Scottish Government and NHS Boards have fully accepted, make clear that reducing expenditure on locums should go hand in hand with improved standards for patients.

Short Life Working Group on Temporary Medical Staff

4. A Short Life Working Group of service stakeholders, chaired by Scottish Government Health Directorates, and including representatives from NHS Boards and the BMA, was established in February 2010. The Group’s remit was to take account of the best practice currently underway across NHSScotland, particularly in relation to Nurse Banks; and to produce guidance for Boards setting out the key issues and solutions in relation to the employment of temporary medical staff, for implementation by the Boards.

5. In June 2010, the Group consulted on a draft version of the guidance with Chief Executives to seek their views on the emerging findings and draft recommendations to which they responded positively. Feedback from the consultation has been reflected in the guidance.

Summary of Guidance “Supplementary Medical Staffing”

6. The guidance describes the steps necessary to reduce demand for supplementary medical staff, and best practice in securing and managing supplementary staff where they are required. It includes proposals on the establishment of a medical bank at NHS Board or regional level that is: supported by
a national database accessible to all boards and regions and hosted by a single NHS Board; and is sufficiently resourced to ensure successful implementation and management.

7. NHS Boards will take the establishment of medical staff banks forward using a number of recommended measures including: building on their current infrastructure for nurse banks, ensuring that they have an agreed escalation process in place when they need to use supplementary medical staff and by ensuring they have appropriate governance and monitoring measures in place.

Timescale for Implementation

8. A list of the specific actions for implementation is included in the guidance (page 15), along with a suggested timetable. However, it will be for the implementation group (see paragraph 10 below) to determine the precise timescale having regard to the need for timely implementation of the recommendations of the June 2010 Audit Scotland report Using Locum Doctors in Hospitals. The action plan set out in the guidance includes the need to address the key findings of the Audit Scotland report.

Supply of staff

9. All eligible doctors will be able to sign up to work in medical staff banks in their own choice of Boards. As one of the key groups is doctors in training we are doing some targeted work to boost the supply with NHS Education for Scotland (NES). This has been done initially by inviting applicants for Specialty Training posts to indicate their interest on the application form in December 2010. Following the specialty training selection and recruitment process candidates who are successful in passing the process (including those who are not offered a place) will be offered the opportunity to register for the medical bank. This will be completed by Spring 2011 and thereafter we will look to roll this out to all other existing doctors in training in Foundation Years and Specialty Training in Scotland.

Implementation

10. An Implementation Group, reporting to Management Steering Group (MSG) is being established and will be led by an NHSS Chief Executive. The Group will provide support to Boards with the practicalities of implementation but also importantly by agreeing the solutions and approaches to HR and terms and conditions issues.

Central employer

11. A key development in the establishment of medical staff banks is the recommendation that a single employer for NHS Boards is identified to host the national IT staff banks database, contracts of bank and medical staff who are not substantively employed by NHSS. This will ensure that all doctors undertaking medical bank work have access to appraisal and revalidation, induction and staff training. The options are for this role to be undertaken either by a large Board familiar with employing supplementary staff or a Special Health Board. Further work
will be undertaken by the implementation group and Health Workforce colleagues to progress this.

12. Effective IT systems will be critical to the delivery of national or regional banks. A programme of work has been initiated to define the requirements for a national system. This work includes exploring the options for integration and interfacing with NHS Boards existing IT systems. This work is being taken forward by a stakeholder group including SG Health, National Services Scotland and E-Health Board colleagues. In the meantime, and until the national IT system is available, Boards will hold details locally.

