

Director-General Health & Social Care and  
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Rebecca Macfie  
Senior Assistant Clerk  
Health and Sport Committee  
Room T3.60  
The Scottish Parliament  
Edinburgh  
EH99 1SP

24 July 2015

Dear Rebecca

### **NHS Boards Budget Scrutiny – 16 June 2015**

Thank you for your email dated 24 June 2015 following the meeting of the Health and Sport Committee on 16 June 2015 where the Committee took oral evidence. At the meeting I offered to provide the Committee with further information, which I am pleased to provide as detailed below:-

1. Response to the Committee
2. Annex A – correspondence between the Scottish Government, the Academy of Medical Royal Colleges and Faculties in Scotland and NHS Boards about 9:1 contracts and job planning (see paragraph 10)
3. CEL 32 (2011) (see paragraph 14)
4. CEL 12 (2012) (see paragraph 29)

I hope this is helpful.

Yours sincerely

**Paul Gray**

## **Health and Sport Committee 16 June 2015**

### **The basis on which the financial plans for NHS boards are constructed, scrutinised and reviewed at the end of the year (Column 9)**

1. Financial plans are constructed as an integral part of the Local Delivery Plan (LDP) process and all NHS Scotland Boards are required to submit detailed financial plans as part of their annual LDP submission. Boards are required to complete financial templates setting out planned performance against key financial targets and outlining trajectories for financial performance and efficiency savings. The financial templates must be accompanied by a detailed narrative.

2. The detailed information included in the templates is used to assess each Board's financial projections, including risks and assumptions, to ensure achievement of financial targets. Monthly performance reviews and assessments of the agreed financial plan are based on the Scottish Government Health and Social Care Directorates (SGHSCD) monthly Financial Performance Returns (FPRs) which reference actual performance to that agreed in the financial plan.

3. Guidance on completion of the LDP financial templates is provided to Boards to ensure consistency and facilitate, as far as possible, meaningful comparisons across NHS Scotland.

4. The financial targets continue to be in line with the HEAT system. Each NHS Board is expected to meet their statutory financial targets. These comprise three annual budget limits which must not be exceeded:

4.1 Revenue Resource Limit – resource funding for net revenue expenditure allocated by the Scottish Government for on-going operations

4.2 Capital Resource Limit - resource funding for net capital expenditure allocated by the Scottish Government for investment in fixed assets

4.3 Cash Requirement – cash required to fund the net payments for all on-going operations and capital investment

5. The financial plans generally cover a **three year period**. However, a **five year plan** is required where any of the following are included:

5.1 major infrastructure development

5.2 brokerage arrangements are in place

5.3 underlying deficit of over 1% of baseline resource funding

5.4 major service redesign

6. Actual performance compared to planned performance is reviewed throughout the year. The FPRs, detailed above, are submitted monthly from the end of the first quarter. Boards also have mid-year and annual reviews; these are formal review meetings where all aspects of financial performance are considered along with other performance measures.

7. The monthly FPRs form the basis of corporate reporting for Boards as well as the identification of risks as they emerge. Performance is assessed by SGHSCD

throughout the year with support and intervention provided, where necessary, on case by case basis.

**In connection to drugs funding, an offer to explain why there appears to be a differential outcome for a couple of NHS boards (Column 9)**

8. It is clear that there are examples of differences in the way in which some NHS Boards account for and present information about current and anticipated costs and utilisation of medicines. While the Scottish Government is satisfied that there are no inexplicable anomalies, there will be further discussions with NHS Boards to explore how a more consistent approach could be adopted.

**A commitment to discuss with Ministers what more might be done to collect information about the incremental costs of meeting the last percentage points of the treatment time guarantee target and other targets. (Column 12)**

9. We have considered what more might be done to collect information about the incremental costs of delivering the last percentage points of the Treatment Time Guarantee. It is clear from the evidence provided to the Health and Sport Committee by NHS Boards (Tuesday 9 June 2015) that most Boards endeavour to have capacity and demand in balance such that use of overtime initiatives and private sector are limited. Given the complexities of setting up a recording system that would accurately track overtime and other costs related solely to waiting time guarantees we do not consider this to be cost effective. However, information on the use of bank, agency, overtime and private sector costs are gathered for each NHS Board in Scotland and are readily available for scrutiny.

**Share with the Committee the letter to NHS boards regarding what was agreed with Academy of Medical Royal Colleges and Faculties in Scotland on leadership capacity. (Column 22)**

10. Annex A (attached separately) provides correspondence between the Scottish Government, the Academy of Medical Royal Colleges and Faculties in Scotland and NHS Boards about 9:1 contracts and job planning. A key element of the approach described is to ensure NHS Consultants are all to undertake leadership notes locally and nationally.

**Provide the Workforce planning framework to the Committee which looks at what services the Scottish Government want for the future, available resources and information on the step-by-step methodology that the Scottish Government expect each NHS board to follow. (Column 23)**

Overview

11. Each NHSScotland Board is required via CEL 32 (2011) to produce annual workforce plans and projections which describe how its workforce will meet population based service requirements, deliver Scottish Government policy and priorities and support capital and financial plans.

12. Workforce planning is a statutory requirement and was established in NHSScotland (NHSS) in 2005 with the inception of HDL (2005) 52 “National Workforce Planning Framework 2005 Guidance” which provided Boards with a base for establishing workforce planning as a key element of the wider planning systems within NHSS. Following a review of this guidance, CEL 32 (2011) issued on 19 December 2011 (attached separately).

13. In NHSScotland, the “Six Steps Methodology to Integrated Workforce Planning” is the high-level approach used by the workforce planning community across Scotland. The six steps comprise:

- Step 1 – Defining the plan
- Step 2 –Service Change
- Step 3 – Defining the Required Workforce
- Step 4 – Workforce Capability
- Step 5 –Action Plan
- Step 6 – Implementation and Monitoring

14. CEL 32 (2011) is used by NHS Boards as part of the service improvement methodology to identify key workforce issues that support future models of care/ service delivery and how they will ensure the highest quality of care for patients. It also provides a tool to:

14.1 Ensure closer integration between NHS Boards and social care providers in planning the wider workforce.

14.2 Identify the key learning and educational needs of the existing and future workforce, the evidence of which will inform national education and training requirements.

14.3 Reference the evidence and material that will support the wider planning agenda (including finance and service planning).

14.4 Ensure that in developing workforce plans they support corporate goals and objectives.

14.5 Take account of the guiding principles of workforce planning.

#### NHS Board Workforce Projections

15. Future demand for NHS staff groups is estimated by NHS Boards in their workforce plans and workforce demand projections, which take into account factors such as changing models of care and patient demography. With advances in medicine, new technology drug treatments, and new ways of delivering services, medium to long term numerical projections are challenging. However, as the majority of the future workforce is the current workforce, projected workforce planning needs to allow for the development of the existing workforce to meet future predicted population and service need.

#### Nursing Workload and Workforce Planning Tools

16. These planning tools help determine the right number of nurses and inform future workforce requirements depending on clinical needs of the patients and the particular specialty areas. The application of these tools has been mandatory for all

boards since April 2013. Developed in partnership with staff representatives, and endorsed by RCN Scotland, a suite of 12 workload tools is now available for use on the IT platform covering 98% of all clinical service areas.

17. All Boards are using the tools where available and where applicable. Recent national run of both mental health tool and maternity tool has supported Boards to make informed decisions on their nursing and midwifery workforce numbers. A national run of the paediatric tool will take place during the summer.

#### Medical Workforce Planning and Profiling

18. Over the last year the Scottish Government has created medical specialty profiles which pull together comprehensive data from a number of sources to provide concise and up to date information on each individual medical specialty workforce at both trainee and consultant level.

19. The work has been strengthened further in being part of the Medical Supply and Demand work stream within Health Workforce Directorate, and falling within the remit of the Scottish Shape of Training Transition Group including support and endorsement from NHS Boards, NES, BMA and Medical Royal Colleges.

20. The information yielded by the profiles is used not only to inform trainee establishments and intakes, but also to support:

20.1 Pre-emptive, targeted and strategic approaches to management of rota gaps and service pressures;

20.2 Better recruitment responses to “hard to fill” posts;

20.3 The transition to Shape of Training (ie in the context of the wider “Greenaway” UK reforms to medical education and training);

20.4 Workforce components of the Sustainability and Seven Day Services programme;

20.5 The National Review of Out of Hours Primary Care; and

20.6 The preparation of submissions to the Migration Advisory Committee in responses to real or perceived national (UK and Scotland-wide) shortages.

21. In future, these profiles will give a much better understanding of the complex supply and demand drivers operating in these areas across NHSScotland. Profiles have been completed for all established hospital specialties and are being used to adjust training numbers to meet future trained doctor demand.

#### Improving Workforce Planning

22. At the beginning of this year, NHS Board workforce planners discussed the recommendations contained in a “Pan Scotland Workforce Planning report”. The recommendations have now been prioritised and suggested ways on how best to implement them have been identified.

23. On 9 March, the HR Executive Forum approved a series of 6 actions to improve NHS workforce planning to be immediately progressed, with tangible outcomes deliverable within the next financial year. These include:

- 23.1 Reviewing current SG guidance on NHS workforce planning and projections;
- 23.2 reviewing how vacancies are recorded and reported nationally;
- 23.3 Establishing a Scotland-wide perspective on the use of job planning and eRostering systems;
- 23.4 Ensuring a collaborative approach to national NHS workforce data and intelligence via a “workforce observatory”;
- 23.5 Employing consistent data coding at Board level; and considering direction on workforce planning for Integrated Joint Boards.

**Some of the thinking and calculation that goes into the rational allocation model looking at short and long term planning including beyond 2020 (Column 30)**

24. The reference to „a rational allocation“ model was a description which John Connaghan (NHSScotland Chief Operating Officer) used to describe a process outlined by Mr Mike MacKenzie MSP, and not a reference to any specific model in use.