Health Workforce Directorate
SUPPLEMENTARY MEDICAL STAFFING ARRANGEMENTS – GUIDANCE TO NHS BOARDS

CONTENTS

Executive summary ............................................................................................................... 2
1. What is this guidance about? .......................................................................................... 4
2. What are we doing now? .................................................................................................. 4
3. Why do we need to change? ............................................................................................ 6
4. What are we going to do differently? ................................................................................ 6
   4.1 Establishing a medical staff bank................................................................. 6
   4.2 Reducing demand for supplementary medical staff ........................................... 13
5. When are we going to do it? ............................................................................................ 14
6. How are we going to do it? Implementation action plan ............................................. 15

Annex 1. Reducing reliance on nurse agency and maximising bank usage .............. 18

February 2011
Executive summary

This guidance for NHS boards sets out a best practice framework for addressing supplementary medical staffing issues and describes the steps necessary to develop a medical bank at NHS board or regional level.

The overall objective is to enhance patient care by reducing demand for supplementary medical staff and by facilitating an affordable, high-quality supply when it is necessary to engage supplementary medical staff.

Work to develop a single NHSScotland database of doctors willing to work locum shifts or in locum posts, accessible to every NHS board is being taken forward nationally to provide the technological platform to deliver supplementary medical staffing. The database will be part of a national staff bank IT system and will be hosted by an NHS Board on behalf of the service as a whole. Individual NHS boards will put in place arrangements to access the database when it is available.

NHS boards will determine their own local processes in managing supplementary medical staffing, against national parameters. An NHS Board will be identified to act as central employer to host the contracts of all bank medical staff on behalf of all NHS boards.

The bank will offer opportunities for doctors to work across a number of boards and in a range of specialties. Where necessary, specific employment terms and conditions will be identified, and agreed through the usual negotiating fora. Processes and standards for internal and external recruitment to the medical staff bank will be set out nationally. NHS boards must ensure appropriate induction for all supplementary medical staff.

There will be a need to ensure that doctors working in temporary posts can demonstrate that they are up to date with current medical practice and are being appropriately appraised. Paid study will be facilitated to enable bank-only staff to meet the requirements for the post. NHS boards will establish systems to collect evidence of supplementary medical staff performance using a standardised feedback mechanism.

Managing the permanent workforce more efficiently and effectively will reduce the need for supplementary medical staffing.

An implementation group will oversee initial implementation of the measures across NHSScotland, after which a national governance group will be developed. NHS boards will nominate an executive lead for strategic oversight at local level (the medical director is recommended as the most appropriate executive lead).

The guidance has been produced by a short-life working group of service stakeholders chaired by Scottish Government Health Directorates and including representatives from NHS boards and the British Medical Association.

NHS boards should collectively take forward the implementation of the measures set out in the guidance. It will be for the implementation group to determine the
timescale for the establishment of the medical bank and other workstreams set out in this guidance, having regard to the need for timely implementation of the recommendations of the June 2010 Audit Scotland report *Using Locum Doctors in Hospitals.*
SUPPLEMENTARY MEDICAL STAFFING ARRANGEMENTS – GUIDANCE TO NHS BOARDS

1. What is this guidance about?

This guidance for NHS boards sets out a best practice framework for addressing supplementary medical staffing issues.

The overall objective is to enhance patient care by:

- reducing the demand for supplementary medical staff;
- facilitating an affordable, high-quality supply when it is necessary to engage supplementary medical staff.

The guidance describes the steps necessary to develop a medical bank at NHS board or regional level that is:

- supported by a national database accessible to all boards and regions and hosted by a central NHS board;
- sufficiently resourced to ensure successful implementation and management.

It is also intended that the new arrangements for engaging supplementary medical staff will increase the attractiveness of supplementary medical assignments, consequently increasing the numbers of medical staff wishing to take up such posts.

The guidance has been produced by a short-life working group of service stakeholders chaired by Scottish Government Health Directorates (SGHD) and including representatives from NHS boards and the British Medical Association.¹

2. What are we doing now?

Most NHS boards currently use a system of defining escalating need for supplementary medical staffing. There is no consistent approach across boards, however, which may be resulting in overreliance on supplementary medical staff.

Best practice typically follows the pathway shown in Fig.1: changes to steps 4 and 5 of the process recommended by the short-life working group have been emphasised.

---

¹ Access the terms of reference and membership of the group at: http://www.sehd.scot.nhs.uk/publications/DC20100922temp.pdf
Fig. 1 What we’re doing now – escalation process in NHS boards

Step 1
Identification of a gap in medical staffing

Step 2
Review of need to cover and options for covering without engaging additional medical time

Step 3
Consider options for cover by current staff on same rota/work pattern as locum

Current Step 4
Consider options for cover by other staff within the department/hospital as a locum

Proposed Step 4
Initiate process for engaging staff through internal cross-cover or the NHS medical bank; this could include the use of staff working in the specialty area in another NHS board

Current Step 5
Initiate process for engaging supplementary medical staff

Proposed Step 5
In exceptional circumstances, initiate process for engaging staff from a contract agency as outlined in the new framework agreement.
3. Why do we need to change?

NHSScotland annual spend on agency locum doctors rose from £19m in 2006 to £36m in 2010. In addition to rising costs, there are also concerns about the suitability of some staff engaged to fulfil supplementary medical staffing requirements.

The Audit Scotland report *Using Locum Doctors in Hospitals*\(^2\) examined issues of safety and efficiency around locum medical staff. The report estimated that NHSScotland could save almost 15% a year – or about £6m – through better planning and procurement. It also emphasised the risks to patient safety when locums are not properly managed.

NHS National Services Scotland (NHS NSS) has put in place a new Agency Framework Contract for NHSScotland\(^3\) to make the procurement process easier and more cost−effective. The new framework agreement, introduced on 1 June 2010, defines pay rates using the NHS Pay Circulars aligned to internal locum rates, and consequently offers significant savings.

Following consideration of all the issues, the short-life working group concluded that the creation of medical staff banks at NHS board or regional level, supported by a central database, would help to resolve issues of quality and cost, and that a number of measures could be taken to improve availability and fill-rates.

4. What are we going to do differently?

4.1 Establishing a medical staff bank

4.1.1 Why a medical staff bank?

Establishing a medical staff bank, modelled on work already successfully undertaken in nursing (Annex 1), will provide a number of potential benefits to NHS boards and regions and to doctors wanting to work in a flexible way. For instance:

- staff engaged through a bank system will be directly employed by the NHS; they will be subject to pre-employment checks, including Disclosure Scotland and occupational health checks, and will undergo assessments of suitability and competence in the same way as all other NHS staff;
- staff will work at NHS agreed rates;
- the bank will maintain a register of appropriately trained and experienced medical staff employed, inducted and supervised by the NHS and with appropriate clinical governance arrangements in place to maintain safe and effective patient care delivery where there are short- and longer-term gaps in the substantive medical workforce;

---


availability will be maximised through use of a national database, matching available doctors to gaps across their region or, in the case of longer vacancies, more widely;

• a system for developing appraisal, revalidation and performance management for doctors engaged in a bank system will be developed across NHSScotland.

A medical staff bank will:

• minimise gaps and ensure continuity of service;

• provide alternative employment that maintains and develops clinical skills in particular groups of staff, such as returnees to the NHS, staff who are between formal training posts and those who are between permanent posts or unable to commit to a permanent post;

• ensure equity in the workforce through, for instance, nationally agreed remuneration and training and development opportunities for permanent and supplementary staff;

• improve efficiency of recruitment to temporary positions by reducing time spent in recruitment processes;

• provide opportunities for those wanting to take on some extra work, in particular those who would like experience in working in other areas of Scotland (perhaps prior to making a specialty training application).

4.1.2 How the medical staff bank will work

A single NHSScotland database of doctors willing to work locum shifts or in locum posts, accessible to every NHS board, will provide the technological platform to deliver supplementary staffing for medical staff. The single national database will be part of a national staff bank IT system and will be hosted by an NHS Board on behalf of the service as a whole. (see Section 4.1.3, “IT and national database”, below)

NHS boards will put in place arrangements to access the national database, enabling supplementary medical staffing to be secured from the internal bank source and consequently reducing reliance on external agency suppliers. It is recommended that boards utilise their existing nurse/staff bank expertise to take forward local operational arrangements, but alternative options, include working in partnership with regional board partners or establishing a sub-contractual arrangement with another board to deliver the service, also exist.