25. As the Committee is aware, the Scottish Government carries out its own Budget processes each year, where funding allocation to each of the major portfolio areas are decided. These are based around the Government’s key priorities as set out in the Programme for Government, and the rationale for spending choices is clearly set out in the Budget documents. Further background is available from the most recent Draft Budget for 2015-16 in the Health and Wellbeing Chapter.

26. The Draft Budget makes clear that spending decisions are driven by the priorities of the 2020 Vision:

„Our actions and spending plans, prioritised in pursuit of the 2020 Vision for Health and Social Care, make a vital contribution to our commitment to the four pillars of public service reform set out in our response to the Christie Report.“ [Draft Budget, Chapter 4].

27. Once the total budget for health has been decided, funding allocations to territorial boards are informed by the NRAC formula, which is an evidence-based, weighted capitation formula which aims to allocate funding equitably across all boards in accordance with their population numbers and the needs of those populations. This provides funding to NHS Boards for the provision of Hospital & Community Health Services (HCHS) and GP Prescribing. The formula calculates target shares (percentages) for each NHS Board based on a weighted capitation approach that starts with the number of people resident in each NHS Board area. It then makes adjustments for the age/sex profile of the NHS Board population, their additional needs based on morbidity and life circumstances (including deprivation) and the excess costs of providing services in different geographical areas. This is the allocation model in use. Thereafter, NHS Boards manage their budgets in accordance with local arrangements but are held to account by the Scottish Government through established performance management arrangements. However, as noted in evidence to the Committee by John Matheson there is an

important point about not micromanaging the boards" financial planning and financial allocations as well as giving them a degree of flexibility at local level.

28. Further information is available in the Resource Allocation Formula is available from ISD Scotland.

### **Further information on CHAS funding (Column 32)**

29. NHS funding for CHAS is administered through NHS Tayside. CEL 12 (2012) (attached separately) sets out the funding arrangements for independent hospices and includes at paragraph 19 a statement that "there is further intent that NHS Boards and local authorities will jointly meet 25% of the running costs of the independent children's hospices which provide specialist palliative care and respite services for children with life limiting conditions". CHAS provided information to the Children's Health Commissioners on funding that stated their NHS funding for 2013-14 was £655,000, whilst their CHAS care costs were £9 million, therefore the percentage of care costs met by NHS was c7.2%. This is because not all CHAS running costs are included in the commissioning discussions with NHS Boards. The expanding service CHAS provide was recognised by the Interim Director of Finance of NHS Tayside, Lindsay Bedford in the Health and Sport Committee evidence session of 9 June 2015 (column 27) where it is noted that "there is a commitment to revisit the baseline and confirm the agreed hospice running costs".

30. The limited data about the numbers of children and young people requiring palliative and end of life care means that it has been difficult for CHAS to provide evidence of the need for their services and the specialist nature of what they provide compared to palliative care provided by Health Boards. The research which is due to be completed in October this year should go assist with this. CHAS has a separate agreement with COSLA regarding funding of some £700,000 per year.

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Chief Executives NHS Boards

By email



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27 March 2015

Dear Chief Executive

Following a series of discussions about job planning and the balance of activities in consultants' contracts, we agreed that there was a need for clearer guidance for the Service. I asked John Burns to take this forward and he has been working in consultation with the Scottish Academy of Medical Royal Colleges and Faculties. I am pleased that we now have revised guidance, which has taken on views from the BMA, and I am grateful to all who have been involved in producing it.

The revised guidance, which was issued by John on behalf of MSG yesterday, recognises the essential role our medical workforce plays in the delivery of high quality, safe and sustainable clinical care to patients and acknowledges that if we want to recruit and retain the highest quality of medical staff Scotland needs to be an attractive place for doctors to train and work.

It seeks to reinforce the importance of effective job planning achieving these aims and outlines how, in practical terms, NHSS employers will operate medical recruitment, appointment and job planning processes to ensure we attract and retain a high quality medical workforce.

A copy of the guidance is appended to this letter. I am convinced that this is a very useful step forward and I look to you to ensure its successful implementation.

Yours sincerely

**Paul Gray**



## Consultant Job Planning- New guidance for NHSS employers

1. NHS Scotland's primary purpose is to provide high quality, safe and sustainable clinical care to patients. The medical workforce plays an essential role in the delivery of patient care. Maximizing medical recruitment and retention is a high priority for Scotland if we are to provide world-class health care. To achieve this Scotland must be an attractive place for doctors to train and work and one which encourages and supports medical staff to develop and grow to their full potential and participate in the development and growth of others. As such Consultant posts must be designed to recruit and retain a high quality medical workforce.

2. This new guidance replaces the guidance issued by MSG in 2009 and 2010 and seeks to address significant concerns expressed by a range of bodies representing the medical profession including the Scottish Academy of Medical Royal Colleges and Faculties and BMA Scotland in relation to the allocation of Programmed Activities. It is not intended to change the consultant contract but seeks to reinforce the importance of job planning, as set out within the contract, in reflecting the way in which effective job planning is key to providing high quality, safe and sustainable clinical care to patients. It outlines how, in practical terms, NHSS employers will operate medical recruitment, appointment and job planning processes to ensure we maintain a high quality workforce.

3. Given the wide ranging contribution of consultants to the NHS both as individuals and as members of clinical teams, it is critical that job plans and job planning strike the right balance between direct clinical care commitments, contractual and regulatory requirements such as appraisal and revalidation, and other important activities undertaken in support of professionalism and excellence in medicine including:

- o Undergraduate and post graduate teaching/training (medical and non-medical),
- o Clinical governance,
- o Quality and patient safety,
- o Research and innovation
- o Service management and planning.
- o Work with professional bodies such as the Royal Colleges, including clinical examinations and standards.

4. Job plans will be required to accommodate the contractual and regulatory requirements associated with consultant posts and ensure that consultants' skills are utilised effectively in supporting other important activities, recognizing the positive impact of SPA PAs on the quality of direct clinical care to patients.

5. To give practical effect to the above NHS Scotland boards will ensure that:

- Full time Consultant posts in Scotland are advertised on the basis of 10 Programmed Activities, with applicants being advised in advance of the fixed clinical care sessions associated with the post in the job pack accompanying the advertisement.
- All Job plans must include a minimum of one SPA for activities associated with job planning, appraisal, and revalidation.
- Other activities as outlined in Section 3 above will require consideration about time allocation.
- The balance between different categories of PA activity must be clear in advance of the interview but can be the subject of discussion in the course of job interview or prior to contracts being agreed. These discussions should reflect the aims outlined in paragraph 1 above.

6. We affirm the valuable role of External Advisers in advising recruiting Boards at each stage in the process, including commenting and advising in advance on the appropriateness of job descriptions, on person specifications, on selection methodology and direct participation in the selection process.

7. The balance of all Programmed Activities will be subject to annual review through a well monitored, fair, and appropriate job planning process, in the course of which the balance between Direct Clinical Care and Supporting Professional Activities PAs will be discussed.

8. As part of the job planning process it is incumbent on both parties to produce evidence of activity in the period under review to support maintaining the status quo or planned change to the balance of PAs for the forthcoming year.

9. As part of routine clinical governance Boards will be required to monitor consultant working patterns, reporting to their Staff Governance Committees annually on the basis of collated, rather than individual data. This monitoring will be expected to demonstrate how agreed working patterns relate to the delivery of high quality, safe and sustainable clinical care to patients, strike the right balance in the allocation of Programmed Activities, and engender recruitment and retention.

10. Job planning processes will take full account of the principles outlined above in seeking to strike the right balance in the allocation of Programmed activities, not

just for newly appointed consultants, but for all consultants employed by NHS Scotland.

11. Consultants' role as part of a broader clinical team with a spectrum of clinical and professional interests and activities should be considered to achieve the appropriate balance in job plans.

# Academy of Medical Royal Colleges and Faculties in Scotland

**Chair  
Secretary**

Mr Ian Ritchie

**Vice Chairs**

Dr Frank Dunn  
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**Honorary**

Dr Miles Mack

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27 March 2015

**BY EMAIL**

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**Letter to Chief Executives to accompany the guidance to the NHS in Scotland**

Dear Colleagues

The Management Steering Group has recently issued guidance for Chief Executives and Boards about the implementation of job planning in the Scottish NHS.

This guidance emphasises the guidance in the existing contract agreed in 2004 at the UK level and removes any expectation that 9:1 job plans will be the norm.

The Scottish Academy is fully supportive of the move away from an expectation that 9:1 job plans should be widely applied.

Underpinning this is the principle that job planning is a dynamic process and job plans must be review at least annually. Furthermore, no allocation of PAs will remain unchanged or unchallenged over a consultant's career.

The Scottish Academy encourages all consultants to engage actively with their employing organisation in the job planning process with the expectation that any change in the allocation of PAs for supporting professional activities will require consideration of the evidence that will be needed to justify a change. It will also be necessary to provide evidence of work achieved following the award of SPAs.

The Scottish Academy will be reviewing the effect of this guidance through the External Adviser network in the coming months with an anticipated annual review by the Scottish Academy.

With kind regards.

Yours sincerely



**Ian K Ritchie**  
**Chair**

Dear Colleague

## REVISED WORKFORCE PLANNING GUIDANCE 2011

### Purpose

1. To provide NHS Boards (and their component services) with a consistent framework to support evidence based workforce planning. The key aims of this framework are to ensure the highest quality of care for patients by ensuring NHSScotland has the right workforce with the right skills and competences deployed in the right place at the right time.
2. This guidance is designed to support and assist those responsible for leading on workforce planning, in particular the development of workforce plans at service, NHS Board and regional level. The guidance will also be of assistance to those in other areas of planning, most notably within financial and service planning functions, and in integrating health and social care planning.
3. This guidance supersedes [HDL \(2005\) 52](#).