This means that doctors who are already substantively employed by an NHS board can register their details through their local NHS board. As the local Board register will be part of the national database, the individual doctor will choose the board areas in which he or she wants to work, providing access to those Boards of his or her details and availability. If a doctor who wants to register is not substantively employed by NHSScotland, he or she would register directly with the host NHS Board. NHS boards will hold the details of their bank staff locally until the national database is activated (see Section 4.1.5, “Human resources processes and agreements”, below).
Doctors registered with the medical staff bank will be able to make themselves available to work in one or more boards across Scotland, according to their preferences.

4.1.3 IT and national database

The Scottish Government has initiated a programme of work to define the requirements of a national IT staff bank system. The options for integration and interfaces with existing systems are being explored. Any national developments will be subject to approval from the Scottish Government e-Health Board.

The e-Health structure for portfolio management groups will be the “gatekeeper” for the development of this system, ensuring that consensus among NHS boards is achieved.

The IT specification underpins the supplementary medical staffing arrangements and will take account of issues specific to medical staff, ensuring that agreed terms and conditions, shift patterns and working arrangements are accommodated.

4.1.4 Management and operational Issues

Governance

An implementation group4 will be convened to initially support implementation of the medical bank across NHS Scotland. The group will report to Management Steering Group (MSG) and its remit will be to:

- support NHS boards to find solutions to reduce reliance on external agencies and ensure best use of bank staff in the context of all staffing (substantive and supplementary);
- propose solutions and approaches to human resource and terms and conditions issues;
- ensure implementation of recommendations from the Using Locum Doctors in Hospitals report (see Section 3, “Why do we need to change?”, above);
- propose how national governance arrangements are taken forward;
- make national recommendations (where appropriate) on managing “hard-to-recruit-to” areas and specialties.

Following implementation, the group will develop into a national governance group covering all staff banks, at which time its remit will be to:

- build capacity and capability within staff banks and share good practice across Scotland;
- set national key performance indicators for banks, boards and specialties;
- agree and implement consistent national data sets with ISD and National Procurement for the national staff bank IT system in relation to staffing and for monitoring agency and bank use.

NHS boards will agree local structures and accountability procedures. This will include the identification of a nominated executive lead for the strategic oversight of the NHS board’s delivery against national guidance, targets and associated recommendations. Boards are advised that in relation to supplementary medical staffing, the medical director is recommended as the most appropriate executive lead, with delegated responsibilities being devolved to clinical directors through the normal clinical and financial governance routes.

NHS boards will determine their own local management processes, which means there will be variations between boards in managing supplementary medical staff. Firm parameters for the success of the project, particularly around requirements for interfacing with the national IT system, will nevertheless be set.

NHS boards will ensure that policies and procedures are in place to authorise the use of supplementary staffing (in a way that minimises additional costs while fully recognising that there is often an urgent clinical need for cover) and ensure ongoing scrutiny. Boards will also be required to consider local processes for managing demand, making bookings, confirming attendance and initiating prompt payment to bank staff, and for managing customer relationships and communications with the staff group. The national IT system will be capable of ensuring accurate finance and recharging of costs and will provide management information to boards.

Board processes should ensure that all potential bank sources are exhausted before making any referral to external suppliers.

Administration
NHS boards will identify a resource to coordinate local access to, and maintenance of, the national medical staff bank IT system, using nationally agreed datasets.

4.1.5 Human resources processes and agreements

Enabling medical staff to work across board boundaries is critical to the success of the medical staff bank arrangement.

Employer
An NHS Board on behalf of the service as a whole will be identified to host the contracts of all bank medical staff on behalf of all NHS boards. The contract for bank services with the identified host will be separate to any concurrent substantive or training contract within an NHS board.