### Background

4. Workforce planning is a statutory requirement and was established in NHSScotland (NHSS) in 2005 with the issuing of HDL (2005)52 "National Workforce Planning Framework 2005 Guidance"<sup>1</sup>, which provided NHS Boards with a base for establishing workforce planning as a key element of the wider planning systems within NHSS.
5. The original HDL was developed at a time when workforce planning was a new development in NHSScotland. There has been discussion at NHS Board level for some time about the need to refresh the workforce planning guidance and to ensure that the methodology could be used by other areas of planning, most notably within financial and service planning. Particularly as we are seeing significant changes in the skill mix of staff groups and consequences of changes in one staff group on other groups it is crucial that NHS Boards use the evidence available to them to develop their workforce plans and workforce projections.
6. This refreshed guidance was drafted by a Drafting Group which included NHSScotland colleagues, partnership representation and Scottish Government.

**CEL 32 (2011)**

**19 December 2011**

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### Addresses

#### For action

Chief Executives, NHSS  
Directors of Human  
Resources, NHSS  
Directors of Finance NHSS  
Workforce Planners, NHSS

#### For information

Scottish Partnership Forum  
Members  
Scottish Workforce And Staff  
Governance Group Members  
(SWAG)  
Employee Directors, NHSS  
Directors of Nursing, NHSS  
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<sup>1</sup> <http://www.scotland.gov.uk/Publications/2005/08/30112522/25230>

## Healthcare Quality Strategy

7. This guidance sits within the Healthcare Quality Strategy for NHSScotland (published in May 2010)<sup>2</sup> which aims to build upon quality healthcare services in Scotland and ensure all work is integrated and aligned to the Quality Ambitions<sup>3</sup> with measurable improvements which include patients' experience to deliver the highest quality healthcare services to people in Scotland and in doing so provide recognised world leading quality healthcare services. This guidance will help NHS Boards to demonstrate in their Workforce plans how they contribute to better quality of care and outcomes for patients and deliver the Quality Ambitions.

### Six Steps Methodology Format

8. The format of the guidance reflects the 6 Step Methodology<sup>4</sup> to Integrated Workforce Planning and contains workforce planning checklists at each step of the process and signposts to other data and information sources that will be of particular help in ensuring that workforce plans are evidence based.

9. This guidance (provided in Annex A) should be used by NHS Boards as part of the service improvement methodology to identify key workforce issues that support future models of care/ service delivery and how they will ensure the highest quality of care for patients. It also provides a tool to:

- Ensure closer integration between NHS Boards and social care providers in planning the wider workforce.
- Identify the key learning and educational needs of the existing and future workforce, the evidence of which will inform national education and training requirements.
- Reference the evidence and material that will support the wider planning agenda (including finance and service planning).
- Ensure that in developing workforce plans they support corporate goals and objectives.
- Take account of the guiding principles of workforce planning (as set out in Annex B).

### Workforce Projections

10. The guidance and six steps methodology refer to workforce projections as part of the wider workforce planning process and you will be aware that SGHD has required NHS Boards to submit projections annually for several years, in part to enable us to develop a national picture of likely trends across all staff groups but specifically to inform annual student intake to the "controlled" groups (medical, dental and nursing and midwifery). You will also be aware that the projections exercise in 2011 raised a number of issues around the challenges of making meaningful projections for year 5 in current circumstances. We have reflected on that and will make changes to the process from next year. We will continue to issue a template for workforce projections, which will include specific guidance on coverage and completion, but will require detailed projections for most staff groups for a 3 year period only. This will align the projections exercise with the normal Spending Review period which provides a higher degree of planning certainty than could be offered for the longer term. The longer term continues to be important. However, in terms of SGHD setting undergraduate numbers for the "controlled" staff groups of medical, dental and nursing and midwifery. Medical and dental are already subject to separate longer term planning processes from which undergraduate intake is derived and those groups have therefore been excluded from the longer term element of workforce projections in recent years. For next year and beyond, we will similarly undertake a

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<sup>2</sup> <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality/QualityStrategy>

<sup>3</sup> <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality/qualityambitions>

<sup>4</sup> [http://www.healthcareworkforce.nhs.uk/resource\\_library/latest\\_resources/six\\_steps\\_refresh.html](http://www.healthcareworkforce.nhs.uk/resource_library/latest_resources/six_steps_refresh.html)

parallel review of nursing and midwifery workforce over the longer term in order develop more robust recommendations to Ministers on student nurse and midwifery intake.

## Summary

11. Significant progress has already been achieved and workforce planning has demonstrated a flexible, integrated approach with service and financial planning arrangements to meet the demands of NHSS. This revised guidance will not only help support those involved in developing workforce plans and projections but will also support workforce planning capability by providing of a consistent framework, and lead to a further step change in workforce planning across NHSS and social care providers.

## Timing

12. This guidance should be used for the development of NHS Board Workforce Plans from 2012. NHS Boards should publish their Workforce Plans on their NHS Board's website by 30 June of each year and submit their workforce projections to Scottish Government on the agreed template, which will be issued in due course, by the same date.

## Action

**13. NHS Chief Executives are asked to ensure that the framework provided is used to develop their Board Workforce Plans from 2012 and specifically to ensure:**

- That integrated workforce planning is effectively undertaken to meet local, regional and national requirements.
- Workforce planning leads are identified to co-ordinate workforce planning and the development and reporting of workforce plans within NHS Boards.
- NHS Board Workforce Plans identify how they contribute to the highest quality of care for patients as set out in the Quality Strategy.
- That NHS Boards have systems in place to support the provision of quality workforce data, and the delivery of the National Data Quality Standard.
- NHS Board Workforce Plans have been developed in line with local partnership and staff governance arrangements as well as reflect an integrated approach with other planning agendas at local, regional or national levels. This is particularly important in demonstrating the integration with social care providers.
- For the nursing and midwifery workforce, professional validated workload measurement and workforce configuration tools should be used. NHS Boards should reference the national nursing and midwifery workload and workforce planning tools (as appropriate) used in deriving the nursing numbers for each clinical area (as appropriate). These tools should be used as part of the triangulated approach incorporating professional judgement with quality measures.

Yours sincerely



RICKY VERRALL  
Deputy Director for Workforce Planning and Development

## REVISED WORKFORCE PLANNING GUIDANCE 2011 – REFRESH OF HDL 52 (2005) WORKFORCE PLANNING FRAMEWORK

### Background

1. Workforce Planning has progressed significantly since 2005 and now supports a strategic and longer term portfolio encapsulating core elements of service and financial planning, identifying education and training needs, socially responsible recruitment and issues around workforce sustainability. This allows for factors influencing developments within the public sector, particularly in areas such as service redesign, the appropriate deployment of staff and the achievement of productivity and efficiency targets.

### Why we workforce plan

2. Effective workforce planning ensures that services and organisations have the necessary information, capability, capacity and skills to plan for current and future workforce requirements. This means planning a sustainable workforce of the right size, with the right skills and competences, which is responsive to health and social care demand and ensures effective and efficient service delivery across a broad range of services and locations. This is particularly important as an increasing amount of service is moving towards community based care.

3. The constantly changing dynamics of service provision and a mobile labour market make it challenging to achieve perfect alignment of workforce supply and demand. However, by applying a systematic and consistent approach to workforce planning, NHS Boards can anticipate and respond proactively to changes in workforce supply and demand. Workforce planning also relates to the preparation of our existing workforce to meet future service need through education and development pathways.

4. The collection and analysis of this workforce evidence and information at national level (including the staff projections exercise using the agreed template) enables the Scottish Government and education providers to have a comprehensive picture of skill requirements across the NHSScotland workforce. This process also identifies a national picture of workforce availability, identifies any hard to recruit to posts and covers all staff employed in NHSS. The process also covers the non-clinical workforce and will be used to support the national commissioning processes for medical, dental and nursing and midwifery training.

5. The term *Workforce Planning* can be used to describe a number of different yet related activities, these being:

#### Designing the future workforce

This is not just about service redesign and workforce alignment, but understanding and influencing the impact that redesigned and new services will have on the current or future workforce - ensuring that these workforce implications are considered as part of the service and financial planning process.

#### Developing the future workforce

This is about understanding what skills and competences will be needed to deliver service redesign and new services, where these skills and competences will come from and making provision to develop these skills and competences if they are not already available within the current workforce. This includes education commissioning, staff development, plus the recruitment and retention process.

#### Delivering the future workforce

This is about the management actions which are needed to ensure that the workforce is engaged, that new ways of working are achieved, that workforce development plans are delivered and that best practice is shared and adopted.



## NHS Board Workforce Plans

6. Although workforce planning is an ongoing process, **NHS Board Annual Workforce Plans should be signed off by the NHS Board Chief Executive and formally published on NHS Board's websites by 30 June of each year.** The structure of these workforce plans should reflect the steps provided in this guidance.

7. NHS Boards should ensure that the workforce planning principles lie at the heart of their approach, in particular applying the tests, where possible, of **affordability, availability and adaptability** in developing sustainable and robust outcomes (definitions included in Glossary).

8. Changes to the economic climate may also impact on the wider population in relation to the health of the population. Workforce plans should therefore make reference to local labour markets and describe strategies that support socially responsible recruitment, which underpins local economies and the health inequalities agenda.

## Regional Workforce Planning

9. The methodology and process provided in this refreshed guidance (CEL 32 (2011)) can be used at local, regional or national level and the NHS Board Workforce Plans developed using it will support and inform regional workforce planning.