As was emphasised in 4.1.2 above, this means that doctors who are already substantively employed by an NHS board can register their details through their local NHS board. As the register will be part of the national database, the individual doctor will choose the board areas in which he or she wants to work, providing access to those Boards of his or her details and availability. If a doctor who wants to register is not substantively employed by NHSScotland, he or she would register directly with the central NHS employer. NHS boards will hold the details of their bank staff locally until the national database is activated.
NHS boards will ensure that appropriate medical staffing support is made available to provide professional support to the local infrastructure delivering a medical staff bank service.

Again, to emphasise what was stressed in 4.1.2, it is recommended that boards utilise their existing nurse/staff bank expertise to take forward local operational arrangements, but alternative options, include working in partnership with regional board partners or establishing a sub-contractual arrangement with another board to deliver the service, also exist.

Terms and conditions/remuneration
The medical staff bank offers an alternative NHS employment option for either ad hoc additional work or as exclusive employment for a period of time. This will provide a more flexible way of working that will ensure the maintenance of skills for clinicians who are not in substantive career or training positions.

The bank will offer opportunities to work across a number of boards and in a range of specialties, dependent upon qualifications, experience and competencies.

The implementation group will consider the range of terms and conditions issues including: grade applied to medical bank staff, locum rates, remote and rural issues, hard to recruit to areas and specialties, arrangements for working at a lower-than-appointed grade, travel and accommodation issues and GP rates for covering hospital grades. Specific negotiations on terms and conditions will be undertaken at national level as appropriate by Management Steering Group, Scottish Government and the BMA, using existing negotiating fora.

As is currently the position with other staff banks, bank medical staff should be offered the opportunity to opt into the NHS Pensions Scheme.

Working hours – Working Time Regulations and the New Deal
The Working Time Regulations (WTR)\(^5\) set limits on the hours of work and define daily and weekly rest requirements. All locum hours worked count towards the average weekly hours limit under WTR (48 hours per week averaged over a 26-week reference period).

Many doctors currently work up to or near the 48-hour limit as part of their standard contracted hours of work. If it is likely that the combined total of standard and bank/locum hours would exceed the WTR limits, the employer should ask the employee to sign the hours opt-out.

There is no opt-out available for the WTR rest requirements, which include an 11-hour continuous rest period in each 24-hour period. A local WTR compensatory rest policy may be required to ensure that all rest limits are met.

\(^5\) Information on WTR can be found at: [www.healthcareworkforce.nhs.uk/workingtimedirective.html](http://www.healthcareworkforce.nhs.uk/workingtimedirective.html)
The New Deal contract\(^6\) sets limits of hours and rest requirements for doctors in training. Again, employers need to ensure that additional work undertaken will not breach New Deal limits.

**Leave entitlement**
Bank-only staff will be entitled to statutory maternity leave and sick leave, subject to the necessary qualifying periods/minimum earnings. All bank staff will be entitled to statutory annual leave and those with concurrent substantive career or training posts will be required to ensure no work is undertaken for the NHS during the periods of statutory leave. Any leave over and above the statutory minimum can be worked should the individual wish to do so.

**Performance management and revalidation**
NHS boards will establish systems to collect evidence of performance from placements using a standardised feedback mechanism (which may be paper-based in the first instance, but which will ultimately be incorporated within the national IT system). These must be completed and returned by department leads. The supervising doctor must complete a performance review form at the end of each locum booking.

If a locum’s performance is reported as unsatisfactory, the clinical director or supervising consultant should inform the medical director as soon as possible. The medical director will decide if further action is required. Supervising consultants and department leads will be responsible for ensuring that locum doctors’ performance review forms are returned to the appropriate contact, keeping the medical bank informed.

**4.1.6 Recruitment, induction, ongoing development and revalidation**

**Recruitment**
The supply of doctors for the medical staff bank is expected to come from:

- doctors between permanent posts;
- recently qualified GPs, many of whom are currently doing out-of-hours or locum work; many have skills useful for junior/middle-grade work in hospitals;
- gender shift in the medical workforce and consequent greater interest in flexible working – some doctors may see short-term contract working as attractive, as is already the case in primary care;
- cross-border working, although doctors not substantively working in NHSScotland would need to go through the external recruitment arm to be included on the central database, as only NHSScotland staff will be eligible for the accelerated internal recruitment process.

The parameters (skills, competencies, level of experience and qualifications) necessary for working at different grades in different specialties will be agreed nationally.

\(^6\) HDL (2000) 17 gives details of the New Deal contract for doctors in training.
Recruitment processes and standards will be set out nationally for internal recruitment (those with concurrent NHSScotland employment) and external recruitment to the medical staff bank (all other applicants).

Recruitment for staff working or residing locally will be carried out by NHS boards. The contract issued for services will be with the identified NHS Board identified to act as central employer of bank medical staff (see Section 4.1.5, “Employer”, above).

Internal recruitment will be a “fast-tracked” process, minimising duplication of effort through the use of existing pre-employment checks carried out by the concurrent employer, although this may be subject to a time limit on applicability. The host NHS board will provide assurances to boards that the transferability of pre-employment checks (including disclosure checks) meets the necessary governance requirements.

A separate occupational health assessment to that carried out for concurrent employment will be required for medical staff undertaking bank work. It is not anticipated, however, that each board will carry out a second check, but that the initial assessment undertaken by the “parent” board will be “passported” to other boards through the use of a standardised proforma.

**Induction**

NHS boards providing placements must ensure appropriate induction for all supplementary medical staff. It is planned that the induction process in boards will be a blended learning package offering generic NHS induction, bank processes and procedures, mandatory input and localised induction delivered via CD-ROM/handouts, e-learning and practical sessions. Some elements of induction may be accessed via concurrent substantive career or training posts, while others will be linked to individual placements.

Boards will be required to identify the prerequisite induction necessary for bank medical staff making themselves available to work in their clinical areas and will provide appropriate support to ensure the requirements can be met.

Arrangements to ensure appropriate access to IT logins for key clinical systems will be included in local induction processes.

**Training**

Paid study will be facilitated to enable bank-only staff to meet the requirements for the post (for example, provision of training in advanced life support). All training will be subject to approval. Training will not be funded via the bank where it is a prerequisite of a concurrent post.

**Revalidation**

Licences to practice for medical practitioners were introduced in November 2009. All doctors will have to revalidate with the General Medical Council in due course: proposals for this process have been the subject of recent consultation and details will be clarified relatively soon.

---

Whatever the detail of proposals for revalidation, there will be a need to ensure that doctors working in a medical bank can demonstrate that they are up to date with current medical practice and are being appropriately appraised. Any revised arrangements for employing supplementary medical staff will need to take this into account.

4.2 Reducing demand for supplementary medical staff

NHSScotland has developed a range of workforce planning and workload management tools to inform NHS boards’ workforce planning. The tools help boards to ensure they have the right number of staff in the right place and at the right price to deliver high-quality patient care.

The full suite of tools is still being developed, but they currently range from a high-level workforce planning methodology to more targeted and detailed workload tools to help assess, for example, the nursing or allied health professional (AHP) workforce required to deliver services. The tools will help boards ensure they are fully utilising their existing workforce and that the requirement for supplementary medical staffing is valid.

Managing the permanent workforce more efficiently and effectively will reduce or eradicate the need for supplementary medical staffing. Actions can be split into shorter- and medium/long-term strategies.

4.2.1 Shorter-term workforce utilisation

There will always be a need for short-term cover for unexpected gaps, but it is easiest to manage gaps when cover can be planned early, so better rota and vacancy management will help reduce the demand to a minimum. NHS boards are already working hard on a range of initiatives to improve workforce utilisation, including:

- annual leave planning
- study leave planning
- maternity and paternity leave planning
- attendance management
- vacancy management.