## NHS Board Workforce Projections

10. Workforce projections (part of Step 3) only present part of the picture in predicting workforce requirements. With advances in medicine, new technology and drug treatments, and new ways of delivering services, medium to long term numerical projections are challenging. However, the majority of the future workforce is the current workforce, therefore projected workforce planning needs to allow for the development of the existing workforce to meet future predicted population and service need. It is the skills the workforce possesses, that will support the quality and governance agenda. Workforce education priorities can be identified through population and service profiles, and used to inform workforce personal development planning and education and training.

11. Detailed **NHS Board Workforce Projections should be submitted to the Scottish Government on the agreed template, which will be issued separately, by 30 June of each year.** The detailed narrative contained within the NHS Board Workforce plans will inform the completion of the template. Completed templates will be signed off by the NHS Board Chief Executive. In the case of the Nursing & Midwifery workforce projections, the Board Nurse Director should have professional oversight of the numbers and endorse these as part of the NHS Board Workforce Plan. NHS Boards should provide details of the workload/workforce planning tools used (where available) in the planning of their nursing and midwifery workforce.

12. SGHD will issue a template for workforce projections annually, which will include specific guidance on coverage, time horizons and completion. NHS Boards' projections, alongside the actions identified in workforce plans, should be informed by consideration of the short, medium and long terms (see Step 5 at Annex A) but detailed projections for most staff groups will be required for a 3 year period only, to align with the usual Spending Review period. Longer term workforce trends for the groups for which student intake is "controlled" (medical, dental and nursing and midwifery) will take into account the 3 year projections and other elements of NHS Boards' workforce plans, but will be considered further in more detailed parallel processes from which annual student intake numbers will be derived.

## Workforce Data Quality

13. The quality of workforce data impacts on all workforce related organisational decisions, including the measurement of performance, for example sickness absence and workforce productivity and efficiency. A great deal of progress has been made in relation to

data quality both at local and national level, but it is imperative that NHS Boards have in place adequate structures to effectively produce, manage and maintain data quality. NHS Boards need to be able to demonstrate implementation of the National Data Quality Standard, and have robust systems in place to provide assurance that all staff involved in the workforce data coding are working to the required standard. NHS Boards should also have systems to identify and rectify data inaccuracies.

14. To ensure the continued improvement in the quality of workforce information and the delivery of the National Data Quality Standard, it is important that NHS Boards make sure provisions are in place to ensure the accurate capture of workforce information. Each NHS Board should have an identified lead to ensure data quality and workforce information, is monitored, and accurately captured on an ongoing basis.

15. NHS Boards will be required to establish information systems which allow for benchmarking across NHSS. In addition, NHS Boards will utilise consistent national data sources to align population and labour market information to inform workforce planning and education and training priorities.

### **Staff Governance and Partnership Arrangements**

16. Workforce Planning is a key component of the NHSS Staff Governance Standard<sup>5</sup> in terms of underpinning the delivery of efficient and effective patient centred services across NHSS. Boards should evidence how workforce planning has been embedded in the partnership working agenda and demonstrate workforce and partnership engagement in the development of workforce plans.

17. NHS Board and Committee papers should include ongoing assessments of any workforce implications as part of core business to ensure workforce demand and supply profiles remain reflective of organisational developments. This should also include an ongoing assessment of education and training needs.

18. In line with Equality and Diversity requirements, NHS Boards should ensure a Rapid Impact Assessment/Planning for Fairness Process is applied prior to the publication of workforce plans.

### **Drivers for Change**

19. Workforce plans should articulate the drivers for change and 'levers' and the impact these will have on the future workforce and ultimately on the provision of future services. These drivers for change and 'levers' will have an impact on the levels of demand for future workforce numbers and skills as well as the ability to ensure a ready supply of workforce resources.

20. Everything that happens in NHSS should be in line with the ambitions of the Quality Strategy and should contribute to measureable improvement. NHS Boards should consider how their workforce plans acknowledge the Quality Strategy Quality Outcomes that in turn represent the key outcomes we expect to achieve in pursuit of the three Quality Ambitions. NHS Boards should articulate how these may impact on future services identifying workforce solutions that ensure:

- People have the best start in life and are enabled to live longer healthier lives
- People are supported to live well at home or in the community
- Everyone has a positive experience of healthcare
- All staff feel supported and engaged
- Healthcare is safe for every person, every time
- Best possible use is made of available resources

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<sup>5</sup> <http://www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard/>

21. As a companion document to the Quality Strategy, the Efficiency and Productivity Framework<sup>6</sup> for SR10 (published February 2011) provides the direction of travel for NHSS to improve quality while reducing overall cost.

### **Demographic Influences**

22. The changing pattern of Scotland's future demographic profile will play a pivotal role in shaping the number and type of health services required as well as how and where these will be delivered. It is imperative that in developing fit for purpose workforce plans, NHS Boards are able to demonstrate how changes in future service demand and workforce supply based on population need can be managed. Annex D provides some suggested data sources.

### **Education and Training**

23. A core element of NHS Board workforce planning function is the identification of organisational education and training requirements to ensure the workforce has the capability and competency to meet current and future service and population need. The national aggregation of this data will influence commissioning and provide a regional picture of supply variances and education requirements.

24. An appropriately skilled, competent and deployed workforce is essential to achieve performance targets and meet local, regional and national objectives. Therefore integration with service and financial planning systems is essential to ensure that the workforce impact is accounted for as an integral component of integrated service planning.

### **Workforce Planning Capacity and Capability**

25. Investment in workforce planning education has been made at NHS Board and national level. This has embedded workforce planning within NHSS and enabled the sharing of responsibility across a range of services and professions, thereby ensuring a step change in workforce planning capacity and capability across NHSS.

26. More specifically workforce planning will:
- Ensure corporate ownership and support organisational goals and objectives.
  - be consistent and evidence-based
  - Operate out-with traditional boundaries and across NHSS and other public sector partners.
  - Support service re-design, new ways of working and achieving key targets. .
  - develop and deploy the workforce based on population need
  - Focus on future staffing requirements linked to issues of productivity and efficiency.

### **6 Steps Methodology**

27. The 6 Steps Methodology sets out a consistent, practical framework that outlines the elements that should be contained in workforce plans whether they are at service, NHS Board or Regional level. The guidance provided in Annex A describes the components which should be included in each part of the NHS Board Workforce Plan.

**December 2011**

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<sup>6</sup> <http://www.scotland.gov.uk/Resource/Doc/341668/0113614.pdf>

## **6 Steps Methodology Guidance**

The following guidance outlines the components that should be included in each step of the NHS Board Annual Workforce Plan.

### **Step 1 - Defining the Plan**

This is the first step in any planning process. NHS Boards should stipulate why a workforce plan is necessary and how it will support the achievement of wider corporate goals and objectives. The purpose, scope and ownership of the workforce plan should be made explicitly clear within this section. To support this, the following information/ data should be considered/ acknowledged at this stage.

Within this section, NHS Boards should provide:

- An overview of the organisation, including, the geography and lay out of the NHS Board area. In addition information on the number and type of services provided along with information on the overall size of the workforce should be provided.
- A clear statement on the purpose and objectives of the workforce plan should be outlined at this stage. This must reflect how the workforce plan links to the achievement of the main goals and objectives of the organisation and in turn supports consistent corporate communication.
- A description of the agreed outputs to be achieved from developing the workforce plan and how these will impact across other service areas within the NHS Board should be highlighted.
- A description of the workforce engagement and partnership working and consultation which supports the Workforce Planning function.
- A description of the Workforce Planning process adopted including reference to agreed governance arrangements and details of workforce engagement and Partnership involvement.
- An update on the actions identified from the previous year's Workforce Plan, indicating any timeframes set against those actions that are being carried forward.

### **Step 2 - Service Change**

This section should indicate the goals and benefits of change, the future context for how services will be delivered, identify the options for future service delivery, the drivers for and/or constraints against future changes and what any preferred option(s) might look like.

This step is an excellent way of ensuring appropriate engagement with a range of stakeholders in the planning process. From here it is possible to determine the specific benefits, goals and objectives of any future service delivery. It is also possible to begin to create a range of service scenarios for the future and how this may specifically impact on the workforce.

Care must be taken not to unduly replicate information that is available in other plans such as the Local Delivery Plan (LDP), finance plan, service plans etc. The intention is not to duplicate reams of information but to ensure that underpinning information and context is taken into consideration.

Within this section, NHS Boards should:

- Describe what the future population profile may look like and highlight the comparison with the current configuration. Reference any data and information gathered from sources such as the General Register for Scotland (GRO). A list of helpful key data sources is provided in Annex D. Need to be mindful that demographic intelligence may vary considerably between NHS Board, regional and national boundaries.
- Make specific reference to any population priorities and/or disease profile for their NHS Board area making reference to appropriate data sources such as the Director of Public Health Annual Report, Scotpho and ISD Scotland (Annex D).
- Describe any known current financial issues facing the organisation as well as those anticipated in the medium to long term. This should already be reflected as part of the Finance Plan and the Local Delivery Plans.
- Describe any major service changes or changes resulting from service redesign which will or are likely to be taken forward in the future, articulating the impact these may have on the future workforce configuration.
- Describe any additional drivers and constraints on the delivery of future services. These would include issues such as economical environment, the political landscape, therapeutic advancements, patient attitudes/expectations, care/service pathways, changes in service location etc.
- Describe the corporate goals and/or targets that will impact on the workforce planning agenda and vice versa. Examples should include Health Efficiency, Access and Treatment (HEAT) targets<sup>7</sup>, LDP, the Quality Measurement Framework and any agreed workforce productivity and efficiency targets.
- Describe the key strategies which are influencing service demand and configuration.
- Describe the workforce implications from strategic projects/developments already agreed by the NHS Board – set out in an action plan with short, medium and longer term timescales.
- Consider any integrated services with key partners including for example links with social care.
- Highlight any local issues being resolved across NHS Board boundaries with partner agencies and/or on a regional basis, e.g. Managed Clinical or Obligate Networks.