Boards are putting in place measures to manage short-term locum demand, including:

- the reallocation of clinical duties
- clinical risk assessment authorisation
- scrutiny of requests for validity and authorisation
- mechanisms to allow budgets to be interrogated before requesting shifts, including when the request is out of hours.

---

8 A link to the key tools and methodologies can be found at: http://www.workforceplanning.scot.nhs.uk/home.aspx
They are also investigating locum usage to identify where and why use is high, particularly in the absence of adverse indicators such as high vacancy levels.

4.2.2 Medium/longer-term workforce utilisation

The design of, and demand for, clinical services drives the shape and size of the workforce. There may be opportunities over time to review and redesign the service and the workforce to reflect wider NHS drivers, such as the Healthcare Quality Strategy for NHSScotland. This may allow longer-term gaps in the medical workforce that are currently filled by supplementary medical staffing to be reduced or eliminated.

It may also provide an opportunity to review the composition and skill-mix of the workforce. NHS boards across Scotland are already actively involved in a range of related initiatives, including:

- exploring opportunities for service redesign through developing nurse/AHP-staffed minor injury units to reduce traffic through A&E departments;
- reshaping the medical workforce and moving to a trained doctor-delivered service as part of a multi-professional team;
- implementing new and advanced roles within nursing and the allied health professions;
- changing skill mixes within teams through, for instance, the development of physician assistant roles;
- introducing new technology to enable changes to traditional working practices – new technology now allows radiologists, for example, to review images remotely or even at home, reducing demands for on-site out-of-hours radiologist cover;
- changing the way services are delivered, such as introducing Hospital at Night teams.

5. When are we going to do it?

NHS boards should collectively take forward the implementation of the measures set out in this guidance. It will be for the implementation group to determine the timescale for the establishment of the medical bank and other workstreams set out in this guidance, having regard to the need for timely implementation of the recommendations of the June 2010 Audit Scotland report Using Locum Doctors in Hospitals.

---

6. How we are going to do it? Implementation action plan

<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Responsibility</th>
<th>Suggested Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Management and operational issues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Establish <strong>implementation group</strong> to support implementation of the medical bank across NHSScotland.</td>
<td>SGHD\textsuperscript{10}</td>
<td>By March 2011</td>
</tr>
<tr>
<td>2.</td>
<td>Establish <strong>National Staff Banks Governance Group.</strong></td>
<td>SGHD</td>
<td>By November 2011</td>
</tr>
<tr>
<td>3.</td>
<td>NHS boards to agree local structures and accountabilities for supplementary medical staffing, including the nomination of an executive lead (recommended – medical director).</td>
<td>NHS boards</td>
<td>By March 2011</td>
</tr>
<tr>
<td>4.</td>
<td>NHS boards to determine own local process for supplementary medical staff bank, ensuring that interim IT arrangements are in place.</td>
<td>NHS boards</td>
<td>By end of 2011</td>
</tr>
<tr>
<td>5.</td>
<td>NHS boards to ensure that policies and procedures are in place to authorise the use of supplementary staffing and ensure ongoing scrutiny.</td>
<td>NHS boards</td>
<td>By June 2011</td>
</tr>
<tr>
<td>6.</td>
<td>NHS boards to identify a resource to coordinate local access to, and maintenance of, the national medical staff bank IT system, using nationally agreed datasets.</td>
<td>NHS boards</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td><strong>IT and national database</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{10} Scottish Government Health Directorates
<table>
<thead>
<tr>
<th></th>
<th>National banks IT system to be developed. Specification to be shared with NHS boards as early as possible to ensure that interim IT arrangements are compatible with national IT systems.</th>
<th>NSS&lt;sup&gt;11&lt;/sup&gt;</th>
<th>By March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human resources processes and arrangements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>NHS Board to act as central employer for NHSScotland to be identified to host the contracts of all bank medical staff on behalf of NHS boards.</td>
<td>Implementation Group</td>
<td>During 2011</td>
</tr>
<tr>
<td>9.</td>
<td>Solutions and approaches to human resource and terms and conditions issues to be nationally agreed.</td>
<td>Implementation Group MSG</td>
<td>During 2011</td>
</tr>
<tr>
<td>10.</td>
<td>NHS boards to establish systems to collect evidence of performance from placements.</td>
<td>NHS Boards</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Recruitment, induction, ongoing development and revalidation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>NHS boards to identify the prerequisite induction necessary for bank medical staff and provide appropriate support to ensure that requirements are made. This includes ensuring access to IT logins for clinical systems.</td>
<td>NHS boards</td>
<td>Ongoing</td>
</tr>
<tr>
<td>12.</td>
<td>Appraisal and revalidation scheme and structure to be nationally developed for supplementary medical staff.</td>
<td>SGHD</td>
<td>By 2012</td>
</tr>
<tr>
<td>13.</td>
<td>Doctors in training who are successful in the specialty training recruitment and selection process in Scotland to be offered the opportunity to register with NHSScotland medical bank.</td>
<td>NES&lt;sup&gt;12&lt;/sup&gt;</td>
<td>By April 2011</td>
</tr>
</tbody>
</table>

<sup>11</sup> NHS National Services Scotland  
<sup>12</sup> NHS Education for Scotland
### Reducing demand for supplementary medical staff

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>All NHS boards to use the medical escalation system shown in Fig. 1 when defining their need for supplementary medical staff.</td>
<td>NHS boards</td>
<td>By June 2011</td>
</tr>
<tr>
<td>15.</td>
<td>NHS boards to use the range of workforce planning and workload management tools available to ensure that the existing workforce is fully utilised and that the requirement for supplementary medical staff is valid.</td>
<td>NHS boards</td>
<td>Ongoing</td>
</tr>
<tr>
<td>16.</td>
<td>NHS boards should take the opportunity when available to review and redesign the service and the workforce to reflect wider NHS drivers.</td>
<td>NHS boards</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
Annex 1. Reducing reliance on nurse agency and maximising bank usage

All boards have made significant inroads to reducing their reliance on nurse agency – indeed, some boards now have virtually no agency usage.

The significant reduction in nurse agency spend from £30m in 2003/04 to £10.4m in 2008/09 is attributable to a range of strategic and operational measures, including:

- unprecedented levels of scrutiny on agency, with leadership and ownership from nurse directors through to frontline staff in NHS boards supported by a nationally coordinated approach;
- introduction of escalation and authorisation policies for nurse agency – NHS HDL (2006) 39 mandating the use of contract agencies was a significant catalyst in this;
- much-improved intelligence and reporting on agency usage at national and local levels via ISD and NSS National Procurement reporting through the Nursing Workload and Workforce Planning Programme (NWWPP);
- development of single NHS board banks (reduction from around 96 banks nationally to 14 NHS board banks), including a focus on improving the efficiency and effectiveness of banks;
- introduction of board IT systems and infrastructure to support the sharing of intelligence on bank and agency usage from clinical level upwards;
- management of market dynamics for nurse agency, in particular by setting up national contracts for agency nurse suppliers to reduce, if not eliminate, the need for premium-rate agency suppliers;
- integration of bank and agency approaches with nursing and midwifery workload tools to set nursing and midwifery establishments;
- development of an education toolkit to help frontline staff roster and manage budgets and set establishments effectively.

Following discussions involving the Scottish Government Health Management Board and NHS chief executives and human resource managers, it was agreed that this approach be tested in relation to other staff groups, such as medical staff.

It is recognised, however, that there is not a direct read-across between nursing and medical staff in relation to temporary work. In general, nurse bank staff work in a ward with regular nursing staff. Medical staff (especially at middle grade and higher) tend to assume on-site medical responsibility for a large number of patients in multiple wards, often in an unfamiliar hospital and with little or no knowledge of local processes and IT access.

February 2011