### **Step 3 – Defining the Required Workforce**

This step should outline the workforce required to meet the predicted service needs and requires all of the key issues local and national which will impact on workforce design and deployment to be taken into account.

Within this section, NHS Boards should:

- Describe the required skills and competencies respond to predicted population and service need, with the objective of establishing a responsive competency based workforce.
- Highlight any workforce reporting requirements as well as any agreed workforce projections.

<sup>7</sup> <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273/targets>

- Describe the need for changing skill sets influenced by, for example, further shifts towards neighbourhood based care, demographics, changes in treatment pathways and technical and medical advances. The geography of service provision should also be accounted for as these may have an impact on the design of the workforce, the availability of the required skills with the local area, the availability of training provision, and the adaptability and retention of staff.
- Use modelling tools such as the Workforce Modelling Tree approach provides a useful planning tool that can be used to visualise and model the current and future shape and size of the workforce, showing ratios and cost.
- Ensure there is parity across the Career Framework in describing vocational and professional qualifications and development needs of staff. The Scottish Credit Qualification Framework<sup>8</sup> will act as the central framework to establish the required level of education for staff.
- Describe the requirements for new roles. The declaration of this within NHS Board Workforce Plans allows for alignment with other NHS Boards undertaking similar work, it also allows NHS Education Scotland (NES) to be informed of development need.
- Workforce projections are part of this Step and will be collected by completing the template agreed by Scottish Government. The use of professional validated workload measurement and workforce configuration tools should be used to assist the calculations. For the nursing and midwifery workforce NHS Boards should reference the National Nursing and Midwifery workload and workforce planning tools (as appropriate) used in deriving the nursing numbers for each clinical area (as appropriate). The tools should be used as part of the triangulation approach incorporating professional judgement with quality measures.
- Describe the systems and forums they have in place to establish data quality standards and to resolve identified data quality issues.
- It is important to acknowledge that projections do not just relate to numerical or short term affordable projections. The projections should also relate to the preparation of existing workforce to meet future service need through education and development pathways.

#### **Step 4 – Workforce Capability**

This section should describe the characteristics of the current workforce (i.e. baseline data), how any supply data can inform workforce forecasting and to identify what options can be implemented in managing future supply.

Within this section, NHS Boards should:

- Describe the provision of available workforce data to inform the development of the workforce plan. NHS Boards should also share what data quality measures have been put in place along with local governance arrangements that allow for robust workforce planning outcomes.
- Undertake to present a profile of the workforce covering individual staff/ professional groups. One of the options at this stage would be to present the profile of the workforce in the form of a Workforce Tree model.

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<sup>8</sup> <http://www.scqf.org.uk/The%20Framework/>

- Highlight any trend data on vacancies outlining any known recruitment hotspots as well as an indication as to whether this is a local, regional or national issue.
- Provide an outline on the expenditure and usage associated with supplementary staffing. This would include analysis on Bank, Agency and Locum deployment.
- Highlight the expenditure made against overtime, excess and part-time hours; and enhanced hours.
- Outline the breakdown of contracted sessions for the Consultant workforce, with particular reference to Direct Clinical Care (DCCs), Extra Programmed Activities (EPAs), Supporting Professional Activities (SPAs) etc. Further information stemming from the Consultant Job Planning process should also be highlighted at this stage (at data level which does not identify individuals).
- Review the local economy, in particular the available labour market, making reference to any labour market statistics including issues such as youth unemployment.
- Describe socially responsible recruitment practices being undertaken/ proposed that may support the appropriate supply of workforce in the future. Examples would include Work Experience placements, Modern Apprenticeships and local initiatives such as the Health Academy model where clear, structured and supported pathways have been developed to enable people from marginalised groups to access employment opportunities.
- Describe any known or projected skill gaps across service/ staff group boundaries making reference to the NHS Career Framework. This has the potential to be aggregated by Scottish Government to present a Scotland wide picture that would support the need for any specific education and training initiatives to be deployed at a local or national level.

## Step 5 – Action Plan

Developing your NHS Board action plan is a high priority in the process because it identifies the actions and sets out how these will be progressed and managed by the NHS Board.

Within this section, NHS Boards should:

- Set out actions indicating whether they are short, medium or longer term, relating to the following time periods:

Short Term – up to 1 year

Medium Term – 1-3 years

Long Term – 3-5 years +

- Describe NHS Board progress on Actions from the previous Workforce Plan (also covered in Step 1). The template for the NHS Board action plan is provided in Annex C.
- Describe the Education & Training priorities. An integrated education and training plan should be part of the NHS Board Workforce Plan; this allows for education and development priorities to be established and understood both at local and national level.
- Describe the detail of the NHS Board Workforce Data Quality Plan and describe the structures which are in place to support the provision of data quality.

- Demonstrate workforce planning capability by describing the Board Workforce Planning structure to demonstrate the credibility, capability and competence of workforce planning function to the Scottish Government.
- Include a Knowledge and Skills/Gap analysis across the career framework aligned to the Scottish Credit Qualifications Framework (SCQF), Career Framework<sup>9</sup>, KSF and national occupational standards to determine the different education levels required.
- Highlight hard to fill posts or any workforce issues that could be progressed at national level. This will enable the Scottish Government to establish an accurate picture of workforce challenges across NHSScotland.
- Describe the NHS Board intervention to support socially responsible recruitment helping line with tackling health inequalities and supporting local economies and infrastructure.
- Outline the NHS Board skills registers/redeployment lists to ensure that the available workforce resource is able to contribute to its potential. The majority of staff for redesigned services will already be in NHSS employment and will be matched to meet service need with the requisite skills and competences required being delivered through training and support.
- Describe future workforce shape and size of the workforce through the use of the agreed projections template (collected by Scottish Government).
- Ensure that actions and progress on stated actions are described each year, so that no actions can be removed without description of progress or amendment. This will demonstrate ongoing iterative workforce planning.
- Highlight that the NHS Board recognise the importance of outlining education requirements in a consistent way that enables NES, Skills for Health and the wider educational sector to aggregate need and develop responsive education solutions.
- Describe the risks associated with the NHS Board Annual Workforce Plan and any steps taken to mitigate or remove these risks.

## **Step 6 – Implementation and Monitoring**

Step 6 is the monitoring process for plans, it also allows for reflection on actions and taking account of any new drivers and any unintended consequences of developments.

The NHS Board Action Plan should be iterative, therefore the actions that are described as short, medium and long term should progress in relation to the immediacy as each year's action plan is developed e.g. medium term, will progress to short term. The monitoring process will be through the agreed NHS Board Committee structure and through Scottish Government monitoring and reporting.

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<sup>9</sup> <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/nhsworkforce/Framework>



## **Guiding Principles of Workforce Planning – operational**

Workforce Planning will:

- Use the 6 steps approach to ensure it is efficient and effective
- Will normally be led by Workforce/HR in NHS Boards.
- Integrate with service and financial planning, as well as other planning systems such as educational and training planning.
- Apply the tests of Affordability, Availability and Adaptability.
- Designing, Developing and Delivering the future workforce
- Improve the balance and alignment of demand and supply, by ensuring that an evidence based approach is used to inform workforce planning.

Dimensions:

- Is an ongoing process
- Is part of the service improvement methodology
- Involves partnership colleagues, finance and service colleagues from across the NHS Board supported by the Chair, Chief Executive and Director of Finance.
- Takes account of any workforce targets

Action Plan Template (see Step 5)

Annex C

	Description of Action	Lead	Timescale for implementation (Short, Medium or Long term)	Description of Potential impact on Workforce	Financial resources required	Progress towards implementation
1						
2						
3						
4						
5						
6						
7						
8						

## Key Sources of data

Scotpho - <http://www.scotpho.org.uk/home/home.asp>

Community Benchmark Tool -

The tool can be accessed by NHS staff via the following web link;

[www.show.scot.nhs.uk/workforce](http://www.show.scot.nhs.uk/workforce)

Projected Population of Scotland (2008 Based) - General Register for Scotland

<http://www.gro-scotland.gov.uk/statistics/theme/population/projections/scotland/2008-based/index.html>

ISD Scotland ([www.isdscotland.org](http://www.isdscotland.org))

NHS Education for Scotland ([www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk))

Labour Market Statistics ([www.scotland.gov.uk/Topics/Statistics/Browse/Labour-Market](http://www.scotland.gov.uk/Topics/Statistics/Browse/Labour-Market))

Skills for Health ([www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk))

Centre for Workforce Intelligence ([www.cfwl.org.uk](http://www.cfwl.org.uk))

Scottish Public Health Observatory ([www.scotpho.org.uk](http://www.scotpho.org.uk))

SHOW ([www.show.scot.nhs.uk](http://www.show.scot.nhs.uk))

Higher Education Statistics Agency ([www.hesa.ac.uk](http://www.hesa.ac.uk))

Office of National Statistics ([www.statistics.gov.uk](http://www.statistics.gov.uk))

Annual Survey of Hours & Earnings ([www.statistics.gov.uk/statbase/product.asp?vlnk=13101](http://www.statistics.gov.uk/statbase/product.asp?vlnk=13101))

## Key Drivers for Change

On consultation with some NHS workforce planners, we have provided a list of drivers for change which may be relevant when producing your workforce plan and projections. The list is by no-means exhaustive, rather some basic guidance on what to consider when compiling the return. Full guidance is provided in HDL 52 (2005) (Step 2)

Driver	Description
Activity	Demographics, epidemiology, population projections, local & national health issues/aims
Local Service Changes	Proposed changes to delivery e.g. opening hours, location, required workforce
Retirements & Age Profile	Changes to legislation e.g. average retirement age, projections for staff behaviour & likely retirement ages
Service Sustainability	If no changes planned, what is the requirement to deliver a sustainable level i.e. backfill for attrition, increase in activity, potential difficulties in recruitment
Forthcoming Projects	Will any have a direct impact on workforce e.g. new build, significant redevelopment
Service Redesign	Skill mix changes, changes to service delivery e.g. Junior doctors being replaced with nurse specialists
Affordability	Efficiency savings impact, effect of

	incremental drift, internal savings targets, capital projects etc
Shrinkage	Items which will reduce the on-floor time e.g. sickness absence, training, secondments, annual leave etc.
Gender	Affect on contributory hours where applicable e.g. career breaks, maternity etc
Productivity & Efficiency	Changes to productivity, reducing requirement.
New guidance	Professional/Government guidance on minimum staffing levels, changes to skill mix, responsibilities etc
Targets	New targets from Government, internal aims affecting the required workforce e.g. 25% reduction in management
Advances & New Technology	Changes to procedures/processes affecting required staff, improvements in technology reducing staffing requirement
Turnover	Slowing/accelerating/static, affect on workforce
Benchmarking	Is your NHS Board's workforce trend in-line with other boards, are there reasons why it may be different, does it highlight any workforce issues?

## Definitions/Glossary

### Affordable, Adaptable and Available –

- **Affordable:** Workforce planning projections are affordable and offer value for money.
- **Adaptable:** The planned workforce is trained and supported, and plans fit with those for service redesign.
- **Available:** There are adequate sources of supply for the planned workforce.

**All medical specialties** – All medical specialties include hospital, community and public health medical specialties, but exclude dental hospital, community and public health specialties. Associate Specialist – A medical practitioner appointed to the Associate Specialist grade will have worked a minimum of four years as registrar, staff grade, clinical medical officer or senior clinical officer. Two of those years are in the relevant specialty. In total, the Associate Specialist will have 10 years of medical experience since graduating from medical school.

**Capability and competency** - Ability and knowledge or skill to do something successfully or effectively.

**Certificate of Completion of Training (CCT)** – A CCT confirms that a doctor has completed an approved training programme and is eligible for entry onto the General Practice Register or the Specialist Register <http://www.gmc-uk.org/doctors/aboutcct.asp>

**Employment** – An employee may hold more than one appointment in NHSS. Their appointments may be in more than one NHS organisation, in more than one region, in more than one specialty, or in more than one grade. The 'Employment' variable will count the employee under each organisation/region/specialty/grade they work i.e. the same employee may be counted more than once.

**Establishment** – Number of funded posts irrespective of whether the posts are filled or not. Establishment is calculated adding the number of staff in post and the number of vacancies at a point in time. It can be measured in WTE or headcount.

**Full-time** – A full time employee works the full weekly conditioned hours for the grade. This will be 37.5 hours per week under Agenda for Change. Under the New Consultant Contract, the 10 Programmed Activities or 40 hours are the conditioned hours for medical staff. Note that prior to the New Consultant Contract, those working a 'maximum part time contract' with 10 sessions and those working 11 sessions were recognised as 'full time'.

**Headcount** – Refers to the count of individuals, allowing some to hold more than one post in different organisation. When converting Whole Time Equivalent (WTE) to headcount using average WTE, decimals are rounded up to reflect that contribution will be delivered by one individual. For example, 1.2 converted headcount would be rounded to 2 individuals. Total headcount for NHSScotland will not be equal to the sum of the headcount working in the various NHS organisations. This reflects that some individuals work in more than one organisation.

**Integrated Workforce Planning** – Workforce Planning means having the right people, with the right skills, in the right place at the right time. An integrated workforce plan requires workforce planners to work closely with service and financial planners and takes account of the Local Delivery Plan. This will ensure a workforce plan, which meets the needs of the population and is affordable.

**Joiners** – The number of employees that join a substantive post, from another staff group, another NHS Board, someone who is new to NHSScotland or someone showing as having not worked in NHSS in the last 10 years would be classed as a 'joiner'. Someone showing up 9 years ago would count as a re-joiner.

**Leavers** – The number of employees that leave a substantive post to move to another staff group, another NHS Board or leave NHSS.

**Local Delivery Plan (LDP)** - LDPs provide details of:

- risks and risk management;
- planned levels of performance for each key performance measure;
- provides financial Templates

**Models of care** - Model of care is a multidimensional concept that defines the way in which health care services are delivered

**National Data Quality Standard** - National Data Standards are essential in order for the health and healthcare data held by ISD Scotland to be of high quality. They ensure that the data are collected throughout Scotland according to the same classifications and rules and the data is interchanged between systems consistently, robustly and securely.

**NHSS** – National Health Service Scotland

**Out of Hours** – The out-of-hours period is 18.30-08.00 on weekdays, all weekend and bank and public holidays.

**Part-timer** – A part time employee works less than the full weekly conditioned hours for the grade.

**Rejoiners** – The number of employees that worked in NHSS, had a minimum break of one year and then came back into NHSS.

**Socially responsible recruitment** – Poverty is the greatest determinant of ill health. Socially Responsible Recruitment is about interventions to support breaking the links between poverty and ill health, these include Healthcare Academies, and inclusive and equitable recruitment to ensure we have a workforce which reflects the population we service.

### **Staff groups**

- Clinical Staff group: This group includes Hospital doctors and dentists, General Practitioners, General Dental Practitioners, nursing and midwifery staff, Allied Health Professionals, ambulance staff, scientific, professional, and technical staff.
- Non-clinical Staff group: This group includes staff in the Administrative & Clerical, Ancillary, Senior Management, Trades and Works groups.

**Stock** - The headcount of individuals in a particular year.

**SWISS** – Scottish Workforce Information Standard System.

**Turnover Rate**– The number of 'leavers' during a defined period, e.g. 2009 and 2010 divided by the average number of staff in post over the period concerned. For the 2009/10 time period, the denominator is calculated as: (staff in post at 30 Sept 2009 + staff in post at 30 Sept 2010)/2.

**Vacancies** – Any unfilled post for which funding is agreed and a decision has been made to fill it; action to fill the post may or may not include advertising the vacancy.

**Waiting Times** – The difference in days from the date the decision was made by the referring person (General Practitioner, Consultant) that the patient should be admitted to the actual date of admission.

**Whole Time Equivalent (WTE)** – Calculated as contracted hours/conditioned hours. A widely accepted method of counting staff based on contracted hours taking into account part time working. If evaluating the overall contribution of a team of individuals who have different terms and conditions, it is necessary to measure contribution in terms of contracted hours. This approach was required for the Out of Hours case study given that General Practitioners and the other staff involved (Nurses, Paramedics, and Allied Health Practitioners) had different conditioned hours.

**Workforce Supply and Demand** – Supply is defined as the population seeking employment in NHS. Demand is defined as the Boards requirement for a particular staffing group.

**Workforce Tree** – Workforce trees provide a visual representation of the NHS workforce based on the NHS career framework.

Dear Colleague,

**A PARTNERSHIP FOR BETTER PALLIATIVE AND END OF LIFE CARE: CREATING A NEW RELATIONSHIP BETWEEN INDEPENDENT ADULT HOSPICES AND NHS BOARDS IN SCOTLAND**

**Summary**

NHS Scotland aims to deliver the highest quality of healthcare services to people in Scotland. This Chief Executives Letter (CEL) sets out new planning arrangements between NHS Boards and independent adult hospices. It reflects the recommendations set out in the report *A Partnership for Better Palliative and End of Life Care: Creating a New Relationship Between Independent Adult Hospices and NHS Boards in Scotland*

<http://www.scotland.gov.uk/Resource/Doc/924/0111432.pdf>

The recommendations in the report were endorsed by the Scottish Government in Living & Dying Well: *Building on Progress*. This CEL supersedes NHS HDL (2003) 18 - Funding of Specialist Palliative Care Provided by Independent Voluntary Hospices in Scotland.

**Action**

NHS Boards should ensure that:

- copies of the report and this CEL are made available to interested parties, but in particular to NHS Board Executive Leads for Palliative and End of Life Care
- interested parties are aware of the background and strategic context of this CEL
- commissioning arrangements for adult independent hospice provision follows the guidance outlined in this CEL
- commissioning arrangements support quality improvement, efficiency and effectiveness.

Yours sincerely

Jill Vickerman  
Policy Director, the Quality Unit

**CEL 12 (2012)**

**May 2012**

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**Addresses**

For action

Chief Executives  
Finance Directors  
NHS Board Executive  
leads for Palliative Care

For information

Nurse Directors  
Medical Directors  
Childrens Hospices  
Local Authority Leads  
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## BACKGROUND

1. NHS Boards and independent adult hospices have close working relationships. Increasingly, they work across boundaries to deliver more integrated and holistic care, consistent with the objectives set out in *Living and Dying Well* (2008). The development and implementation of the Quality Strategy has also signalled a shift to a service more closely focused on offering more consistent and better outcomes for people and their families.

2. This CEL seeks to support the development of an even closer collaboration and co-operation between independent adult hospices and NHS Boards.

3. The Audit Scotland 2008 *Review of Palliative Care Services* noted the scope to improve the consistency in funding arrangements between independent adult hospices and NHS Boards, and recommended that NHS Boards put in place commissioning and monitoring arrangements which would ensure that value for money was achieved. In examining the Audit Scotland report, The Public Audit Committee of the Scottish Parliament recommended robust commissioning arrangements in the delivery of specialist palliative care services to ensure value for money, and also recommended that the Scottish Government should supplement existing guidance on what should be included in NHS Board funding allocations to voluntary sector bodies.

4 The Scottish Government accepted these recommendations and a Short Life Working Group (SLWG) was established with representation from the Scottish Hospices Forum and the six NHS Boards with independent adult hospices in their areas. This group, chaired by one of the co-chairs of the *Living and Dying Well* National Advisory Group, adopted a collaborative approach and explored opportunities, within the context of today's challenging financial environment and increasing expertise in quality assurance issues, to build a viable and enduring partnership and commissioning framework between NHS Boards and independent adult hospices in Scotland.

5 The report of the SLWG was presented to the Scottish Government in July 2010 and published alongside *Living and Dying Well: Building on Progress* in January 2011. In accepting the recommendations, the Scottish Government agreed to consider the implications for the existing guidance, as set out in HDL(2003)18 [http://www.sehd.scot.nhs.uk/mels/HDL2003\\_18.pdf](http://www.sehd.scot.nhs.uk/mels/HDL2003_18.pdf).

6 At the Scottish Government's request a Short-Life Working Group, with representation from NHS Board's and Hospices as outlined in Annex C, has considered the opportunities to refresh and update HDL(2003)18 in light of the Quality Strategy, the commissioning report and *Living and Dying Well*. The work of this group is reflected in this CEL.

7 NHS Boards and independent adult hospices should ensure that progress is made over the course of 2012-13 to support the implementation of the recommendations. It is expected that all NHS Boards with independent adult hospices will have new arrangements in place to inform funding for 2013-14 onwards.

## STRATEGIC CONTEXT

8 *Living and Dying Well* advocates a comprehensive and cohesive approach to the planning and improving of palliative and end of life care. It describes palliative and end of life care as integral aspects of the care delivered by any health or social care professional, focusing on the person, not the disease, and applying a holistic approach to meet the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement. It is essential that NHS Boards, with key stakeholders, including, for example, the voluntary sector and social care partners, work together in order for the aims of *Living and Dying Well* to be fully realised.

9 As envisaged at the publication of *Living and Dying Well*, NHS Boards and the independent providers of specialist palliative care have built a strong and effective alliance for change. The report, *Building on Progress* described the substantial progress already achieved across the NHS, and in collaboration with the independent sector, in improving the quality of palliative and end of life care.

10 A central aspect of the work of the SLWG has been to ensure that the original strategy and policy intent for HDL(2003)18 was not undermined but rather shaped to meet current circumstances. Independent adult hospices value their status, as being separate from the NHS, whilst offering a distinctive contribution to the provision of palliative and end of life care. The 50% funding formula is intended to respect this position and to ensure continuity of support for independent adult hospices.

11 The SLWG also recognised the scope to ensure clarity regarding funding and a greater focus on evidencing outcomes and value for money, within an integrated commissioning framework.

12 The **Individual Elements** set out in HDL(2003)18 are updated in Annex A. The updating of these elements reflects changes in the position of NHS bodies, legislation and accountabilities since 2003. Such individual elements should be brought into the commissioning cycle set out in the recommendations of the SLWG and considered in the determination of agreed running costs.

## **GUIDANCE FOR ESTABLISHING AN INTEGRATED COMMISSIONING FRAMEWORK**

13 NHS Boards and independent adult hospices should take steps to establish longer-term commissioning arrangements, consistent with the recommendations in the SLWG report. It is recognised that good commissioning practices are important determinants to providing quality care. NHS Boards should ensure that the overall commissioning approach contributes to the aims and ambitions of the Quality Strategy.

14 The SLWG report referred to the need for commissioners “to view hospices more as *partners* in commissioning than simply as *providers* of commissioned services. Similarly, hospices need to have a fuller understanding of the tight financial environment in which NHS Boards are operating and the need to make difficult choices between and within priority areas.”

15 The following principles should underpin the approach to commissioning:

- transparency and openness
- a focus on outcomes
- clinical effectiveness
- cost effectiveness
- value for money

16 To maximise the value from commissioning therefore, the process needs to be owned and led by the NHS Board Executive Lead for Palliative and End of Life Care, working in partnership with Executive staff and Trustees of local independent adult hospices. Following these principles a more structured partnership approach to commissioning should be taken, that is informed in particular by:

- value for money and efficiency
- benchmarking of costs, activity and quality
- quality outcome measures.

17 The quality outcome measures should be informed by the work being led by Living and Dying Well, National Advisory Group.

18 In establishing the longer-term partnerships and commissioning cycle between NHS Board and independent adult hospices, NHS Boards should draw upon:

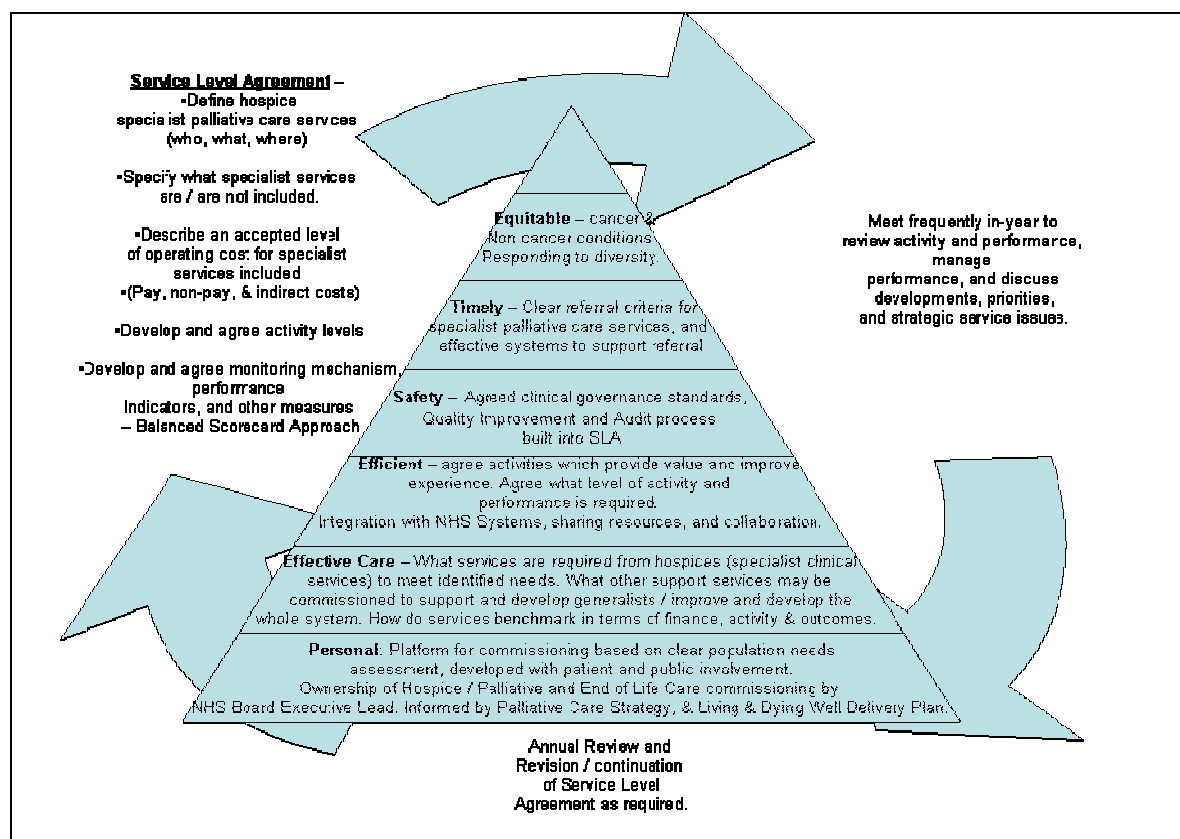
- 18.1 a common and consistent approach to commissioning between NHS Boards and the independent adult hospices
- 18.2 an explicit statement of commissioning intentions by NHS Boards of what level of service that will be purchased and which fully reflect *Living and Dying Well* and local Delivery Plans

- 18.3 an “open book” approach between NHS Boards and independent adult hospices to expenditure in the Hospices
- 18.4 a clear, consistent and detailed definition of agreed running costs
- 18.5 a balanced scorecard of level 3 measures (quantitative and qualitative) with agreed performance trajectories - measures should be consistent with the Quality Strategy and the quality improvement role of Health Improvement Scotland. The balanced scorecard is intended to underpin the commissioning framework
- 18.6 a commitment to agree and sign-off Service Level Agreements in a timely fashion, as part of the overall commissioning cycle
- 18.7 a commitment to regular, open dialogue and flow of information between NHS Boards and independent adult hospices
- 18.8 the work of NHS Boards Managed Clinical Networks for palliative care in which independent adult hospices have a key role to ensure they can help to inform service improvement and development
- 18.9 the findings of the published Healthcare Improvement Scotland inspection reports based on national care standards.

19 Funding of mutually agreed specialist palliative care services (eg drawn from the list of core specialist palliative care services in Annex B) should be reached by NHS Boards and independent adult hospices on a 50% calculation of agreed costs reflecting the intent within HDL (2003) 18 and over a 3 year period, however a longer period may be agreed if appropriate with individual NHS Boards. The commissioning principles and approach outlined (sections 15 and 16) should be used to support the agreement of costs to be included in the 50% calculation. There is further intent that NHS Boards and local authorities will jointly meet 25% of the running costs of the independent children’s hospices which provide specialist palliative care and respite services for children with life-limiting conditions.

20 The SLWG set out a proposed new commissioning framework (figure 1). The framework recognises that effective hospice commissioning requires a number of core dimensions to be developed and put in place in partnership (between independent adult hospices and NHS Boards) in each local health and social care system. These dimensions provide the platform for commissioning hospice care, and are outlined in the pyramid in the centre of the diagram. Service Level Agreements should be developed around these dimensions, clearly responding to identified need and in line with local plans. The commissioning framework should underpin service level agreements and these should be regularly monitored and reviewed on an annual cycle.

**Figure 1: A new mutual commissioning framework for hospice care – for use by NHS Boards and Independent Hospices in Scotland**



## QUALITY IMPROVEMENT, EFFICIENCY AND EFFECTIVENESS

21 The SLWG made reference to the need to establish a Hospice Quality Improvement Forum to allow the ready exchange and development of information to support effective communication.

## MONITORING IMPLEMENTATION

22 It is proposed to establish a Hospice Quality Improvement Forum, overseen by the Living and Dying Well National Advisory Group, which will bring together NHS Boards and independent adult hospices to;

- build a common set of quality measures, drawn from the work being advanced by the Living and Dying Well National Advisory Group;
- ensure an open approach to benchmarking of the cost, activity and quality of independent adult hospice services;
- share good practice between NHS Boards and independent adult hospices in the development of efficiency and productivity programmes.
- ensure a link to the Healthcare Improvement Scotland scrutiny model to support quality and service improvement.

23 The National Advisory Group for Living and Dying Well will continue to oversee progress of its action plan.

24 NHS Board Executive leads for palliative and end of life care should take responsibility for working in partnership with Executive staff and trustees of independent adult hospices. This will promote relationships between organisations based on mutual understanding, trust and openness. This will also be supported by participation in a Hospice Quality Improvement Forum which would build on and support the application of national quality performance indicators.

25 Monitoring arrangements should demonstrate mutually agreed outcomes, standards and shared objectives.

## ANNEX A: INDIVIDUAL ELEMENTS

In order to promote the fullest possible mutual understanding of future plans, NHS Boards must be included at the earliest stage in the consideration of any developments which could generate running costs that would be eligible for the 50% of agreed running costs.

1. The contribution of hospices to education and training has long been recognised. For many hospices education provision may be an integral part of their role as providers of specialist services. Costs associated with education and training should therefore be considered within the service level agreement. Agreed costs should be based on the requirement locally for education and training support. The calculation should however relate to the running costs net of any income to the hospice generated by this activity.

2. Agreement on the appropriate multi-disciplinary team establishment, including any out-of-hours resource, if required, from trainee doctors where the post graduate dean has given educational approval for the trainee, should form part of the basis for funding.

3. **Depreciation.** Where the buildings and services concerned have been agreed as appropriate for inclusion in the 50% calculation of agreed costs, depreciation on the relevant assets should also be covered. Similarly, where new capital investment is not for purposes agreed as appropriate for inclusion in the 50% calculation of agreed costs, depreciation on those assets should not be included.

4. **Pharmaceutical Services.** The intention has always been that hospices would receive pharmaceutical services, which is understood as covering specialist pharmaceutical advice as well as pharmaceuticals, free of charge. These services are not covered by the 50% arrangement, and should always be identified as a separate element in the service level agreement between independent adult hospices and NHS Boards. Local arrangements for provision/supply can take a variety of forms, but all must ensure that they are cost-effective, ensure compliance with legislation and are high quality. Appropriate local arrangements need to be in place to ensure adequate governance and safety.

5. **Fundraising.** This was not an element in the original 50% calculation of agreed running costs, but it is now accepted that the basic costs of fundraising should count towards hospices' agreed running costs. These 'basic costs' relate to the employment of an appropriate level of fund-raising staff, but not the costs associated with organising individual fund-raising events and excludes charity shop and lottery staff costs. The rationale is that unless this aspect of hospice activity is recognised, hospices' ability to meet their share of the agreed running costs could be put in jeopardy. In relation to the 50% calculation of agreed costs, the 'appropriate level' of staff should be agreed between hospices and Boards.

6. **Out of area transfers.** The 50% agreement relates to the costs of providing the totality of a hospice's specialist palliative care services. It is not calculated on a cost-per patient basis, which means that hospice should not be sending invoices to Boards outwith their own area. But where a hospice provides a substantial service to people from more than one NHS Board area, the hospice should agree jointly with the relevant Boards how the 50% contribution should be shared between them.

7. **Charging for inspection by Healthcare Improvement Scotland.** There are no plans to exempt hospices, as the arrangements cover other bodies which operate on a not-for-profit basis. In view of the importance of ensuring compliance with standards, these charges should form part of the 50% calculation".

8. **Information Provision.** NHS Boards are required to ensure that information in the form of Scottish Morbidity Records (SMRs) are transmitted to Information and Services Division (ISD) for all NHSScotland patients treated in the independent healthcare sector. Hospices have their own information and IT requirements, but this additional responsibility is one imposed by NHSScotland. SMR data, especially if they cover all hospice activity, will be a valuable resource to support financial accountability, palliative care strategy development, epidemiology and local and national service planning. The funding implications stemming from the requirement to provide SMR data, and the IT infrastructure necessary to supply them, should therefore be included in the 50% calculation of agreed costs. Hospices should agree with NHS Boards the most cost-effective way to meet these needs.



## **ANNEX B: Palliative Care**

### **Palliative Care**

Palliative care is defined by the World Health Organisation as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.

### **Specialist Palliative Care**

Specialist Palliative Care is the active total care of patients with progressive, advanced disease and their families. Care is provided by a multi-professional team who have undergone recognised specialist palliative care training. The aim of the care is to provide physical, psychological, social and spiritual support, and it will involve practitioners with a broad mix of skills. (Tebbit, 1999)

Specialist Palliative Care requires effective multi-professional working within specialist teams and co-ordination across a wide range of professions to ensure that all appropriate patients, including those with non-malignant disease, can access the appropriate service and achieve the best quality of life possible.

These teams work in partnership with those who provide generalist palliative care, to ensure that patients' and families' complex needs are met.

Complex needs are identified as needs that cannot be addressed through simple or routine interventions/care.

Specialist Palliative Care seeks to:

- meet complex needs through a multi-professional team that meets regularly, and where individual team members understand and respect each other's roles and specialist expertise;
- enable team members to be proactive in their contact, assessment and treatment of patients and their families/carers;
- discern, respect and meet the cultural, spiritual and religious needs, traditions and practices of patients and their families/carers;
- recognise the importance of including the needs of families in the patient's care, since good family care improves patients' quality of life and contributes positively to the bereavement process;
- share knowledge and expertise as widely as possible;
- promote and participate in research in order to advance the speciality's knowledge base for the benefit of patients and carers.

A number of essential components make up a specialist palliative care service and the lists below are not exhaustive. These include:

- effective communication
- symptom control
- rehabilitation
- education and training

- research and audit
- continuity of care
- terminal care
- bereavement support

**The core clinical specialist palliative care services comprise:**

- **In-Patient care** facilities for the purposes of symptom management, rehabilitation and terminal care
- **24 hour access** to the In- Patient service which includes specialist medical and adequate specialist nursing cover
- **24 hour telephone advice service** for healthcare professionals
- **24 hour telephone support service** for known out-patients and their carers
- **Day services** provided by an out-patient model or day hospice model where patients attend for a determined part of the day (eg. from 11-3)
- **Education programme**
- **Research and audit** undertaken within a framework of clinical governance
- Formalised arrangements for specialist **input to local and community hospitals**

**Key Elements of Specialist Palliative Care within a Specialist Palliative Care Unit**

The core team comprises dedicated sessional input from

- Chaplain
- Doctors
- Nurses
- Occupational therapist
- Pharmacist
- Physiotherapist
- Social worker

The range of integrated service components which can meet patients' needs at different stages of the disease process will include written referral guidelines to;

- Bereavement services
- Community specialist palliative care services
- Complementary therapies
- Counselling services
- Day services
- Hospital specialist palliative care services
- Lymphoedema services
- Patient transport services
- Psychological support services
- Social services
- Spiritual support services

Clinical Standards Board for Scotland (2002) Clinical Standards Specialist Palliative Care NHS Scotland.

In addition to referring onto these services externally, many Scottish Hospices provide them as part of the holistic range of integrated care and services.

Increasingly this includes services which assist with people's information and education needs (patients and carers) and also working with community groups to develop a shared understanding of care, loss death and dying.

#### **ANNEX C: MEMBERSHIP OF SHORT LIFE WORKING GROUP**

- Robbie Pearson, Scottish Government
- Peter McLoughlin, NHS Lothian
- Anne Harkness, NHS Greater Glasgow and Clyde
- Rhona Baillie, The Prince and Princess of Wales Hospice
- Carol Somerville, Bethesda Hospice
- Maria McGill, CHAS
- Kenny Steele, Highland Hospice
- Irene McKie, Strathcarron Hospice
- Marion Ford, ACCORD Hospice
- Geoff Sage, St Andrews Hospice
- Edward McGuigan, St Margaret of Scotland Hospice
- Anne Willis, Marie Curie
- Aileen Anderson, Ayrshire Hospice
- Mark Hazelwood, Scottish Partnership for Palliative Care
- Rachael Dunk, Scottish Government
- Patrick McAuley, Scottish Government

## References

- Living & Dying Well: A National Action Plan for Palliative and End of Life care in Scotland. The Scottish Government (2008). <http://www.scotland.gov.uk/Resource/Doc/239823/0066155.pdf>
- Living & Dying well: *Building on Progress*. The Scottish Government (2011). <http://www.scotland.gov.uk/Resource/Doc/340076/0112559.pdf>
- A Partnership for Better Palliative and End of Life Care: Creating a New Relationship Between Independent Adult Hospices and NHS Boards in Scotland. Living and Dying Well National Advisory Group (2010) <http://www.scotland.gov.uk/Resource/Doc/924/0111432.pdf>
- NHS HDL (2003) 18 Funding of Specialist Palliative Care Provided by Independent Voluntary Hospices in Scotland. The Scottish Executive (2003). [http://www.sehd.scot.nhs.uk/mels/HDL2003\\_18.pdf](http://www.sehd.scot.nhs.uk/mels/HDL2003_18.pdf)
- Audit Scotland 2008 Review of Palliative Care Services. Audit Scotland (2008) [http://www.audit-scotland.gov.uk/docs/health/2008/nr\\_080821\\_palliative\\_care.pdf](http://www.audit-scotland.gov.uk/docs/health/2008/nr_080821_palliative_care.pdf)
- The Healthcare Quality Strategy for NHS Scotland. The Scottish Government (2010) <http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf>