Name	Role	Organisation
Carol Potter (Co-Chair)	Chief Executive	NHS Fife
Amy Wilson (Co-Chair)	Deputy Director, Health Workforce Planning and Development	Scottish Government
Caroline Hiscox	Chief Executive	NHS Lothian
[redacted]	Senior Medical Advisor	Scottish Government
[redacted]	Medical Director	NHS Ayrshire and Arran
[redacted]	Medical Director	NHS Borders
[redacted]	Scottish Academy Chair	Medical Royal Colleges and Faculties in Scotland
[redacted]	Executive Medical Director	NHS Education for Scotland
[redacted]	Deputy Medical Director	NHS Education for Scotland
[redacted]	Director of Finance	NHS Grampian
[redacted]	Director of Finance	NHS Shetland
[redacted]	Director of People and Culture	NHS Highland
[redacted]	Specialist Lead	NHS Education for Scotland
[redacted]	Head of Programme	NHS Education for Scotland
[redacted]	Senior Financial Improvement Manager	Scottish Government
[redacted]	Head of HR Resourcing	NHS Forth Valley
[redacted]	Medical Locum Supplementary Staffing Manager	NHS Lothian
[redacted]	Medical Staff Bank Manager	NHS Greater Glasgow and Clyde
[redacted]	Medical Pay and TCS Lead	Management Steering Group
[redacted]	Deputy Director of Nursing	NHS Lothian
[redacted]	Regional Secretary	BMA Scotland
[redacted]	Staffside	Unite Union
[redacted]	Head of Recruitment and Capacity Building	Scottish Government
[redacted]	Head of NHS Pay	Scottish Government
[redacted]	Unit Head, Pay, Terms and Conditions (Medical and Dental)	Scottish Government
[redacted]	Head of Strategic Sourcing & Commercial	NHS National Services Scotland
[redacted]	Category Manager	NHS National Services Scotland
[redacted]	NES Digital	NHS Education for Scotland
[redacted]	NES Digital	NHS Education for Scotland
[redacted]	Unit Head, Sponsorship and Infrastructure	Scottish Government
[redacted]	Sponsorship and Infrastructure	Scottish Government

Medical Locum Engagement Task & Finish Group
Wednesday 3 April 2024, 14:00-15:30

Attendees

Gillian Russell (GR) (Chair)	Director of Health Workforce – Scottish Government
Mary Morgan (MM)	Chief Executive - NSS
Caroline Hiscox (CH)	Chief Executive – NHS Tayside
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Deputy Director of Nursing – NHS Lothian
[redacted]	Director of Medicine - NES
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Specialist Lead, Recruitment and Supply – Centre for Workforce Supply, NES
[redacted]	Head of Programme – Centre for Workforce Supply, NES
[redacted]	Staffside Representative - Unite Union
[redacted]	Medical Director – NHS Ayrshire and Arran
[redacted]	Senior Finance Manager - NHS Grampian (deputising for Alex Stephen)
[redacted]	Senior Medical Advisor – Scottish Government
[redacted]	Category Manager - NSS
[redacted]	Deputy Medical Director - NES
[redacted]	Medical Locum Bank Manager – NHS Lothian
[redacted]	Head of Recruitment and Capacity Building – Scottish Government
[redacted]	Executive Director of People and Culture – NHS Highland
[redacted]	Medical Director – NHS Borders
[redacted]	Financial Support Senior Manager – Scottish Government (deputising for Elizabeth Wilson)
[redacted]	Professional Advisor, Medical Education, Training and Development Unit – Scottish Government
[redacted]	Scottish Academy Chair - Medical Royal Colleges and Faculties in Scotland
[redacted]	Medical Staff Bank Manager - NHS GGC
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Sponsorship and Infrastructure Unit – Scottish Government

Apologies:

Carol Potter	Co-chair/ Chief Executive, NHS Fife
[redacted]	Regional Secretary (West of Scotland), British Medical Association
[redacted]	Director of Finance, NHS Grampian – Sarah Irvine (Senior Finance Manager, NHS Grampian) will deputise
[redacted]	Head of Medical and Dental Pay Unit, Scottish Government
[redacted]	Head of HR – NHS Forth Valley
[redacted]	Financial Improvement Senior Manager – Scottish Government

Welcome and Introductions:

1. GR welcomed all colleagues to the second meeting of the Medical Locum Engagement Task & Finish Group.
2. An updated terms of reference was shared with the group and GR noted the changes that had been made as a result of discussion at the last meeting.
3. GR outlined that the main focus of the meeting was to discuss two potential interventions aimed at ensuring appropriate locum usage: staff banks and consistent escalatory processes, as well receiving updates on the ongoing work to address medical supply deficits and ensure appropriately sized workforces for service configuration.

Project Team Update

4. [redacted] provided a run through of the meeting pack and advised that each of the current actions, listed below, would be closed:
    (a) Revised terms of reference to be circulated with a number of amendments to the membership, governance, Meeting Frequency, Secretariat and Decision Making sections – now circulated.
    (b) Further work to be done to clarify the roles and responsibilities in relation to the risks – Health Boards identified as risk owners.
    (c) Revised workplan to be shared via correspondence in advance of the next meeting. – now circulated.
5. GR noted that mitigations have now been added to the risk register and risk 001 has been upgraded to Very High given the requirement to carry out this work in the absence of any funding.
6. [redacted] commented that whilst the group has a specific focus on the medical workforce, there is a need to be thoughtful about risks in relation to Board capacity, following the introduction of a reduced working week, protected learning time and Band 5 review. GR also noted the implementation of the Health and Care Staffing Act from 1 April.
7. [redacted] requested that references to the Nurse agency work be removed from the terms of reference due to limited analogies. [redacted] also requested that the wording in the scope section of the terms of reference be amended to read 'Developing a national approach to guide all Health Boards in ensuring the appropriate use of medical locum agency,' rather than 'Developing a national approach for adoption by all Health Boards…'

Action: Amend ToR and put on the agenda for the next meeting for agreement.

'Right-sizing' the Medical Workforce

8. [redacted] gave an overview of the CDF Programme in Borders which has supported the Board to reduce their overall agency locum costs. [redacted] noted that, as a result of the deanery allocation, the Board experienced a number of vacancies within the registrar grade, which led to an increase in locum usage and a negative response in the national training survey.
9. From 2016, the CDF Programme was introduced and the number of places were expanded to mitigate against any vacancies that arose following the deanery allocation. The programme is now being used across a number of specialities within Borders General Hospital and has improved the overall experience for trainee doctors and ultimately made a positive difference to the level of patient care that can be provided.

10. In terms of costs, [redacted] advised that there were potential savings of £105k a year, with the added benefit that doctors are engaged and committed to the organisation. [redacted] noted that a number of doctors who have worked on the CDF Programme are now looking to pursue Speciality Doctor roles within the organisation.
11. [redacted] informed the group that NHS Border's agency spend in 2016 was close to £3 million compared to £967k following the introduction of the CDF Programme.[redacted] noted that spend on middle grade agency locums has remained low since and there has been enormous improvement in the feedback received by the deanery.
12. [redacted] reinforced the importance of right-sizing the workforce to reduce locum spend and highlighted a similar programme of work in Ayrshire and Arran where they saved £6 million over three years.
13. GR clarified that while the group had decided service redesign should lie out with the scope of the group, if the group felt there was merit in exploring the right-sizing piece further then discussions as to how we could support this work would need to take place.
14. [redacted] reiterated the need to remain connected to the work commissioned last year by the Medical Workforce Sustainability and Value Group (MWSG), primarily focused on sustainability of the substantive medical workforce.
15. [redacted] asked what measures were being taken to attract staff to the CDF Programme in Borders and [redacted] confirmed that offering one day a week for development and being in one organisation for a whole year have been beneficial in attracting staff.
16. [redacted] asked members if they understood why rota gaps on ST4-6 have appeared so quickly out of nowhere. [redacted] noted that 28% of the workforce are less than full time working and although 94% of all training posts within Scotland are filled this gives false reassurance around the workforce.
17. [redacted] highlighted the importance of this group focussing on improving the governance and structure surrounding medical locum usage in order to highlight the problem areas. [redacted] suggested that controls have lapsed across all staffing groups in recent years. [redacted] also emphasised the need to right size the workforce in general and explore skill mix opportunities to determine where different workforce models may be appropriate, however this would be for individual Boards to decide.
18. [redacted] suggested that instead of developing a business case when locum use is required, a business case should be developed to set out what Boards are doing to stop agency use.
19. GR summarised that there is a need to focus on the governance and technical operational issues around the use of locums, but the group recognise that there are a wider set of issues beneath this, including right-sizing, workforce planning, innovation and learning from good practice. While the focus of the group remains on the governance and technical aspects, it is important to remain connected to the work going on to address the underlying issue of how we ensure value for money while providing good quality care. GR encouraged members to continue the sharing of good practice at the task & finish group.

Mitigating Medical Supply Deficits

20. [redacted] provided an update on the work of the Centre for Workforce Supply (CWS) that's underway to address the medical supply deficits. [redacted] confirmed that following a series of individual Health Board insight meetings, a paper has now been completed and the action plan for the next financial year finalised. These will be shared with wider stakeholders once signed off.
21. [redacted] made members aware of the upcoming learning sessions, information for which was shared alongside the meeting papers. The learning sessions may be useful to

support Boards in identifying practical alternatives to using high cost/ long-term locums. The meetings will cover topics such as international and domestic recruitment, and training pipelines.

22. [redacted] also advised that CWS are working with staff bank managers to develop a set of national marketing materials and a centralised landing page to support the promotion and advertisement of staff bank opportunities. This work is part of a commission from the Nursing Supplementary Staffing Task & Finish Group which aims to improve staff bank optimisation. [redacted] also informed the group that CWS are looking to develop a Psychiatry marketing toolkit for Boards to use to bolster their international and domestic recruitment efforts for Psychiatry.

Benefits of Medical Staff Banks

23. [redacted] presented the benefits of staff banks SBAR which makes a number of recommendations based on evidence gathered and good practice sharing from across the country, including that Boards who do not currently operate a Medical Staff Bank mechanism should develop a business case outlining the pros and cons of doing so. The group were also asked to give a view as to whether or not the timescale for reporting progress on the development of this by 3 June was reasonable.
24. [redacted] asked whether geographical variation in bank fill rates exists between Boards, and whether something was required to incentivise individuals to take up shifts in more rural Boards.
25. [redacted] confirmed that, anecdotally, there does appear to be variation in fill amongst smaller, more rural Boards and larger more central Boards. Forth Valley have chosen to leave the WoS consortium using a Managed Service Provider (MSP) to supply agency locums as a result of not achieving high fill rates. They do however remain as part of the WoS Regional Medical Bank and regularly upload shift requests and get shifts filled with Medical Bank doctors.
26. As an example, Forth Valley had chosen to leave the West of Scotland (WoS) consortium as a result of not achieving high fill via the WoS bank.
27. [redacted] informed members that the WoS consortium is increasingly being asked to fill more shifts for Boards such as Dumfries and Galloway and Ayrshire and Arran. Doctors also tend to rotate in their substantive posts to these areas and feedback from them suggests they have good experiences in smaller Boards and often opt to go back.
28. [redacted] posed that rather than operating 14 separate medical banks, it would be beneficial to have a regional or national approach. In order to migrate agency workers to bank roles, the process for doing so needs to be as simple as possible. [redacted] noted that a training passport would also be useful in supporting the movement of staff between Boards in the way that agency workers currently do.
29. [redacted] agreed with [redacted] and the recommendation within the paper that a business case should be developed, either on a regional or national basis, but noted that the timescales for reporting progress were too tight and would require further thought.
30. MM also supported the development of regional/ national banks but asked that clarity around what Boards would be expected to be involved was provided. MM also requested that any suggestions around an increase in weekly pay be considered fully as a result of the burden this creates on payroll.
31. CH further supported the idea of creating one national bank for medical staff and highlighted that the strength of the impact of the nursing approach was due to all Boards moving in tandem. The number and difference in terms and conditions for the medical cohort of staff doesn't lend itself to developing 14 different business cases for separate banks. CH noted that a business case would need to reflect and incorporate the risks in relation to remote and rural Boards as well as the evidence why a national approach

would be best. The timeline for completion would be dependent on whether and how quickly staff can be mobilised to develop the business case.

32. [redacted] made members aware that the WoS consortium has had success in transitioning agency doctors to the bank. [redacted] clarified that bank doctors get priority access to shifts, benefit from weekly pay and feedback is positive.
33. GR summarised that the group were supportive of developing a medical bank business case on a national basis rather than 14 or 22 separate banks. GR advised that the project team would discuss how best to approach this, ensuring CE, MD and HRD approval.

Action: **Project team to work with Board colleagues to arrange the development of a business case in support of a national approach to medical staff banks.**

Escalatory Process

34. [redacted] presented the escalatory process SBAR which sets out the work done previously to try and create a consistent approach. A survey conducted in October 2023 found that there is significant variation in escalatory processes across Boards and so there is opportunity to create a more consistent approach in relation to engaging medical locums.
35. [redacted] outlined the recommendations within the paper, including that Medical Directors take on the role of Executive Lead for medical locum engagements and, in this role, assume responsibility for sign-off of any engagements which exceed 3 days in duration and/or attract a pay rate in excess of that set out in the relevant National Procurement Framework. Also, that any medical locum engagements exceeding 4 weeks in duration require to be underpinned by a Business Case to be approved by the Board's Medical Director in consultation with HR, Finance and Clinical Leads.
36. A number of members agreed that the 3 day and 4 week timescales set out in the recommendations were too short.
37. [redacted] noted that new escalation and approval processes won't reduce demand or move agency workers to bank or substantive. FI suggested implementing a set of enablers to set out our intentions to the market, as well as focussing on the triggers for when agency is being used.
38. [redacted] and [redacted] offered to share the paper with SAMD for comment and work with the project team to update the paper based on feedback. Both were supportive of a standardised approach across Scotland.
39. CH emphasised the importance of understanding how many services are currently maintained predominantly by locums.
40. MM agreed and reemphasised the need to understand the different groups, for instance groups who could be transferred from agency to bank compared to longer term locums. MM noted that the timelines, impacts and risks for all groups must be fully explored before addressing all locum use in a single solution and way.
41. [redacted] reiterated the importance of right sizing the medical workforce in order to reduce locum requirements.
42. GR summarised that there was support in principle for national guidance, however there is a need to understand the underlying landscape of locum usage across Scotland, why it's being used and what services it's holding up.
43. CH offered that once the paper has received feedback from SAMD and undergone further work, that it could be added to a Board Chief Executive meeting to ensure consistent implementation.

Action:[redacted] and [redacted] to seek feedback on the escalatory process SBAR from SAMD and work with the project team to update the paper accordingly.

AOB

44. Date of next meeting Thursday 9 May.

SUMMARY OF ACTION POINTS

Action	Owner
Action: Amend ToR and put on the agenda for the next meeting for agreement.	[redacted]
Project team to work with Board colleagues to arrange the development of a business case in support of a national approach to medical staff banks.	[redacted]/ [redacted]
[redacted] and [redacted] to seek feedback on the escalatory process SBAR from SAMD and work with the project team to update the paper accordingly.	[redacted]/ [redacted]/ [redacted]/ [redacted]

Medical Locum Engagement Task & Finish Group
Thursday 9 May 2024, 14:00-15:30

Attendees

Carol Potter (CP) (Chair)	Chief Executive – NHS Fife
Gillian Russell (GR)	Director of Health Workforce – Scottish Government
Caroline Hiscox (CH)	Chief Executive – NHS Tayside
[redacted]	Director of Health Workforce – Scottish Government
[redacted]	Chief Executive – NHS Tayside
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Deputy Director of Nursing – NHS Lothian
[redacted]	Specialist Lead, Recruitment and Supply – Centre for Workforce Supply, NES
[redacted]	Head of Programme – Centre for Workforce Supply, NES
[redacted]	Senior Medical Advisor – Scottish Government
[redacted]	Deputy Medical Director - NES
[redacted]	Medical Locum Bank Manager – NHS Lothian
[redacted]	Director of Finance – NHS Shetland
[redacted]	Medical Pay and TCS Lead – Management Steering Group
[redacted]	Head of Recruitment and Capacity Building – Scottish Government
[redacted]	Medical Director – NHS Borders
[redacted]	Deputy Director of People – NHS Highland (deputising for Gareth Adkins)
[redacted]	Regional Secretary (West of Scotland) - British Medical Association
[redacted]	Head of HR Resourcing– NHS Forth Valley
[redacted]	Financial Improvement Senior Manager – Scottish Government
[redacted]	Scottish Academy Chair - Medical Royal Colleges and Faculties in Scotland
[redacted]	Medical Staff Bank Manager - NHS GGC
[redacted]	Assistant Director of Finance – NHS Grampian (deputising for Alex Stephen)
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
	Sponsorship and Infrastructure Unit – Scottish Government
	Health Workforce Directorate Support Unit - Scottish Government

Apologies:

Mary Morgan	Chief Executive - NSS
[redacted]	Unit Head, Sponsorship and Infrastructure - Scottish Government
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Staffside representative – Unite Union
[redacted]	Director of People and Culture - NHS Highland

Welcome and Introductions:

1. CP welcomed all colleagues to the third meeting of the Medical Locum Engagement Task & Finish Group.
2. CP outlined that the main focus of the meeting was to discuss a further two interventions aimed at ensuring more appropriate locum usage and value for money: benchmarking of locum pay rates and reviewing commission rates, as well as receiving updates from colleagues in NES who are leading a number of pieces of work in relation to addressing the medical supply deficits.
3. CP welcomed [redacted], who was joining as a new member to ensure join up with Management Steering Group and the specific work ongoing to look at the costs associated with short term medical cover.
4. An updated terms of reference was shared with the group and CP noted that a further update would be made to the schematic diagram under the governance section, to show the connection into the joint negotiating committee.

Action: Terms of reference to be amended to show links to Joint Negotiating Committee.

Project Team Update

5. [redacted] gave a run through of the meeting pack and provided an update on each of the open actions:
    - Action 004: Amend ToR and put on the agenda for agreement at next meeting – [redacted] noted the changes to the text stating that only applicable learning would be taken from the Nursing Supplementary Staffing Task & Finish Group. This action will now be closed.
    - Action 005: Project team to work with Board colleagues to arrange the development of a business case in support of a national approach to medical banks – a subgroup of the task & finish group met on 14 April to discuss the development of an options appraisal exploring both a regional and national approach to banks, acknowledging that the group's preference was for a national approach.
    - Action 006: [redacted] and [redacted] to seek feedback on the sign off process SBAR from SAMD and work with the project team to update the paper accordingly – [redacted] and [redacted] sought feedback from SAMD and shared this with project team on 26 April and agreed to work together to develop a checklist that will be brought back to the group.

6. [redacted] asked members to make the project team aware if they thought that any amendments to risk register were required.

Mitigating Medical Supply Deficits Update

7. [redacted] updated members on three specific pieces of work relating to trainee recruitment, right-sizing the medical workforce and trainee distribution according to population need.
8. [redacted] highlighted that core training fill rates for round 1 are currently sitting at 99%, while round 2 is sitting at 93%. [redacted] clarified that there is variation across fill in terms of specialities and that the overall WTE will be less than this due to high rates of less than full time training.

9. [redacted] highlighted the importance of stability around the number of doctors in training and advised that a short life working group has been established with SAMD to mitigate against the challenges currently faced by Boards. The SLWG will meet for the first time at the end of May.
10. [redacted] also made members aware that NES would be undertaking a piece of internal work to ensure that trainee distribution is right for the population need. A programme of work is now underway to determine how appropriate distribution can be ensured, without destabilising the workforce.
11. [redacted] referenced the 2 insight papers and executive summary that were shared as part of the papers for the meeting. These provide detail of the work undertaken by Centre for Workforce Supply (CWS) in the past year when they met with each of the territorial Health Boards and Golden Jubilee to discuss and understand their medical workforce challenges. Based on these discussions, CWS have developed their workplan, which places a focus on attraction, such as improving website and social media content, as well as producing marketing toolkits.
12. [redacted] advised that CWS are also facilitating innovative supply interventions and hosting monthly learning sessions around a broad range of topics including supply, diversification, retention and pastoral support.
13. [redacted] made reference to a recent learning session involving NHS Wales and a Government to Government agreement with Kerala in India and advised members that CWS are working with colleagues to scope the possibility of doing something similar in Scotland.
14. CWS are also looking at producing information around the equivalency of training as well as guidance around the differences between MTI and IMTF approaches to international recruitment.
15. [redacted] also provided an update on the bespoke support approach whereby CWS work directly with a small number of Boards in a practical, intensive way and carry out a deep dive into their medical workforce challenges in order to support the Board to manage these and offer solutions to help stabilise the workforce and reduce reliance on long term locums.
16. [redacted] highlighted specific work ongoing with Lanarkshire in Psychiatry and Golden Jubilee across a number of specialities. The work in Lanarkshire has been brought about as a result of a data review which highlighted that Lanarkshire was the most challenged across all Boards in terms of Consultant Psychiatrist vacancies. The CWS have met with the Board to discuss the challenges and have since presented them with a menu of options to explore to mitigate against these. These options included international recruitment at scale, which the Board are keen to engage with and so CWS have presented them with 8 ways they could go about international recruitment and have helped them make connections with relevant external organisations to support. [redacted] advised that all options are based on a invest to save model.
17. [redacted] also advised that CWS were keen to invite Lanarkshire colleagues to the group to update on the work as it progresses.
18. [redacted] noted the success with international recruitment for Nursing and Clinical Fellows in NHS Borders, but highlighted the additional support required for international medical graduates (IMGs) and concerns around Borders ability as a small Board to support some of the requirements for IMGs. [redacted] confirmed that CWS are doing a piece of work around IMG support to connect all of the support offerings from NES, GMC, Boards etc. In terms of direct bespoke support, CWS guide Boards through the process, including the preparedness of teams/ departments for the arrival of IMGs.
19. To emphasise the requirements for IMGs, [redacted] noted that Forth Valley were unable to attract any emergency room practitioners to their vacant posts as a result of the level

of training, expertise and experience required. [redacted] confirmed he would be supportive of looking into the Kerala example and mass recruitment. [redacted] agreed to share the recording from the Kerala session and highlighted the benefits of this type of arrangement in terms of ensuring the quality and consistency of applicants.

Action: [redacted] to share recording of Kerala session with members.

20. [redacted] asked what was being done to aid the retention of UK trained doctors and encourage them to remain in Scotland. [redacted] agreed to provide an update in relation to this at an upcoming meeting of the group.

Action: [redacted] to provide retention update at upcoming meeting of the group.

Benchmarking of Locum Pay Rates

21. [redacted] presented the Benchmarking SBAR which sets out a proposed approach to benchmarking pay rates for medical locum engagements across NHS Scotland Boards. [redacted] clarified that the aim of the paper is to provide members with a basis for discussion and the opportunity to feed back, before any decisions are made in relation to the recommendations.
22. The paper highlights that despite the relative consistency in commission rates paid by Boards in order to access supplementary medical staff via agencies, there is significant variation in the rates of pay offered to locums engaged via this route.
23. [redacted] outlined each of the suggested options explored in the paper, including option 1, which suggests to do nothing except gather the Discovery Scorecard, option 2 which suggests collecting the Discovery Scorecard alongside monthly monitoring of average/median agency locum rates and finally option 3, which suggests collecting everything set out in option 2 but include reporting on high-value locum engagements (by speciality). The aim of the options is to support Boards to understand whether they are accessing best value.
24. [redacted] expressed the importance of understanding what the data would be used for and seeing a template in advance of being asked to complete it.
25. CP emphasised that the data would be used for learning and identifying best practice which could be shared between Boards.
26. [redacted] noted that it would be helpful to align the reporting with the Safe Staffing reporting and the project team agreed to explore this with the relevant colleagues.
27. [redacted] highlighted that using a direct engagement model can allow locum pay rates to be reported more easily.
28. [redacted] noted that the data suggests that Health Boards have different thresholds when it comes to agreeing rates with agencies and it would be beneficial to collect agency specific information to understand the market and agency behaviour. The benefit of the task & finish group will be taking a collective approach to managing this behaviour and addressing the market. [redacted] also highlighted the benefit in negotiating a reduced rate for longer term engagements.
29. [redacted] confirmed that in Lothian there is one central hub for all agency dealings, which contains individuals who understand the market and have the necessary negotiation skills to negotiate with agencies.
30. [redacted] confirmed that Forth Valley have also adopted this approach with the support of Lothian colleagues.
31. [redacted] also advised that the WoS collaboration also has a similar set up and collaborative approach with neighbouring Boards.
32. GR noted that there is evidence of best practice and this group should be used to share that and determine how this could also be implemented across the country. GR

suggested a starting point may be to invite Lothian to present their ways of working to the group.

Action: Invite colleagues from Lothian to present their approach to the engaging of medical agency.

33. CH sought clarity on the thoughts of the group around the approach to a national medical staff bank and whether the expectation would be that, if established, local engagement would be done via the bank process in order to address the variation in rates.
34. [redacted] agreed that it would make sense to include the potential for a hub to negotiate locum engagements in the discussions surrounding the development of a business case for a national bank.
35. [redacted] highlighted the challenges associated with setting a binding rate for the type of work required.
36. [redacted] referenced exploratory work done previously by the project team which found that setting a national rate encouraged the ceiling to become the floor.
37. CP summarised that there is work to be done to learn from the approach taken in Lothian and now Forth Valley and that the group have a strong view that this should be connected to the ongoing discussions surrounding a national staff bank. In terms of data collection, the group are also keen to gather agency specific information to better understand the market.

<u>Commission Rate Review</u>

38. [redacted] presented the Commission Rates SBAR which explores the potential benefits associated with reviewing the commission structure for long-term locum engagements. Similar to the paper on pay rates, it also sets out 3 options for the group to consider and discuss.
39. The paper highlights that despite the consistency in commission rate, the length of engagement differs significantly between Health Boards. [redacted] advised that within the terms and conditions of the NP50022 Framework, it states agencies should provide Boards with a discount on commission for any engagement lasting 4 weeks or more.
40. [redacted] noted that the framework does not define a specific step down rate, but that National Procurement colleagues have confirmed this would form part of the re-tendering exercise in 2027, following an extension to the framework in 2025.
41. Members were in agreement that NSS should be asked to re-tender the framework rather than extend as soon as possible, to ensure that a national step down rate is defined and agreed as a matter of priority.
42. CP noted the calculations within the paper which demonstrate that agreeing a Once for Scotland percentage discount for long-term engagements wouldn't generate a significant return on investment, however it would be helpful to remind Boards that they have the opportunity to negotiate commission rates for any engagements lasting 4 weeks or more.
43. Members agreed that it would be helpful to include this reminder within the sign-off process checklist being developed.

<u>AOB</u>

44. None raised.
45. Date of next meeting Thursday 6 June.

SUMMARY OF ACTION POINTS

Action	Owner
Terms of reference to be amended to show links to Joint Negotiating Committee	[redacted]
[redacted] to share recording of Kerala session with members.	[redacted]
[redacted] to provide retention update at upcoming meeting of the group.	[redacted]
Invite colleagues from Lothian to present their approach to the engaging of medical agency.	[redacted]

Medical Locum Engagement Task & Finish Group
Thursday 6 June 2024, 14:00-15:30

Attendees

Gillian Russell (GR) (Chair)	Director of Health Workforce – Scottish Government
Mary Morgan (MM)	Chief Executive - NSS
[redacted]	Deputy Director of Nursing – NHS Lothian
[redacted]	Specialist Lead, Recruitment and Supply – Centre for Workforce Supply, NES
[redacted]	Programme Lead – Centre for Workforce Supply, NES
[redacted]	Senior Medical Advisor – Scottish Government
[redacted]	Deputy Medical Director - NES
[redacted]	Medical Locum Bank Manager – NHS Lothian
[redacted]	Director of Finance – NHS Shetland
[redacted]	Medical Pay and TCS Lead – Management Steering Group
[redacted]	Unit Head, Sponsorship and Infrastructure – Scottish Government
[redacted]	Medical Director – NHS Borders
[redacted]	Medical Director – NHS Ayrshire and Arran
[redacted]	Director of People and Culture – NHS Highland
[redacted]	Regional Secretary (West of Scotland) - British Medical Association
[redacted]	Head of HR Resourcing– NHS Forth Valley
[redacted]	Financial Improvement Senior Manager – Scottish Government
[redacted]	Medical Staff Bank Manager - NHS GGC
[redacted]	Assistant Director of Finance – NHS Grampian (deputising for Alex Stephen)
[redacted]	Category Manager, National Procurement - NSS
[redacted]	Sponsorship and Infrastructure Unit – Scottish Government

Apologies:

Carol Potter	Chief Executive – NHS Fife
Caroline Hiscox	Chief Executive – NHS Tayside
[redacted]	Executive Medical Director, NES
[redacted]	Chair, Academy of Medical Royal Colleges and Faculties
[redacted]	Director of Finance, NHS Grampian
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Scottish Clinical Leadership Fellow - Scottish Government

Welcome and Introductions

1. GR welcomed all colleagues to the fourth meeting of the Medical Locum Engagement Task & Finish Group.
2. GR outlined that the purpose of the meeting was to consider direct engagement and the potential for this to reduce costs associated with locum engagements, as well as hearing from NHS Lothian colleagues about their approach to medical locum engagements and how this could be shared with other Health Boards for adoption. The group will also discuss the proposed locum reporting template and receive updates in relation to the ongoing work to address the underlying medical supply deficits.
3. There were no comments on the minutes of the previous meeting.
4. GR made members aware that due to challenges securing availability over the summer period, the next meeting of the group will be held in August.

Project Team Update

5. GR provided updates in relation to the following open actions:
    - Action 005: Work is ongoing to develop an options appraisal for regional/national medical staff bank. The group agreed at the last meeting of the group that a national bank model should include capabilities for negotiation, in order to ensure best value.
    - Action 006: Work is ongoing to develop a sign-off checklist which will be shared with [redacted] and [redacted] for comment, and then SAMD, before being brought back to the group in.
    - Actions 009 and 010 are included on the meeting agenda for discussion.

6. [redacted] advised that all milestones remain on track against the project plan, however the SBAR on price caps has been labelled as late, as it was originally the project team's intention to bring this to the June meeting. This paper will now be scheduled for the August meeting.

7. [redacted] highlighted that risk 006 in relation to medical staff banks has been updated to reflect the position that an options appraisal will be developed in advance of producing a business case for sharing with the relevant stakeholders.

Mitigating Medical Supply Deficits Update

8. [redacted] highlighted the work being done to look at the distribution of medical trainees against population need, as well as the establishment in relation to whole time equivalent (WTE) rather than headcount, which will support the filling of gaps created by less than full time training.

9. [redacted] advised that the Centre for Workforce Supply (CWS) are continuing to provide packages of bespoke support to a handful of Boards, including Lanarkshire and Golden Jubilee. CWS are working with Lanarkshire to address their Psychiatry vacancies with actions around improving marketing and attraction, as well as exploring international recruitment options. The CWS are supporting Golden Jubilee with a range of specialities and are also providing support to other Boards who have approached them following learning sessions.

10. [redacted] made the group of aware of the next learning session due to take place at the end of June, which focusses on reducing locum spend.

11. [redacted] highlighted the importance of looking at the equity of trainee allocation, as well as funding associated with WTE and expansion posts, given the challenging financial climate.

12. [redacted] confirmed that issues around WTE adjustments, expansion posts and associated funding are central to the remit of the shape of training transitions group and that these were discussed at the last meeting of that group. [redacted] agreed that the work is key to ensuring the medical workforce is right sized.

13. [redacted] also noted the importance of ensuring that any national developments are linked to Board level work in order to make sure that they enhance rather than cut across local developments.

Action: [redacted], [redacted] and [redacted] to discuss issues relating to WTE adjustments, expansion posts and associated funding.

Consultant Retention

14. [redacted] advised that members had requested an update in relation to retention at the last meeting of the group.

15. The Scottish Clinical Leadership Fellows will bring a paper to the next meeting of the group which explored the NES digital and GMC tracking and progression data, in relation to trainees.

16. In terms of consultant retention, [redacted] highlighted the Director's Letter issued on 4 June which was circulated to the group. The progress review, included in Annex A, reinstates key issues raised in the Improving Medical Retention Group's report, including pension taxation and career planning and development, as well as a number of mitigating factors and other key developments.

17. [redacted] confirmed that the potential for a national retention hub was still being explored, which is something NHS England have set up.

Direct Engagement

18. [redacted] presented the Direct Engagement SBAR which highlights the potential financial savings associated with accessing medical locums via direct engagement.

19. [redacted] advised that when directly engaging medical locums, Health Boards pay commission directly to the supplier, with the appropriate VAT payment added on and therefore they are not required to pay VAT on the hourly rate of the locum engagement. This allows a 20% VAT saving for the Health Board on the total cost of the locum.

20. Direct engagement compliance differs between Health Boards, with some Boards using it for all their locum engagements and others not using this method at all. [redacted] advised that Forth Valley have reported savings of over £250,000 last year by utilising direct engagement.

21. [redacted] highlighted the intention to introduce direct engagement reporting into the monthly financial performance reports in order to monitor uptake and the associated savings.

22. [redacted] invited the group to offer comments on the recommendations set out in the paper and indicate whether they are supportive.

23. [redacted] noted that the rate of take up for direct engagement will be linked to the maturity of the staff bank in each Board and indicated that there isn't currently a formal medical staff bank within NHS Highland, so a national staff bank could be an enabler for this in Boards who don't yet have a mature medical staff bank.

24. [redacted] also raised concerns about the difficult in reporting within primary care out of hours, where negotiation is more local. [redacted] assumes this would be more of an issue in rural areas.

25. [redacted] highlighted the importance of IR35 considerations, determination of status. and taking this into account.

26. [redacted] raised the issue that when someone is directly engaged they become an employee and are therefore entitled to pension contributions, which can cause the total cost of the engagement to be higher than it could have been with an individual who was not directly engaged.

27. [redacted] confirmed that all agency workers on direct engagement within Forth Valley are entitled to the pension scheme, but choose to opt out of it. Forth Valley have achieved significant financial savings by using the direct engagement method and are therefore supportive of it.

28. [redacted] also confirmed that GGC have a high percentage of direct engagement usage and all agency workers are within IR35. Similar to the situation in Forth Valley, individuals choose to opt out of the pension scheme or go into a NEST pension. [redacted] advised that GGC have also made financial savings as a result of utilising direct engagement.

29. GR summarised that there was broad agreement for reporting on direct engagement, but recognised that there was a number of wider factors, including maturity of the staff bank, which would impact on level of direct engagement uptake.

<u>NHS Lothian's approach to accessing medical locums</u>

30. [redacted] and [redacted] provided the group with an overview of NHS Lothian's approach to accessing medical locums, which includes using only direct engagement for all locums.

31. [redacted] advised that Lothian moved to an in house direct engagement model for agency in 2017 and since then all locum engagements have been via direct engagement.

32. [redacted] confirmed that Lothian operate a single staff bank for all staffing groups and while work was done to develop a regional approach in 2019, it didn't progress as a result of the pandemic. The entire bank is operated on a recharge arrangement, so the amount of bank that is supplied brings in the income to run the bank. [redacted] advised that the recharge rate is 7%.

33. The team within Lothian are responsible for recruiting medical locums, issuing all contracts (bank and direct engagement), matching the bank to service requirements, all the negotiations with agencies, generating payroll outputs and reconciliation of agency.

[redacted – Section s.36(1)].

34. [redacted] provided members with a walkthrough of the process taken in NHS Lothian to engage medical locums and agreed to share the slides and associated documentation with members.

35. [redacted] reported that Lothian have saved close to £5 million since the introduction of the direct engagement model in 2017. [redacted] also advised that Lothian's overall agency locum doctor spend has reduced year on year since 2021/22 and early indications for this year suggest that the trend is continuing.

36. [redacted] noted that Forth Valley were using a neutral vendor for the provision of medical agency until last year, but have now replicated the Lothian model which has been beneficial to Forth Valley.

37. [redacted] raised concerns that encouraging a shift in the market can be more challenging in remote locations where the pool of people is smaller. [redacted] also asked how Lothian managed the clinical risks associated with the implementation period.

38. [redacted] confirmed that the Board gave notice to locums that they would be moving to a direct engagement model and the Board began looking for alternative individuals for those locums who weren't prepared to be directly engaged. [redacted] clarified that services had a 3 month lead in period to find suitable alternatives and advised that services were never left short of locum supply.

39. Both [redacted] and [redacted] raised that it can be challenging when a locum has been in post for a number of years and is familiar with systems and sites, but is not prepared to move to a direct engagement contract. Both agreed that it's important to hold the line and [redacted] confirmed that in GGC there has been no issues with directly engaged doctors who've replaced non-direct engagement doctors who've been in post for a long time. [redacted] has also found that agency doctors who have initially pushed to remain non-directly engaged tend to agree to direct engagement once they see other direct engagement doctors taking up shifts.

40. [redacted] again raised that the level of compliance would be related to the level of investment in staff bank arrangements.

41. [redacted] noted that the Executive team in Grampian have mandated that all locum engagements should be via direct engagement, however they have some particularly hard to fill posts that have had to be filled with non-direct engagement doctors. [redacted] highlighted that having the clear steer from the executive team is helpful.

42. GR summarised that the group were supportive of encouraging direct engagement, with the recognition that compliance will be dependent on bank maturity and there will be some instances where it is not possible to get a direct engagement doctor.

43. [redacted] asked the group how best to formalise the position in relation to direct engagement and communicate it to Boards. [redacted] noted that in the other supplementary staffing group, Director's Letters have been used, but also papers routed through Chief Officer groups, including Board Chief Executives and Directors of Finance.

44. [redacted] noted that Director's Letters have been helpful in the nursing group, as they can set the formal direction of travel from the Scottish Government and can be used as leverage with agencies.

45. [redacted] agreed with the principle, but said it would be unhelpful to have a Director's Letter that mandates something dependent on other factors, as it puts Boards that are behind the curve at a disadvantage.

46. [redacted] suggested using the case study in Lothian as a learning opportunity rather than issuing a Director's Letter. [redacted] recommended that direct engagement be promoted as best practice, rather than directed at this stage.

47. GR advised that a note could be shared to highlight direct engagement as best practice, as it is recognised that Boards are all at different stages of implementation and compliance. GR acknowledged that some members thought a Director's Letter may be useful in the future, for Boards to use as leverage with agencies.

48. [redacted] highlighted that some Boards will struggle to fill certain hard to fill posts with non-direct engagement doctors. GR clarified that any Director's Letter would take this into account and would only be for the purpose of firmly signalling the direction of travel directed by Scottish Government to agencies.

Action: Note from co-chairs to be circulated to Boards to signal the direct engagement approach as best practice.

Medical Locum Reporting

49. [redacted] presented a proposed medical locum reporting template that is intended to gather data from Boards in relation to locum usage and spend on a monthly basis.

50. The group were invite to indicate whether or not they were supportive of the reporting metrics, noting that it is the intention to review the template and reporting process regularly to ensure it is fit for purpose and gathering meaningful data.

51. A number of members highlighted the need to understand what the data would be used for, given the added burden it creates for Boards.

52. [redacted] agreed to trial completion of the report and feed back to the group on how onerous the process is. He noted that collecting data for the nursing work has been beneficial in driving the work forward.

53. [redacted] advised that the purpose of data collection was to help understand the impact of the interventions that the group are discussing and looking to implement. Beyond this, [redacted] confirmed the data would be used to identify where further interventions may be of value, which has worked well in the nursing group and resulted in targeted activity in a number of areas.

54. [redacted] raised that the ability of Boards to facilitate data collection would again be dependent on the maturity of systems and processes in place around medical banks.

55. GR summarised that members felt a pilot of the reporting template was required, in Boards with both mature and less mature systems in place, in order to allow feedback to be gathered.

56. [redacted] confirmed that Ayrshire and Arran would take part in the pilot and noted that the benefits of collating this data may be evident once the pilot exercise is complete. [redacted] suggested a pilot timescale of 3 months.

57. [redacted] advised that Borders don't have the infrastructure in place to support the pilot at this stage, but that it might be possible to take part, dependent on pilot timescale.

58. [redacted] volunteered Highland to take part in the pilot and feed back to the group. [redacted] also volunteered on behalf of Grampian.

Action: Reporting template to be circulated to Boards who agreed to take part in the pilot.

AOB

59. [redacted] made members aware that it is the project team's intention to expand the remit of the Supplementary Staffing Annual reviews, which are bi-lateral engagement meetings with each of the Health Boards, to include the supplementary medical workforce. To date, these have only covered supplementary nursing staff.

60. [redacted] confirmed that a meeting had been arranged for 20 June to discuss next steps in relation to the medical staff bank work.

61. Date of next meeting Friday 16 August.

SUMMARY OF ACTION POINTS

Action	Owner
[redacted], [redacted] and [redacted] to discuss issues relating to WTE adjustments, expansion posts and associated funding.	[redacted]/ [redacted]/ [redacted]
Note from co-chairs to be circulated to Boards to signal the direct engagement approach as best practice.	[redacted]
Reporting template to be circulated to Boards who agreed to take part in the pilot.	[redacted]

Medical Locum Engagement Task & Finish Group
Friday 16 August 2024, 10:00-11:30

Attendees

Gillian Russell (GR) (Chair)	Director of Health Workforce – Scottish Government
Carol Potter (CP)	Chief Executive – NHS Fife
[redacted]	Deputy Director of Health Workforce, Planning and Development – Scottish Government
[redacted]	Specialist Lead, Recruitment and Supply – Centre for Workforce Supply, NES
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Scottish Clinical Leadership Fellow – Scottish Government
[redacted]	Medical Locum Bank Manager – NHS Lothian
[redacted]	Director of Finance – NHS Shetland
[redacted]	Medical Pay and TCS Lead – Management Steering Group
[redacted]	Unit Head, Sponsorship and Infrastructure – Scottish Government
[redacted]	Medical Director – NHS Ayrshire and Arran
[redacted]	Regional Secretary (West of Scotland) - British Medical Association
[redacted]	Head of HR Resourcing– NHS Forth Valley
[redacted]	Financial Improvement Senior Manager – Scottish Government
[redacted]	Chair, Academy of Medical Royal Colleges and Faculties
[redacted]	Director of Finance – NHS Grampian
[redacted]	Head of Strategic Sourcing and Commercial - NSS
[redacted]	Category Manager, National Procurement - NSS
[redacted]	Sponsorship and Infrastructure Unit – Scottish Government

Apologies:

[redacted]	Director of People and Culture – NHS Highland	
[redacted]	Deputy Medical Director - NES	
[redacted]	UNITE representative	
[redacted]	Medical Staff Bank Manager – NHS GGC	

Welcome and Introductions

1. GR welcomed all colleagues to the fifth meeting of the Medical Locum Engagement Task & Finish Group.
2. GR outlined that the purpose of the meeting was to consider a revised medical locum sign-off checklist, to hear updates in relation to the ongoing work to develop a medical staff bank options appraisal and feedback from the medical locum reporting template pilot, as well as to discuss some of the interventions being explored in NHS England and the implications associated with re-tendering the national procurement framework for medical locums early.
3. There were no comments on the minutes of the previous meeting.

Project Team Update

4. [redacted] provided updates in relation to the following open actions:
    - Action 005: An update in relation to the development of a medical staff bank options appraisal will be given under agenda item 4.
    - Action 006: A revised sign-off checklist will be shared with the group under item 3.
    - Action 009: A paper in relation to trainee retention is being developed and will be added to the agenda for the meeting in October.
    - Action 011: This action will be closed, following a discussion with [redacted], [redacted] and [redacted] on 24th June.
    - Action 012: This action will be closed following a co-chair letter being issued to Board Chief Executives on 13th July to encourage the use of direct engagement as a best practice approach.
    - Action 013: This action will be closed following the sharing of a medical locum reporting template with those Boards who agreed to be part of the pilot.

5. The group had no further comments on the risk log.

Medical Locum Sign-Off Process Checklist

6. [redacted] provided an overview of the work done to date to develop a consistent sign-off process across Health Boards for medical locum engagements, which the group had previously signalled would be beneficial to ensure the necessary rigour around locum engagements.
7. [redacted] highlighted that a previous version of the checklist had been shared with members in April, but that members had requested further work be done to engage with Medical Directors via [redacted] and [redacted] in order to test aspects of the checklist and review the timeframes and thresholds proposed.
8. [redacted] thanked [redacted] and [redacted] for their support in developing the latest iteration of the checklist and confirmed that the group's feedback had been taken into account and the timeframes and thresholds previously proposed had been adjusted.
9. [redacted] also advised that the checklist was being reframed as best practice, to support the development of local procedures and as such the status of the document would be advisory.
10. In order to further test the checklist, [redacted] signalled that the project team had engaged in discussions with NHS England's Temporary Staffing Workforce Team to understand how their medical locum sign-off process operates. NHS England currently

require that all off-framework locum engagements and any engagements exceeding £100 an hour or more require Chief Executive sign-off. [redacted] noted that they had previously set the threshold at £120 an hour, but within a year of introducing the control, they had eradicated all spend above this.

11. The revised checklist for NHS Scotland suggests implementing a cost threshold of £126.29 an hour, which aligns with the Health and Care (Staffing) (Scotland) Act 2019 definition of high cost agency and recommends that any engagements lasting 2 weeks in duration or more are signed off by a Board's Medical Director or relevant deputy.
12. [redacted] asked the group to comment on the revised checklist and signal whether they would be content for it to be distributed to Boards with a request that is be adopted as an example of best practice.
13. [redacted] welcomed the sharing of best practice and advised that Forth Valley are planning to develop a medical workforce governance group chaired by their Medical Director, with input from budget holders and finance, to oversee all decision making in relation to the engagement of medical locums.
14. [redacted] also suggested making it clear that the cost threshold should apply specifically to new locum engagements, noting that it will take some time to get the current workforce at those rates.
15. [redacted] suggested adjusting the checklist to request that sign-off for any engagements exceeding the cost or time threshold should be signed off by a Board's accountable officer or nominated deputy.
16. [redacted] also asked members to consider whether it would make sense to match NHS England's cost threshold, given that an hourly rate of £126.29 is still excessive for a medical locum and England manage the market for the whole of the UK based on their size.
17. [redacted] highlighted the importance of expanding the checklist to include staff engaged via staff banks, as there are instances where bank staff are paid above NHS rates of pay for bank work.
18. [redacted] noted that Medical Directors are committed to reducing the costs associated with accessing medical locums, but that the checklist needs to be flexible enough to account for the differences between Boards, noting that each one will be starting from a different position.
19. CP supported the checklist and voiced that she felt it was sufficiently flexible to be utilised by Boards across the country and agreed with [redacted] comment that the checklist shouldn't be prescriptive as to which specific individual signs off engagements.
20. [redacted] also supported the checklist and noted that the suggested arrangements are similar to what has been put in place around nurse agency and therefore there is a level of equity in relation to how doctors and nurses are being treated.
21. [redacted] also advised that, during conversations with agencies, it is clear that they care most about the level of commission they are receiving, rather than the rate of pay that's being offered to locums.
22. GR summarised that there was broad support for the checklist and ensuring a coherent and collective approach across NHS Scotland, but that we should work alongside Boards to offer them the support required to make progress.
23. Members were supportive of the checklist being amended to reflect that it should be an appropriate Executive Lead(s) identified by the Chief Executive as accountable officer who has ultimate sign-off responsibility and agreed that a range of perspectives should be considered.
24. [redacted] confirmed that there is a programme of bi-lateral engagement meetings with Boards in the coming weeks and that this would be a good place to discuss the approach

with Boards and how we can support both them and the sharing of learning and best practice across Boards.

25. [redacted] also suggested doing a separate piece of work to introduce greater consistency to the rates of pay for bank staff.
26. [redacted] suggested that the variation in rates of pay for bank staff would be a natural and inevitable factor when Boards have such differing requirements.

Action: Develop a letter to issue to Boards to signal the development of the checklist, highlight its advisory status while encouraging itis use.

Medical Staff Bank Options Appraisal Update

27. [redacted] provided members with an update in relation to the development of a medical staff bank options appraisal, which considers 4 options: do nothing (status quo), target operating model, regional bank, national bank.
28. [redacted] advised that a small subgroup of the Task and Finish Group has been brought together to develop the options appraisal and provide representation from Boards across the country, with a range of bank structures.
29. [redacted] set out each of the options and assessment criteria and asked members to provide any feedback on the outlined approach.
30. Members were content with the approach and HA advised that the subgroup would be meeting shortly to score options, with a fuller update being provided to the Task & Finish Group at the October meeting.

NSS – Retendering Temporary Agency Medical Locum Doctors Framework

31. [redacted] advised that at the meeting of the Task & Finish Group on 9th May, members indicated that, as part of the National procurement framework, it would be helpful to define a national step down rate for long term locum engagements. NSS had advised that this would form part of the retendering exercise in 2027, however the group felt it should be done as soon as possible.
32. [redacted] outlined that there are a number of risks associated with retendering the framework at this stage, including that suppliers may increase their rates due to the current financial climate.
33. [redacted] also noted that a percentage of locum engagements will be off-framework and only some will exceed four weeks in duration, and so asked the group whether they felt the potential savings outweighed the risks associated with retendering at this stage.
34. [redacted] also confirmed that Boards do have the ability to negotiate a step down rate for long term engagements within the current framework terms and conditions.
35. [redacted] highlighted the important of consistently applying framework rates and noted that it was not an appropriate time within the cycle to introduce a retender.
36. [redacted] suggested that NSS may be able to accommodate something within the extension exercise, at which point demand metrics may have changed, that encourages agencies to agree to national step down rates, but a decision would need to be made as to whether this was made a condition of the framework or not.
37. [redacted] advised that commission rates are capped as part of the framework, but within the extension exercise, NSS could ask agencies if they can propose a secondary commission rate for long term engagements, noting that some may choose not to.
38. GR summarised that members were in agreement that this is not an appropriate time within the cycle to retender the whole framework, however within the existing framework there are opportunities to drive consistency and reset the market.

Action: Project team to work with NSS to develop proposition for the current framework.

NHS England Medical Locum Engagements

39. [redacted] informed members that the project team had engaged in discussions with colleagues from NHS England's Temporary Staffing Workforce Team to understand the range of interventions being explored and implemented in NHS England in an attempt to reduce the costs associated with accessing medical locums.
40. [redacted] advised that the conversation with NHS England had originally been to discuss price caps, which the group had committed to exploring as part of the original work plan, however because price cap compliance has never been above 16% in NHS England, the project team did not feel it was worthwhile implementing them in NHS Scotland at the current time.
41. [redacted] highlighted a number of other steps NHS England have taken including targeting off-framework locum usage in the first instance before turning to framework engagements and requiring Chief Executive sign off for any off-framework engagements or engagements costing £100 an hour or more.
42. [redacted] also advised that NHS England currently collect monthly data from Trusts in relation to locum usage, the top 10 highest paid and top 10 longest serving, in order to target these engagements. The medical locum reporting template currently being piloted by three NHS Scotland Boards requests the top 5 spends on a monthly basis.
43. [redacted] confirmed that NHS England have taken a similar approach to direct engagement by encouraging Trusts to use it correctly where possible.
44. [redacted] was supportive of targeting off-framework engagements in the first instance and advised that the medical locum reporting template has allowed him to identify the off-framework engagements within Forth Valley and target these.
45. Both [redacted] and [redacted] advised that some of this should already be captured as part of local governance and HCSA reporting.
46. [redacted] suggested developing a better evidence base in relation to the frequency of off-framework engagements and the circumstances surrounding these before developing a proposal for targeting off-framework engagements.

Action: Develop action plan in relation to off-framework medical locum engagements.

Medical Locum Reporting Pilot Feedback

47. [redacted] offered feedback to members on behalf of the three Boards, Grampian, Highland and Forth Valley, who volunteered to support a pilot of the medical locum reporting template.
48. [redacted] thanked Boards for their support in completing the template and advised members that the feedback had been positive, with Boards suggesting that collation of the data was helpful and would be used to inform internal reports.
49. [redacted] noted that the information requested in the template was more easily collated as a result of the preparation for Q1 and Q2 HCSA reports and that the report provides a focus for the workforce teams to tackle areas that can be replaced with lower cost options.
50. [redacted] suggested collecting 6 months worth of data to understand the national picture, before deciding whether or not to target off-framework use. Collation of the data would also provide assurance around value for money.

51. [redacted] highlighted that having current data is critical to the success of the group. [redacted] suggested offering a slightly extended lead time for the first return to give Boards sufficient notice to satisfy the request once it is issued.

52. CP supported this approach and suggested implementing across all Boards from October, with reporting into November.

AOB

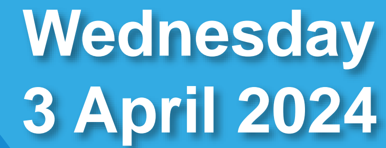
53. GR advised members that an update from CWS and NES Medical Directorate colleagues would be provided at the meeting in October in relation to the ongoing work to mitigate the medical supply deficits.

54. Date of next meeting: 22nd October 2024.

SUMMARY OF ACTION POINTS

Action	**Owner**
Develop a letter to issue to Boards to signal the development of the checklist, highlight its advisory status while encouraging its use.	Project Team
Project team to work with NSS to develop proposition for the current framework.	Project Team
Develop action plan in relation to off-framework medical locum engagements.	Project Team

NHS National Services Scotland



Medical Locum Engagement Task & Finish Group – Meeting Pack

NHS National Services Scotland

Medical Locum Engagement Task & Finish Group Agenda

Time	No.	Item	Member/Presenter	Papers
14:00-14:05	1	Welcome & Apologies • Approval of previous minutes • Approval of updated ToR	Gillian Russell	-
14:05-14:10	2	Project team update • Actions • Updates • Risks/Issues	[redacted]	*Medical Locum Engagement Task & Finish Group March Meeting Pack*
14:10-14:15	3	Revised Workplan	Gillian Russell	*Medical Locum Engagements Task & Finish Group Workplan V2*
14:15-14:30	4	'Right sizing' the Medical Workforce	[redacted] [redacted]	-
14:30-14:40	5	Mitigating Medical Supply Deficits Update	[redacted] [redacted] [redacted]	*CWS Medical Network Documents*
14:40-15:00	6	Benefits of Medical Staff Banks	[redacted]	*MLTFG – Benefits of a Staff Bank SBAR*
15:00-15:25	7	Escalatory Process	[redacted]	*MLTFG – Escalatory Process SBAR*
15:25-15:30	8	AOB	Gillian Russell	-

Programme Management

Actions

NHS National Services Scotland

Action No.	Action Date	Status	Action	Owner	Comments
001	29/02/2024		Revised terms of reference to be circulated with a number of amendments to the membership, governance, Meeting Frequency, Secretariat and Decision Making sections.	[redacted]	22/03/24 – Revised terms of reference circulated to members on 28/03/24.
002	29/02/2024		Further work to be done to clarify the roles and responsibilities in relation to the risks.	[redacted]/[redacted]	25/03/24 – Mitigations now added to the risk register and it has been identified that Health Boards will be responsible for owning the risks associated with this work.
003	29/03/24		Revised workplan to be shared via correspondence in advance of the next meeting.	[redacted]	22/03/24 – Revised workplan circulated to members on 28/03/24 and to be agreed at meeting on 3 April.

Period for report: 29/02/24 to 04/04/24

NHS National Services Scotland

Medical Locum Engagement Update

Programme Aims

- Strengthen NHS Scotland's approach to the use of medical locums.
- Ensuring Health Boards secure best value when accessing medical locum support.
- Achieving the above without compromising delivery or quality of care.

Programme Streams - Highlights

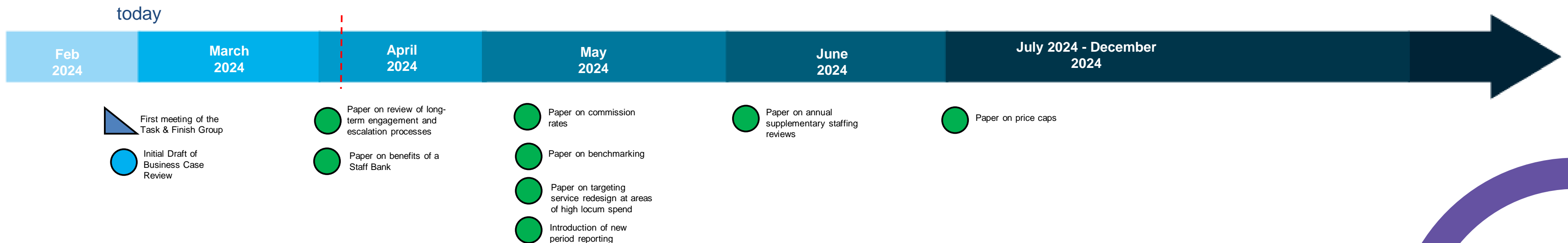
- Revised workplan shared with the group for agreement.
- Benefits of Staff Banks and Escalatory Process SBARs to be presented for discussion at the group.

Recent achievements

- Development of Staff Bank and Escalatory Process Papers for discussion at the group.

Challenges & Opportunities

- Boards are under significant financial pressure.
- Reliance on locums may bring limitations in terms of quality of care.
- Reliance on locums may bring wider challenges in terms of medical staff wellbeing/morale.



Programme Management

Timeline

NHS National Services Scotland

Timeline

February 2024	March 2024	April 2024	May 2024	June 2024	July 2024
	29/02 Initial Meeting of revised MWSG (Key Meeting) 29/02/2024 Initial Draft of Business Case review (On track)	03/04 Paper on review of long-term engagements and escalation processes (On track) 03/04 Paper on Benefits of a Staff Bank (On track)	09/05 Paper on Commission Rates (On track) 09/05 Paper on Benchmarking (On track) 09/05 Introduction of periodic reporting (On track)	06/06 Paper on Annual Supplementary Staffing Reviews (On track) 06/06 Paper on Price Caps (On track)	

Key

- On track
- At risk
- Late
- Complete
- Key Meeting
- Key Comms Activity
- Today

Risks

RISK ID	DESCRIPTION	EFFECT / IMPACT	MITIGATION	RISK			
				IMPACT	LIKELIHOOD	SCORE	LEVEL
R001	There is a risk that Health Boards have insufficient financial resources to afford to implement recommended measures.	Cost saving measures may not be possible to implement due to high up-front costs.	Many of the potential interventions identified in the Task & Finish Group workplan are intended to be implemented with little to no additional financial investment. Where proposals are brought forward which carry financial implications, these will be quantified in order to support the T&F Group in fully understanding affordability.	25	5	125	Very High
R002	There is a risk that Health Boards have insufficient staff resources to carry out the work necessary to implement recommended measures.	Cost saving measures may not be possible to implement due to a lack of available staff.	Many of the potential interventions identified in the workplan are intended to be implemented with little to no investment in additional staff. Where interventions are likely to require additional workforce capacity, these will be assessed in advance in order that the T&F Group can arrive at an informed decision.	25	3	75	High
R003	There is a risk that due to the desire to realise savings as fast as possible, timelines for implementation of measures may be artificially shortened.	Projects will not deliver to timeline, leading to potential cost overruns.	A milestone timeline for the group has been developed which sequences interventions based on both deliverability and impact.	10	5	50	High

NHS National Services Scotland

Risks

RISK ID	DESCRIPTION	EFFECT / IMPACT	MITIGATION	RISK			
				IMPACT	LIKELIHOOD	SCORE	LEVEL
R004	There is a risk that the mobility of the medical locum workforce makes the implementation of measures to control costs difficult to maintain without impact on service delivery.	Measures may have to be reversed to preserve service delivery or delivery of some services may be compromised.	Any measures will be explored in detail via papers to the group before a decision is made as to whether or not to implement. The implementation of any measures will be monitored to ensure the impacts on service delivery are acceptable.	50	3	150	Very High
R005	There is a risk that the legal requirement for Health Boards to deliver services makes it difficult for measures to reduce locum usage in the short to medium term to have any impact.	Boards repeatedly break controls to ensure service delivery.	Periodic reporting will be put in place later this year to allow the group to track and monitor locum usage. This will help identify areas/ specialities where additional support may be required.	25	5	125	Very High
R006	There is a risk that if Boards establish staff banks, they do not receive sufficient interest to mitigate setup costs.	Boards incur setup costs without realising sufficient benefit to justify the expenditure.	It is recommended that Health Boards who do not currently operate a Medical Staff Bank develop a business case setting out the potential return on investment.	50	2	100	Very High

NHS National Services Scotland

Risks

RISK ID	DESCRIPTION	EFFECT / IMPACT	MITIGATION	RISK			
				IMPACT	LIKELIHOOD	SCORE	LEVEL
R007	There is a risk that the make-up of the medical workforce makes the use of national levers such as price caps ineffective and in some cases counterproductive.	National interventions are ineffective or actively counter-productive to the goals of the work.	A paper exploring the full benefits and drawbacks associated with introducing price caps will be shared with the group in June.	50	5	250	Very High
R008	There is a risk that Boards view themselves as in competition with each other for locums and are therefore averse to sharing best practice that they feel gives them an advantage over other Boards in the market.	The most potentially effective measures may not be identified due to efforts to maintain a competitive advantage over other Boards. Benchmarking information could be used to facilitate competitive advantage.	The Medical Locum Engagement Task & Finish Group will act as a space for the sharing of best practice and learning. The Group will encourage shared learning based on the benefits this brought to the nursing work and the advantages associated with taking a national approach.	25	2	50	High

NHS National Services Scotland

Scottish Government Risk Matrix

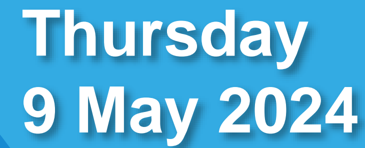
Risk Level	Score	Risk Level Description
VERY HIGH	100-250	Rating: Unacceptable level of risk exposure that requires immediate mitigating action. Reporting: A decision should be taken whether to report the risk to Accountable Officer/Audit Committee level or Programme Board or for possible reporting to the Executive Team and Corporate Board.
HIGH	40-75	Rating: Unacceptable level of risk which requires controls to be put in place to reduce exposure. Reporting: A decision should be taken as to whether risks recorded as high should be escalated. Scores between 40 and 50 would not usually be escalated where scores of 75 should be given careful consideration.
MEDIUM	10-30	Rating: Acceptable level of risk exposure subject to regular active monitoring. Reporting: At directorate level.
LOW	1-5	Rating: Acceptable level of risk subject to regular passive monitoring. Reporting: At directorate level. Consideration should be given as to whether risks recorded as low are still extant.

IMPACT	CRITERIA
50 VERY HIGH	Destructive and unacceptable impact on objectives that would result in a major change to overall approach. Potentially large resource consequences that outweigh current operational circumstances.
25 HIGH	Significant and unacceptable impact on objectives that would require a material change to critical approach/procedure/ process. Resource implications would be challenging to absorb within current operational circumstances.
10 MEDIUM	Moderate impact on objectives that may require multiple changes in approach/procedure/process. Acceptable level of resource consequences.
5 LOW	Minor impact on objectives, requires little overall change in approach. Few resource consequences.
1 NEGLIGIBLE	No real impact on achieving objectives.

LIKELIHOOD	CRITERIA
5 VERY HIGH	>75% chance of occurring – almost certain to occur
4 HIGH	51-75% chance of occurring – more likely to occur than not
3 MEDIUM	26-50% chance of occurring – fairly likely to occur
2 LOW	6-25% chance of occurring – unlikely to occur
1 RARE	1-5% chance of occurring – extremely unlikely to occur

Programme Management

NHS National Services Scotland



Medical Locum Engagement Task & Finish Group – Meeting Pack

NHS National Services Scotland

Medical Locum Engagement Task & Finish Group Agenda

Time	No.	Item	Member/Presenter	Papers
14:00-14:10	1	Welcome & Apologies • Approval of previous minutes • Approval of updated ToR	Carol Potter	*Medical Locum Engagement Task & Finish Group – ToR V.03*
14:10-14:20	2	Project team update • Actions • Updates • Risks/Issues	[redacted]	*Medical Locum Engagement Task & Finish Group May Meeting Pack*
14:20-14:40	3	Mitigating Medical Supply Deficits Update	[redacted] [redacted] [redacted]	*Presentation*
14:40-15:00	4	Benchmarking of Locum Pay Rates	[redacted]	*MLTFG – Benchmarking SBAR*
15:00-15:20	5	Commission Rate Review	[redacted]	*MLTFG – Commission Rates SBAR*
15:20-15:30	6	AOB	Carol Potter	-

Programme Management

Open Actions

NHS National Services Scotland

Action No.	Action Date	Status	Action	Owner	Comments
004	03/04/2024		Amend ToR and put on the agenda for agreement at next meeting.	[redacted]	29/04: Amended ToR added to agenda for agreement at meeting on 09/05/2024.
005	03/04/2024		Project team to work with Board colleagues to arrange the development of a business case in support of a national approach to medical banks.	[redacted]/[redacted]	29/04: Project team met with a small subgroup of the task and finish group on 14 April to discuss the development of an options appraisal exploring both a regional and national approach to banks, acknowledging that the group's preference was for a national approach.
006	03/04/2024		Crawford McGuffie and Lynn McCallum to seek feedback on the sign off process SBAR from SAMD and work with the project team to update the paper accordingly.	[redacted]/[redacted]	29/04: CM and LM discussed feedback from SAMD with project team on 26/04/24 and agreed to work together to develop a checklist that will be brought back to the group.

Period for report: 29/02/24 to 04/04/24

NHS National Services Scotland

Medical Locum Engagement Update

Programme Aims

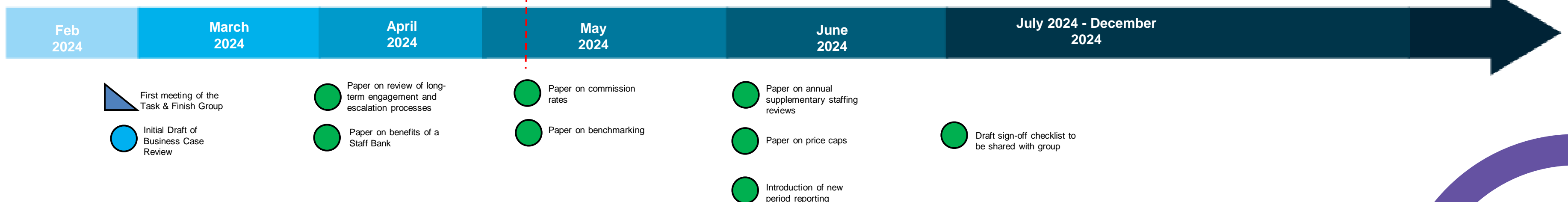
- Strengthen NHS Scotland's approach to the use of medical locums.
- Ensuring Health Boards secure best value when accessing medical locum support.
- Achieving the above without compromising delivery or quality of care.

Recent Developments

- Development of Benchmarking Pay Rates and Commission Rate Review SBARs.
- Meeting with subgroup to discuss approach to options appraisal for regional/ national medical bank model.
- Meeting to discuss SAMD feedback to sign-off process SBAR and next steps.

Challenges & Opportunities

- Boards are under significant financial pressure.
- Reliance on locums may bring limitations in terms of quality of care.



Programme Management

Timeline

Key

- On track
- At risk
- Late
- Complete
- Key Meeting
- Key Comms Activity
- Today

Risks

NHS National Services Scotland

RISK ID	DESCRIPTION	EFFECT / IMPACT	MITIGATION	RISK			
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R001	There is a risk that Health Boards have insufficient financial resources to afford to implement recommended measures.	Cost saving measures may not be possible to implement due to high up-front costs.	Many of the potential interventions identified in the Task & Finish Group workplan are intended to be implemented with little to no additional financial investment. Where proposals are brought forward which carry financial implications, these will be quantified in order to support the T&F Group in fully understanding affordability.	25	5	125	Very High
R002	There is a risk that Health Boards have insufficient staff resources to carry out the work necessary to implement recommended measures.	Cost saving measures may not be possible to implement due to a lack of available staff.	Many of the potential interventions identified in the workplan are intended to be implemented with little to no investment in additional staff. Where interventions are likely to require additional workforce capacity, these will be assessed in advance in order that the T&F Group can arrive at an informed decision.	25	3	75	High
R003	There is a risk that due to the desire to realise savings as fast as possible, timelines for implementation of measures may be artificially shortened.	Projects will not deliver to timeline, leading to potential cost overruns.	A milestone timeline for the group has been developed which sequences interventions based on both deliverability and impact.	10	5	50	High

Risks

NHS National Services Scotland

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NHS National Services Scotland

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R008	There is a risk that Boards view themselves as in competition with each other for locums and are therefore averse to sharing best practice that they feel gives them an advantage over other Boards in the market.	The most potentially effective measures may not be identified due to efforts to maintain a competitive advantage over other Boards. Benchmarking information could be used to facilitate competitive advantage.	The Medical Locum Engagement Task & Finish Group will act as a space for the sharing of best practice and learning. The Group will encourage shared learning based on the benefits this brought to the nursing work and the advantages associated with taking a national approach.	25	2	50	High

NHS National Services Scotland

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Programme Management

NHS
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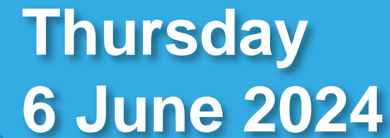


Medical Locum Engagement Task & Finish Group – Meeting Pack

NHS National Services Scotland

Medical Locum Engagement Task & Finish Group Agenda

Time	No.	Item	Member/Presenter	Papers
14:00-14:05	1	Welcome & Apologies • Approval of previous minutes	Gillian Russell	-
14:05-14:10	2	Project team update • Actions • Updates • Risks/Issues	[redacted]	*Medical Locum Engagement Task & Finish Group June Meeting Pack*
14:10-14:20	3	Mitigating Medical Supply Deficits Update	[redacted] [redacted]	-
14:20-:14:35	4	Consultant Retention	[redacted]	-
14:35-14:55	5	Direct Engagement	[redacted]	*MLTFG – Direct Engagement SBAR*
14:55-15:15	6	NHS Lothian's approach to accessing medical locums	[redacted] [redacted]	*Presentation*
14:15-15:25	7	Medical Locum Reporting	[redacted]	*Medical Locum Monthly Reporting Template*
15:25-15:30	8	AOB • Annual Supplementary Staffing Reviews	Gillian Russell	-

NHS National Services Scotland

Open Actions

Action No.	Action Date	Status	Action	Owner	Comments
005	03/04/2024		Project team to work with Board colleagues to arrange the development of a business case in support of a national approach to medical banks.	[redacted]/[redacted]	28/05: Work is ongoing to develop an options appraisal for regional/national medical staff bank. Agreement from Task & Finish group in May that a national bank model should include capabilities for negotiation to ensure best value.
006	03/04/2024		Crawford McGuffie and Lynn McCallum to seek feedback on the sign off process SBAR from SAMD and work with the project team to update the paper accordingly.	[redacted]/[redacted]	28/05: Work is ongoing to develop a sign-off checklist which will be shared with CM and LM for feedback before it is taken to SAMD and then back to the group. Intention to share draft checklist at August meeting.
007	09/05/2024		Terms of reference to be amended to show links to Joint Negotiating Committee	[redacted]	28/05: ToR have been amended to reflect this change
008	09/05/2024		Lindsay Haines to share recording of Kerala session with members.	[redacted]	28/05: Recording and associated documents shared with the group on 28 May 2024.
009	09/05/2024		John Colvin to provide retention update at upcoming meeting.	[redacted]	28/05: Consultant retention added to the 6 June meeting agenda. Paper on trainee retention to be added to future meeting agenda.
010	09/05/2024		Invite colleagues from Lothian to present their approach to the engaging of medical agency.	[redacted]	28/05: Fiona Ireland and Kenny Solway to present at meeting on 6 June.

Period for report: 29/02/24 to 04/04/24

NHS National Services Scotland

Medical Locum Engagement Update

Programme Aims

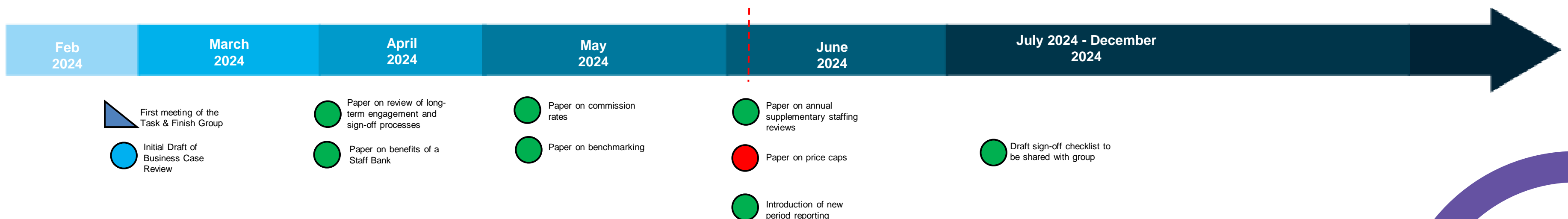
- Strengthen NHS Scotland's approach to the use of medical locums.
- Ensuring Health Boards secure best value when accessing medical locum support.
- Achieving the above without compromising delivery or quality of care.

Recent Developments

- Development of monthly reporting template.
- Development of direct engagement SBAR.

Challenges & Opportunities

- Boards are under significant financial pressure.
- Reliance on locums may bring limitations in terms of quality of care.



Programme Management

Timeline

	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024
Timeline	29/02 Initial Meeting of revised MWSG 29/02/2024 Initial Draft of Business Case review		03/04 Paper on review of long-term engagements and escalation processes 03/04 Paper on Benefits of a Staff Bank	09/05 Paper on Commission Rates 09/05 Paper on Benchmarking	06/06 Paper on Annual Supplementary Staffing Reviews 06/06 Paper on Price Caps 06/06 Introduction of periodic reporting 06/06 Paper on direct engagement		10/07 Draft sign-off checklist to be shared with the group.

Key

- On track
- At risk
- Late
- Complete
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NHS National Services Scotland

Risks

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R006	There is a risk that if Boards establish staff banks, they do not receive sufficient interest to mitigate setup costs.	Boards incur setup costs without realising sufficient benefit to justify the expenditure.	An options appraisal, exploring the pros and cons of regional/ national bank structures will be produced, with a view to developing a business case for a national bank structure, which the group felt would be most beneficial. This business case will be shared with the relevant stakeholders before	50	2	100	Very High

NHS National Services Scotland

Risks

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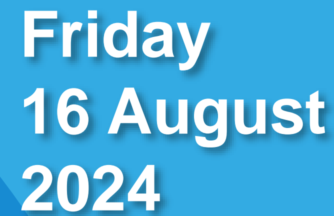

Medical Locum Engagement Task & Finish Group – Meeting Pack

NHS National Services Scotland

Medical Locum Engagement Task & Finish Group Agenda

Time	No.	Item	Member/Presenter	Papers
10:00-10:05	1	Welcome & Apologies • Approval of previous minutes	Gillian Russell	-
10:05-10:10	2	Project team update • Actions • Updates	[redacted]	*Medical Locum Engagement Task & Finish Group August Meeting Pack*
10:10-10:25	3	Medical Locum Sign-Off Process Checklist	[redacted]	*Medical Locum Sign-Off Process Checklist*
10:25-10:40	4	Medical Staff Banks Options Appraisal Update	[redacted]	*Presentation*
10:40-10:55	5	NSS – retendering	[redacted]	-
10:55-11:20	6	NHS England Medical Locum Engagements	[redacted]/[redacted]	*NHS England Medical Locum Engagements*
11:20-11:25	7	Medical Locum Reporting Pilot Feedback	[redacted]	-
11:25-11:30	8	AOB	Gillian Russell	-

Open Actions

Action No.	Action Date	Status	Action	Owner	Comments
005	03/04/2024		Project team to work with Board colleagues to arrange the development of a business case in support of a national approach to medical banks.	[redacted]/[redacted]	31/07: An update in relation to the development of an options appraisal will be given at meeting on 16/08. Subgroup are due to score options on 22/08.
006	03/04/2024		Crawford McGuffie and Lynn McCallum to seek feedback on the sign off process SBAR from SAMD and work with the project team to update the paper accordingly.	[redacted]/[redacted]	31/07: An updated sign-off checklist will be shared with the group on 16/08 for discussion.
009	09/05/2024		John Colvin to provide retention update at upcoming meeting.	[redacted]	31/07: Trainee retention paper being developed and will be added to agenda for meeting in October.
011	06/06/24		John Colvin, Lindsay Donaldson and Lynn McCallum to discuss issues relating to WTE adjustments, expansion posts and associated funding.	[redacted]/[redacted]/[redacted]	31/07: Discussion took place on 24th June.
012	06/06/24		Note from co-chairs to be circulated to Boards to signal the direct engagement approach as best practice.	[redacted]	31/07: A co-chair letter was issued to Board Chief Executives on 13 July to encourage direct engagement and make them aware that direct engagement compliance would form part of the monthly financial performance returns going forward.
013	06/06/24		Reporting template to be circulated to Boards who agreed to take part in the pilot.	[redacted]	31/07: Reporting template shared with Grampian, Highland and Forth Valley on 13 June.

Period for report: 07/06/24 to 16/08/24

NHS National Services Scotland

Medical Locum Engagement Update

Programme Aims

- Strengthen NHS Scotland's approach to the use of medical locums.
- Ensuring Health Boards secure best value when accessing medical locum support.
- Achieving the above without compromising delivery or quality of care.

Recent Developments

- Discussion with NHS England colleagues regarding their approach to accessing medical locums.
- Development of medical staff bank options appraisal and date scheduled for scoring options.
- Updated sign-off checklist developed for sharing with the group.

Challenges & Opportunities

- Boards are under significant financial pressure.
- Reliance on locums may bring limitations in terms of quality of care.

Timeline

NHS National Services Scotland

Timeline

April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024

- 03/04 Paper on review of long-term engagements and escalation processes
- 03/04 Paper on Benefits of a Staff Bank
- 09/05 Paper on Commission Rates
- 09/05 Paper on Benchmarking
- 06/06 Paper on Annual Supplementary Staffing Reviews
- 06/06 Paper on Price Caps
- 06/06 Introduction of periodic reporting
- 06/06 Paper on direct engagement
- 10/07 Draft sign-off checklist to be shared with the group.
- 22/10 Medical Staff Bank Options Appraisal to be shared with the group.

Key

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- Late
- Complete
- Key Meeting
- Key Comms Activity
- Today

NHS National Services Scotland

Risks

RISK ID	DESCRIPTION	EFFECT / IMPACT	MITIGATION	RISK			
				IMPACT	LIKELIHOOD	SCORE	LEVEL
R001	There is a risk that Health Boards have insufficient financial resources to afford to implement recommended measures.	Cost saving measures may not be possible to implement due to high up-front costs.	Many of the potential interventions identified in the Task & Finish Group workplan are intended to be implemented with little to no additional financial investment. Where proposals are brought forward which carry financial implications, these will be quantified in order to support the T&F Group in fully understanding affordability.	25	5	125	Very High
R002	There is a risk that Health Boards have insufficient staff resources to carry out the work necessary to implement recommended measures.	Cost saving measures may not be possible to implement due to a lack of available staff.	Many of the potential interventions identified in the workplan are intended to be implemented with little to no investment in additional staff. Where interventions are likely to require additional workforce capacity, these will be assessed in advance in order that the T&F Group can arrive at an informed decision.	25	3	75	High
R003	There is a risk that due to the desire to realise savings as fast as possible, timelines for implementation of measures may be artificially shortened.	Projects will not deliver to timeline, leading to potential cost overruns.	A milestone timeline for the group has been developed which sequences interventions based on both deliverability and impact.	10	5	50	High

NHS National Services Scotland

Risks

RISK ID	DESCRIPTION	EFFECT / IMPACT	MITIGATION	RISK			
				IMPACT	LIKELIHOOD	SCORE	LEVEL
R004	There is a risk that the mobility of the medical locum workforce makes the implementation of measures to control costs difficult to maintain without impact on service delivery.	Measures may have to be reversed to preserve service delivery or delivery of some services may be compromised.	Any measures will be explored in detail via papers to the group before a decision is made as to whether or not to implement. The implementation of any measures will be monitored to ensure the impacts on service delivery are acceptable.	50	3	150	Very High
R005	There is a risk that the legal requirement for Health Boards to deliver services makes it difficult for measures to reduce locum usage in the short to medium term to have any impact.	Boards repeatedly break controls to ensure service delivery.	Periodic reporting will be piloted to allow the group to track and monitor locum usage. This will help identify areas/ specialities where additional support may be required, as well as monitor the impact of interventions.	25	5	125	Very High
R006	There is a risk that if Boards establish staff banks, they do not receive sufficient interest to mitigate setup costs.	Boards incur setup costs without realising sufficient benefit to justify the expenditure.	An options appraisal, exploring the pros and cons of a range of bank structures will be produced, with a view to developing a business case for a the preferred option. This business case will be shared with the relevant stakeholders before implementation.	50	2	100	Very High

Risks

RISK ID	DESCRIPTION	EFFECT / IMPACT	MITIGATION	RISK			
				IMPACT	LIKELIHOOD	SCORE	LEVEL
R007	There is a risk that the make-up of the medical workforce makes the use of national levers such as price caps ineffective and in some cases counterproductive.	National interventions are ineffective or actively counter-productive to the goals of the work.	The Medical Locum Engagement Task & Finish Group will draw on learning from NHS England's experience of implementing price caps before any decisions with regards to implementation are made.	50	5	250	Very High
R008	There is a risk that Boards view themselves as in competition with each other for locums and are therefore averse to sharing best practice that they feel gives them an advantage over other Boards in the market.	The most potentially effective measures may not be identified due to efforts to maintain a competitive advantage over other Boards. Benchmarking information could be used to facilitate competitive advantage.	The Medical Locum Engagement Task & Finish Group will act as a space for the sharing of best practice and learning. The Group will encourage shared learning based on the benefits this brought to the nursing work and the advantages associated with taking a national approach.	25	2	50	High

NHS National Services Scotland

Scottish Government Risk Matrix

Risk Level	Score	Risk Level Description
VERY HIGH	100-250	Rating: Unacceptable level of risk exposure that requires immediate mitigating action. Reporting: A decision should be taken whether to report the risk to Accountable Officer/Audit Committee level or Programme Board or for possible reporting to the Executive Team and Corporate Board.
HIGH	40-75	Rating: Unacceptable level of risk which requires controls to be put in place to reduce exposure. Reporting: A decision should be taken as to whether risks recorded as high should be escalated. Scores between 40 and 50 would not usually be escalated where scores of 75 should be given careful consideration.
MEDIUM	10-30	Rating: Acceptable level of risk exposure subject to regular active monitoring. Reporting: At directorate level.
LOW	1-5	Rating: Acceptable level of risk subject to regular passive monitoring. Reporting: At directorate level. Consideration should be given as to whether risks recorded as low are still extant.

IMPACT	CRITERIA
50 VERY HIGH	Destructive and unacceptable impact on objectives that would result in a major change to overall approach. Potentially large resource consequences that outweigh current operational circumstances.
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1 NEGLIGIBLE	No real impact on achieving objectives.

LIKELIHOOD	CRITERIA
5 VERY HIGH	>75% chance of occurring – almost certain to occur
4 HIGH	51-75% chance of occurring – more likely to occur than not
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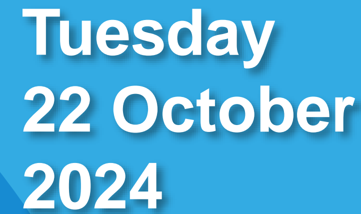
NHS National Services Scotland



Tuesday
22 October
2024

Medical Locum Engagement Task & Finish Group – Meeting Pack

NHS National Services Scotland

Medical Locum Engagement Task & Finish Group Agenda

Time	No.	Item	Member/Presenter	Papers
14:00-14:05	1	Welcome & Apologies • Approval of previous minutes	Carol Potter (Chair)	-
14:05-14:10	2	Project team update • Actions • Updates	[redacted]	*Medical Locum Engagement Task & Finish Group October Meeting Pack*
14:10-14:25	3	Mitigating Medical Supply Deficits	[redacted]and [redacted]	-
14:25-14:45	4	Psychiatry Recruitment and Retention Working Group Update	[redacted] [redacted] [redacted] [redacted] [redacted]	*Presentation*
14:45-15:15	5	Medical Staff Bank Options Appraisal	[redacted]/[redacted]	*Medical Staff Bank Options Appraisal*
15:15-15:25	6	Medical Framework Retendering Exercise – Agreeing Step Down Rates for Long Term Engagements	[redacted]	-
15:25-15:30	7	AOB	Carol Potter	-

Open Actions

Action No.	Action Date	Status	Action	Owner	Comments
005	03/04/2024		Project team to work with Board colleagues to arrange the development of a business case in support of a national approach to medical banks.	[redacted]/[redacted]	15/10: A medical staff bank options appraisal will be discussed at the meeting on 22/10.
006	03/04/2024		Crawford McGuffie and Lynn McCallum to seek feedback on the sign off process SBAR from SAMD and work with the project team to update the paper accordingly.	[redacted]/[redacted]	15/10: An updated sign-off checklist was shared with Boards on 27/09. Work is ongoing to engage with MD's.
009	09/05/2024		An update in relation to trainee retention to be provided to group.	[redacted]	31/07: Trainee retention is being explored by the Medical Education and Training Unit within SG and an update will be provided at a later date.
014	16/08/2023		Develop a letter to issue to Boards to signal the development of the sign-off checklist, highlight it's advisory status while encouraging it's use.	[redacted]	15/10: Letter issued to Boards on 27/09 to encourage use of checklist and advise of its advisory status.
015	16/08/2024		Project team to work with NSS to develop proposition for the current framework.	[redacted]/[redacted]	15/10: SG to provide an update at the meeting on 22/10 in relation to NSS timeline and plans for framework retendering.
016	16/08/2024		Develop action plan in relation to off-framework medical locum engagements.	[redacted]	15/10: Project team are proposing to wait until locum reporting has begun to determine the scale of off-framework locum use before next steps are decided.

Period for report: 16/08/24 to 22/10/24

NHS National Services Scotland

Medical Locum Engagement Update

Programme Aims

- Strengthen NHS Scotland's approach to the use of medical locums.
- Ensuring Health Boards secure best value when accessing medical locum support.
- Achieving the above without compromising delivery or quality of care.

Challenges & Opportunities

- Boards are under significant financial pressure.
- Significant media interest in NHS Scotland locum usage with a particular focus on psychiatry.
- Reliance on locums may bring limitations in terms of quality of care.
- Commencement of HCSA will result in the availability of additional local and national data on high-cost agency usage.

Recent Developments

- Development of a medical staff bank options appraisal and scoring of options.
- Circulation of checklist and medical locum reporting template. Further discussions required with Medical Directors.
- Bilateral engagements conducted with 3 of 14 territorial Boards. Remainder to be undertaken by the end of November with report to follow thereafter.

NHS National Services Scotland

Risks

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R008	There is a risk that Boards view themselves as in competition with each other for locums and are therefore averse to sharing best practice that they feel gives them an advantage over other Boards in the market.	The most potentially effective measures may not be identified due to efforts to maintain a competitive advantage over other Boards. Benchmarking information could be used to facilitate competitive advantage.	The Medical Locum Engagement Task & Finish Group will act as a space for the sharing of best practice and learning. The Group will encourage shared learning based on the benefits this brought to the nursing work and the advantages associated with taking a national approach. The introduction of periodic reporting will result in greater visibility of the different approaches to locum engagement across NHS Scotland.	25	2	50	High

NHS National Services Scotland

Scottish Government Risk Matrix

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Medical Locum Engagement Task & Finish Group
Terms of Reference

Date Published:
Version: v0.2
Document Type: Governance
Review Date:

DOCUMENT CONTROL SHEET

1.1.1 Key Information:

Title:	Medical Locum Engagement Task & Finish Group Terms of Reference
Date Published/Issued:	
Date Effective From:	
Version/Issue Number:	
Document Type:	Governance
Document Status:	Draft
Author:	[redacted]
Owner:	
Approver:	
Approved by and Date:	
Contact:	
File Name:	

1.1.2 Revision History:

Version	Date	Summary of Changes	Name	Changes Marked
0.1	**11/12/2023**	**First Draft**	**[redacted]**	
0.2	**07/03/2024**	**Following first meeting of the group, a number of amendments have been made including additional membership.**	**[redacted]**	

1.1.3 Distribution:

2. This document has been distributed to:

Name:	Title/Board:	Date of Issue:	Version:
All invitees to Medical Locum Engagement Task & Finish Group	**Medical Locum Engagement Task & Finish Group**	**01/02/2024**	**0.2**

1. Background

It is acknowledged that NHS Scotland's current approach to the use of supplementary staff is not delivering best value. The previously formed Medical Workforce Sustainability Group (MWSG), which met for the final time in November 2023 commissioned the development of an action plan designed to ensure that NHS Scotland Health Boards secure best value when accessing supplementary medical staff. It was agreed that the MWSG be reconfigured to form a Task & Finish Group with the necessary membership to deliver the action plan.

2. Purpose of the Medical Locum Engagement Task & Finish Group

Considerable work has been taken forward to improve NHS Scotland's approach to nurse agency staffing which has resulted in Boards reporting significant progress in reducing reliance on agency nursing staff. The reconfigured Medical Locum Engagement Task & Finish Group will be responsible for overseeing the delivery of a similar programme of work for the medical workforce. In pursuance of this, the group's primary focus will be on the appropriate targeting of locum usage and, where locums are engaged, ensuring Health Boards secure best value when accessing them.

The MWSG endorsed a number of workstreams aimed at addressing the underlying supply deficits across the medical workforce and these being delivered by the NES Medical Directorate, NHS Scotland Centre for Workforce Supply and Scottish Government's Health Workforce Directorate. The Task and Finish group will wish to remain apprised of progress with these workstreams given their relevance

3. Scope

The scope includes all locum/agency medical staff engaged directly by NHS Scotland Health Boards, including those accessed via staff banks and those engaged via an agency.

The group will work with key stakeholders to identify best practice and areas for improvement in order to achieve best value whenever NHS Health Boards are accessing supplementary medical staff. This work will include:

- Learning from the work of the Nursing Supplementary Staffing Task & Finish Group to ensure appropriate use of Medical Locums.
- Developing a national approach for adoption by all Health Boards to ensure the appropriate use of medical locum agency resource to a proportionate level (to be determined by the Task & Finish Group), while balancing considerations regarding patient safety and staff wellbeing.
- Optimising the use of local staff banks to provide the safest and best value model of resourcing temporary gaps with staff who have knowledge of local procedures and policies, as well as the skills and competencies to contribute effectively.
- Achieving the above without compromising quality of care experienced by patients in NHS Scotland.

4. Membership

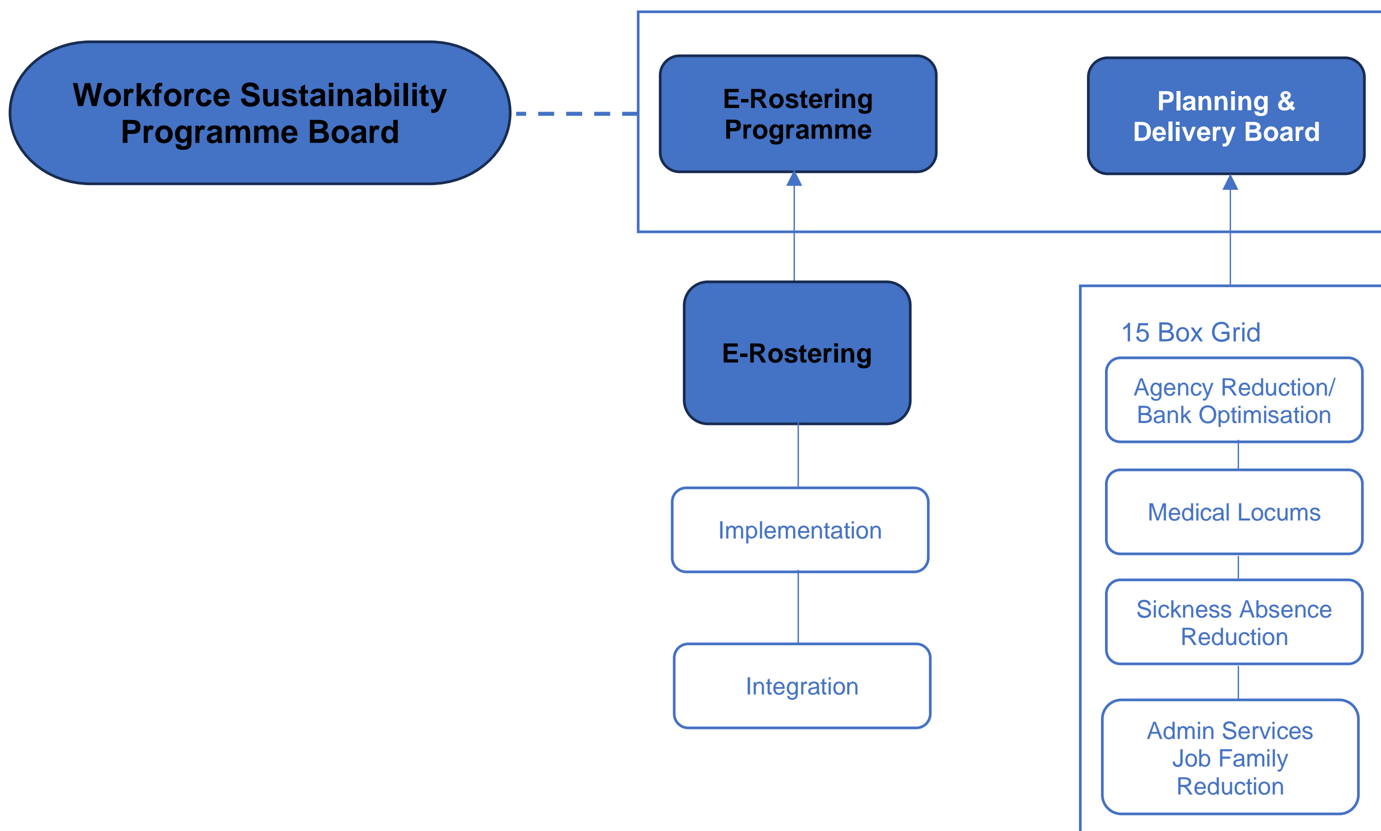
Full membership of the Medical Locum Engagement Task & Finish Group is provided in Annex A. The Group will work in partnership with colleagues from the Scottish Government Health Workforce and Chief Medical Officer Directorates, NHS Education for Scotland (NES), NHS National Services Scotland (NSS), NHS Scotland Centre for Workforce Supply (CWS), British Medical Association and other NHS Scotland Health Board colleagues.

Meetings will be co-chaired by Carol Potter, NHS Fife Chief Executive and Gillian Russell, Director of Health Workforce, Scottish Government. Members may nominate a deputy to represent their interests if they are able to attend or to support discussions on a particular matter. Members should make the secretariat aware in advance of the meeting if they are sending a deputy on their behalf.

5. Governance

The Medical Locum Engagement Task & Finish Group will report to both the NHS Scotland Planning and Delivery Board and the newly established Scottish Government Health Workforce Sustainability Programme Board. The latter is a new, Scottish Government led, programme tasked with supporting service development and delivery in the context of the 2024/25 budget.

The Task & Finish Group will maintain connections with the various Executive groups (CE's, HRDs, DoFs, SAMD) via the identified representatives within the membership.



6. Meeting Frequency, Secretariat and Decision Making

The Group will meet monthly, with the first meeting of the group taking place on 29th February 2024. The Co-Chairs may convene additional meetings as deemed necessary and the frequency of meetings will be kept under regular review. Meetings will take place virtually using Microsoft Teams, with ad-hoc correspondence via email as required by the group.

Secretariat support for the group will be provided by the Scottish Government Health Workforce Directorate's Sponsorship and Infrastructure Unit.

Decisions and actions will be recorded within the meeting minutes, and formal approval for these will be sought at the following meeting of the group before they are finalised. Group members are expected to complete actions assigned to them as per the timescales agreed. Any papers will normally be circulated 3 working days prior to the meetings.

The quorum for decision making and carrying out the business of the group will be half of members, and decision making will be by majority. No single member will have a veto, and in the event of a 'split' decision, the Chair will be the final arbiter.

7. Confidentiality

It is likely that information may be of a sensitive or confidential nature. It is vital that all members understand their responsibility to treat as confidential, information that may be available to them, or obtained by them, or that may be derived whilst working in the Group. Authors should be aware and consider that information considered to be Confidential may be required to be disclosed under the Freedom of Information (Scotland) Act 2002 or Environmental Information (Scotland) Regulations 2004.

8. Recordings

The meeting chair must seek informed consent from every member in attendance if a meeting is to be audio recorded. For meetings of the group that are audio recorded, following sign off of the minute/action notes, recordings will be deleted.

9. Lifespan

The group will continue to meet until such times as the desired outcomes are sufficiently achieved. Membership and terms of reference of the group will be reviewed as and when necessary to ensure they remain extant.

Annex A - Membership

Individual	Representing	Role/Responsibility
Co-chair: Carol Potter, Chief Executive, NHS Fife	Board Chief Executives	Chair, provision of advice on key options appraised and support decision making. Provide CE perspective and link with BCE group and Management Steering Group
Co-chair: Gillian Russell, Director of Health Workforce, Scottish Government	Scottish Government Health Workforce Directorate	Chair, provision of advice on key options appraised and support decision making
[redacted]	Chief Medical Officer and Health Workforce Directorates, Scottish Government	Provision of advice from medical perspective.
[redacted]	SAMD	Providing Medical Director perspective to work and link with SAMD and individual MD's
[redacted]	Board Medical Directors	Providing the perspective of Board Medical Directors and representing their interests
[redacted] [redacted]	Medical Royal Colleges and Faculties in Scotland	Representing the interests of the Medical Royal Colleges and Faculties in Scotland.
[redacted]	NES Medical Directorate	Support with elements relating to doctors in training
[redacted]	National Services Scotland	Provide perspective on behalf of NSS and the delivery of national infrastructure
[redacted]	Health Workforce Directorate, Scottish Government	Provide Scottish Clinical Leadership Fellow support to group work program
[redacted]	Directors of Finance, NHS Boards	Support financial considerations at Board level
[redacted]	HR Directors, NHS Boards	Support HR considerations at Board level, link with HRD's group and with 'Once for Scotland' Program
[redacted]	NES Centre for Workforce Supply	Support Consultant supply mitigation and communication with Boards
[redacted] [redacted]	Director of Health Finance, Corporate Governance and Value, Scottish Government	Support the set-up of the work and provide advice and support on behalf of Health Finance
[redacted] [redacted]	Staff Bank Managers	Provide perspective on behalf of Staff Bank Managers
[redacted]	Staff Bank Managers/ West of Scotland Consortium	Provide perspective and advice based on the WoS Consortium
[redacted]	Nursing Supplementary Staffing Task & Finish Group	Providing advice based on the work of the Nursing Supplementary Staffing Task & Finish Group.

[redacted]	British Medical Association Scotland	Represent the interests of the BMA
[redacted]	Staffside	Represent staffside interests
[redacted]	SG Health Workforce Recruitment and Capacity Building Unit	Providing SG official support to ongoing work and linking with the relevant SG units
[redacted] [redacted]	SG Pay, Practice and Information Governance Division	Represent the interests of the Pay team within SG
[redacted] [redacted]	NSS National Procurement	Supporting work on bank vs agency; best value
[redacted], [redacted]	NES Digital	Data and analytic support
[redacted]	SG Health Workforce Sponsorship and Infrastructure Unit	Providing SG official support to ongoing work and linking with the relevant SG units
[redacted]		Taking actions and minutes at formal meetings. Issuing key papers and agenda ahead of formal meetings

MEDICAL LOCUM ENGAGEMENT TASK & FINISH GROUP

Purpose: To set out the identified interventions that will be explored by the Medical Locum Engagement Task & Finish Group in spring/summer 2024 following the first meeting of the group on 29 February 2024.							
For Decision	X	For Action		For Discussion		For information/ To note	X

Title	Medical Locum Engagement Task & Finish Group – Updated Workplan

Situation	At the first meeting of the Medical Locum Engagement Task & Finish Group, it was agreed that the draft workplan would be amended based on the group's discussion and re-circulated to members for agreement.

Background	At the first meeting of the Medical Locum Engagement Task & Finish Group on 29 February 2024, members were asked to agree a workplan which entailed the development of a series of detailed papers offering an assessment of a set of proposed interventions. In the interests of time, the project team agreed to amend the workplan based on the group's discussion and circulate for agreement.

Assessment	Members agreed that the Task & Finish Group's focus should be on the appropriate use of Medical Locums and securing value for money. As a result, the group agreed that service redesign should be the responsibility of individual Health Boards and should not sit within the scope of the group. It has therefore been removed from the workplan and corresponding diagrams in Annex A and B. Discussions also included reference to the supply challenges associated with the medical workforce and a requirement on the part of Boards in conjunction with the Scottish Government to determine whether the medical workforce is the correct size for the current service configuration. The absence of nationally agreed planning tools for the medical workforce was noted. The project team confirmed that the previously established Medical Workforce Sustainability and Value Group (MWSG) had taken forward a detailed programme of work focussed on the identification and addressing of key supply challenges impacting on the medical workforce. The Group consequently set out a number of actions to address the supply deficit challenges, which are outlined in the MWSG summary report. The Centre for Workforce Supply (CWS) and NES Medical Directorate are now implementing these actions and will keep the group apprised of progress. Each of the interventions set out in Annex A will be explored in greater detail in the form of a series of papers to allow for the benefits and drawbacks associated with each to be fully considered before a decision is made as to whether or not the intervention is implemented.

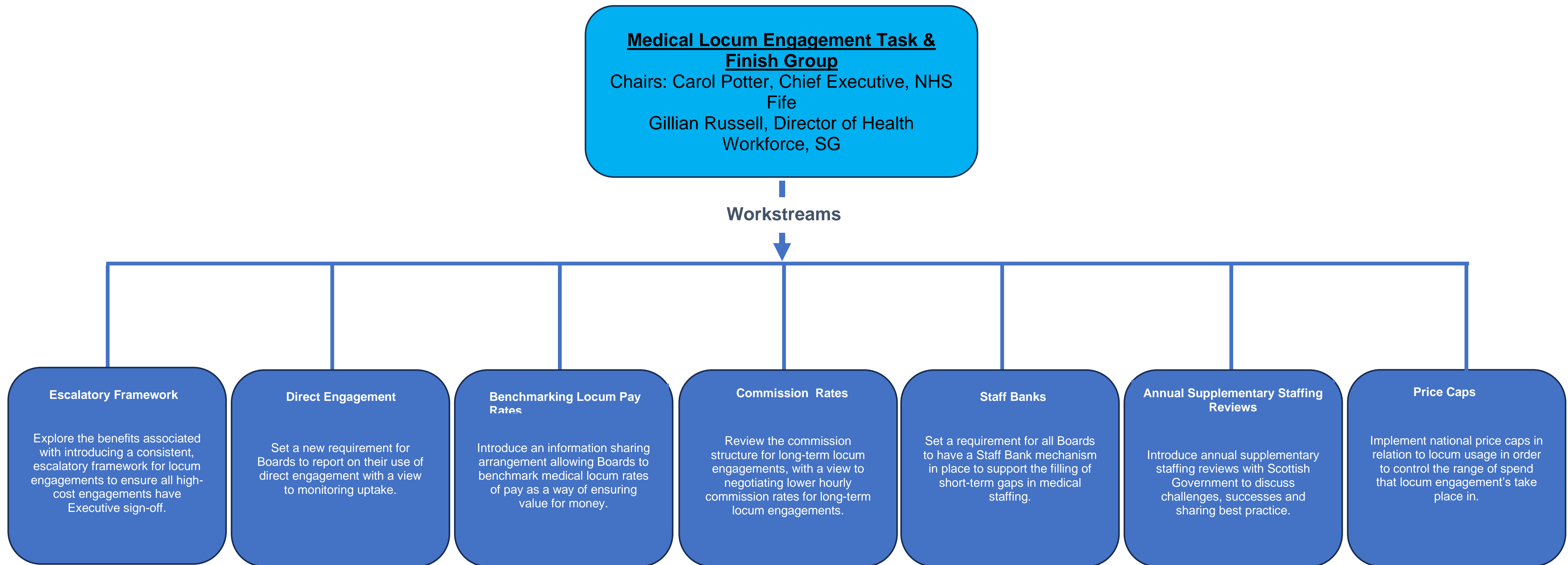
Recommendation	It is recommended that the updated proposed work plan and associated timeline be agreed by the Group.

Action required	The Group is invited to: • Agree to the development of detailed papers offering an assessment of the interventions outlined in Annex A.

	• Agree the suggested timetable for those papers to be brought forward.

Author	Project Team
Date	08/03/24

ANNEX A



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NHS SCOTLAND

ANNEX B

MEDICAL LOCUM ENGAGEMENT TASK & FINISH GROUP

Date of Meeting: 3 April 2024

Purpose: To explore the benefits and drawbacks associated with operating a staff bank for all staffing groups, including Medical, to fill short-term gaps in medical staffing.							
For Decision	X	For Action		For Discussion	X	For information/ To note	

Title	Medical Locum Engagement Task & Finish Group – Staff Banks Paper

Situation	The newly established Medical Locum Engagement Task & Finish Group agreed to explore the case for a set of identified interventions over spring/summer 2024. The first intervention to be considered is the potential to set a requirement for all Boards to have a medical staff bank mechanism in place to support the filling of short-term gaps in medical staffing.

Background	A number of Health Boards already have an established Medical Bank, although the structures differ significantly. We issued a supplementary medical staffing survey to all Boards in October 2023 and the survey identified a number of different bank structures across the country, including: • No Bank exists, with agency managed by a locum desk. • Divisions operate own small banks for staff with substantive posts, with no centralised provision. • Small bank exists but with no active recruitment. • No bank within the Board but access services via the West of Scotland Consortium run by GGC. • A fully centralised Bank covers provision for all roles.

Assessment	The outputs of the medical supplementary staffing survey point towards significant potential for improved consistency in the operation of bank structures for the medical workforce. <u>Structures and Processes</u> As part of the work to drive down high-cost Nurse agency usage and encourage staff to transition from agency to either substantive or staff bank contracts, the Supplementary Staffing Task & Finish Group (SSTFG) commissioned a number of workstreams aimed at optimising staff banks and improving our approach to the recruitment and retention of bank staff. The workstreams gathered evidence of best practice from a number of NHS Scotland Health Boards to provide advice and guidance to ensure optimal operation of banks across the country. As part of this work, the SSTFG explored the differing bank structures and provided a recommendation as to the most optimal bank structure, drawing on best practice from across the country and exploring the benefits and drawbacks with a number of structures currently in place across NHS Scotland. While the SSTFG had a particular interest in Nursing and Midwifery staff banks, the evidence gathering exercise and subsequent recommendation took into account Medical banks, given the clear

potential for greater integration of supplementary staffing arrangements for both of these (and other) clinical and non-clinical groups.
Based on the evidence gathered, the group recommended that operating a single staff bank, encompassing all staffing groups, was more efficient than running multiple banks for different staffing groups. The centralisation of staff banks was seen to improve governance and control and during discussions with colleagues from NHS England, they confirmed that centralised banks are an element of best practice they have identified and now encourage across their Trusts. As a result of the recommendation, a number of Boards are now working towards establishing a single bank for all staffing groups including Medical, Nursing, Midwifery, AHP and non-clinical.

In terms of governance structure, the SSTFG also recommended that a triumvirate approach to the running of staff banks should be taken by Health Boards. As such, each Board's Medical and Nursing Director should be involved with understanding and managing service demand, while HR Directors should be responsible for securing the workforce supply to manage this demand. The SSTFG saw no need to mandate the professional group with ultimate oversight of the bank, as long as each of the areas has an input and role in ensuring effective operation of the bank.

Another of the SSTFG's workstreams focussed on the development of a best practice staff bank recruitment checklist for dissemination across Boards. The checklist, which was developed in conjunction with staff bank managers and deputy HRDs and has now been shared with Health Boards, adopts elements of best practice through engagement with Boards who have worked to optimise local bank recruitment procedures and is to be used primarily as a tool by Board Executive Leads to drive improvement based on best practice across NHS Scotland. Members of the previously established Medical Workforce Sustainability and Value Group considered the checklist and advised that its contents would also be applicable to the recruitment arrangements for medical banks and therefore the checklist can be used to support the recruitment and retention of medical bank staff.

As well as improving the staff bank recruitment processes, the SSTFG placed an emphasis on the importance of attraction and retention. As such a workstream aimed at effectively marketing and promoting bank opportunities was commissioned by the group. Scottish Government officials are now working in collaboration with Centre for Workforce Supply (CWS) to develop a set of national marketing assets which can be used to advertise staff banks and attract individuals to work for them. The types of assets requested include web content, infographics for social media, digital banners, leaflets and posters. The brief for CWS emphasised that any marketing materials should be tailorable to different professional groups, including medical staff. It would therefore be the case that the marketing assets developed by CWS would be applicable to medical staff, allowing the advertisement and promotion of medical bank roles, with a view to encouraging more medical staff to join the bank and take up shifts.

The final workstream commissioned by SSTFG which has relevance to the medical workforce was the development of National Principles for the Management of Staff Banks, which has now been approved by the SSTFG. The aim of the principles document is to provide Health Boards with the elements that they should adopt to best operate and maintain a successful Bank. Embedding these principles across all Health Boards will ensure controls around the use of supplementary staffing are as strong as possible, preventing escalating usage and subsequently costs to the service, while ensuring patient safety standards and safe staffing levels are maintained.

	It has been brought to our attention that in some instances, bank staff are waiting 2 to 3 months to receive pay for shifts worked on the medical staff bank. The National Principles document states that bank workers should be paid weekly, however they can opt to monthly pay if preferred. As well as allowing staffing to supplement their income, weekly pay supports the retention of bank staff and allows competition with agencies, who tend to offer weekly or faster pay. The final recommendation requested that Boards should continue to have autonomy around the ability to operate their own staff bank, however where a bank is routinely struggling to fill staffing gaps, Boards should consider engaging in a regional approach with neighbouring Boards. Regional Approach As an example of a regional bank, the Task & Finish group may find it instructive to consider the experience of Boards participating in the West of Scotland (WoS) Consortium when considering the benefits of collaborative approaches to the attraction, recruitment and deployment of supplementary staff. NHS Ayrshire and Arran, Dumfries and Galloway, Greater Glasgow and Clyde, Forth Valley, Golden Jubilee and Lanarkshire are all part of the West of Scotland (WoS) Consortium, which currently uses Retinue as their Managed Service Provider. NHS Greater Glasgow and Clyde are the lead Health Board for the WoS Medical Staff Bank and process shift requests for supplementary medical staffing from Lanarkshire, Ayrshire and Arran, Dumfries and Galloway, Golden Jubilee and Forth Valley (who also have their own Medical Bank). If a Health Board is unable to fill shifts with doctors from the Medical Bank, they have the opportunity to outsource shifts to the Managed Service Provider, currently Retinue. There are a number of benefits to the WoS Consortium, including access to a larger pool of doctors who are familiar with and have good working knowledge of the services, systems and sites. It also allows Medical Bank doctors the opportunity to work in a variety of sites where they are often encouraged to apply for substantive posts. Services also become familiar with the Medical Bank doctors and their skills and abilities and as such they can be better integrated to support service needs. The WoS approach also strengthens Health Board's ability to ensure agency doctors work via direct engagement. Data from GGC demonstrates that when the Medical Bank was set up in 2017, the overall fill rate from their managed service provider, Retinue, was c.80%, compared to 20% from the Medical Staff Bank, however fill is now 20% from Retinue and 80% from the Medical Staff Bank. As a result, the majority of shifts being offered to the bank are being filled by bank doctors rather than agency or locum doctors. Cost Implications Banks can play a substantial role in the reduction of Supplementary Staffing costs. Where there are centrally run Banks within Boards there is a clear cost saving versus the use of Agency per engagement.

	In Q1 of FY23/24, the Bank in Forth Valley provided 10,060 hours of supplementary staffing cover at a cost of £630863.12, in comparison Agency provision totalled 10563 hours at a cost of £780984.09. This equates to a total cost per hour averaged across all grades of £62.71 for the Bank vs £73.94 per hour for Agency. The primary area of Bank usage in Forth Valley was at consultant level, where 3870.25 hours were filled by Bank vs 5819.5 hours by Agency. The average cost per hour for a Consultant through the Bank was £58.08 per hour while the average cost per hour for Agency was £104.97. This equates to 40% of hours of consultant spend that would otherwise have had to be filled via agency instead being filled at a rate on average 55% lower via the Bank. It should be noted that for some roles Bank provision appears to have been more expensive per hour than agency provision, but this is substantially outweighed by the savings made in the areas mentioned above. In the same quarter NHS Lothian filled 2643 roles via its Bank vs 1403 roles by agency. The total spend on roles filled by the Bank came to £1,741,150.19 vs Agency spend of £958,833.33. The spend per role on Bank was on average therefore £658.78 vs an agency cost of £683.42 per role. The area with the largest return was Agency Locum Specialty Doctors where 211 shifts were filled by the Bank at a cost of £89,896.96, versus 17 shifts being filled by Agency at a cost of £10,691.24. This equates to a difference in cost per shift filled of £202.84. Consultant roles filled by the Bank equalled 511 over the same quarter with 481 roles being filled by Agency. Spend on the Bank came to £466,079.41 vs agency spend of £492,487, which shows that use of the Bank to fill these roles was on average £111.79 per role cheaper than agency. It should be noted that for the area of highest usage, Specialty Registrar, the average spend per role filled slightly favoured agency, with Bank costing £599.60 per role vs £523.65 per role for agency. It is possible that were this information to be captured on an hourly basis instead of per role filled then this scenario would be different. For Boards where a medical staff bank is not already in operation, there are a number of financial implications that must be considered. While the costs associated with the set up and operation of a medical bank will differ between Health Boards, the potential return on investment should be explored by each Health Board in full. <u>Quality of Care</u> Alongside the potential return on investment, there are also benefits associated with the quality and safety of patient care linked to the operation of staff banks. Utilising staff who are familiar with local policies and procedures to cover shifts can impact positively on the quality of patient care as staff are able to do a wider range of duties without having to receive instruction prior to doing so. Staff Banks also allow services to access staff who have completed all their statutory and mandatory training.

Recommendation	Ultimately, the decision to establish a medical staff bank, where this does not already exist, lies with individual Health Boards. However in light of the evidence gathered by the SSTFG and set out in the paper, the Medical Locum Engagement Task & Finish Group are asked to consider the following recommendations:

	• That Boards should develop a business case setting out the return on investment for introducing a Staff Bank which facilitates access to medical workforce, where this does not already exist.
	• The business case should assume the operation of a single Bank within the Board (one bank encompassing all staffing groups) or a regional approach (where neighbouring Boards work together to fill medical staffing gaps).
	• That Boards should feed back to the Medical Locum Engagement Task & Finish Group by 03 June 2024 to provide an update on the progress made in producing a business case, expected timescales for completion, and if already complete, detail the outcome of the exercise.
	• Encourage that all Boards who operate a Medical Bank embed:
	  ○ An integrated Bank model which covers the breadth of their supplementary staffing needs and is overseen by the medial director, Nurse Director and HR Director.
	  ○ The Best Practice Recruitment Checklist developed by SSTFG.
	  ○ National marketing/attraction materials developed by the Centre for Workforce supply (once available).
	  ○ National principles for the Management of Banks as approved by SSTFG.

Action required	The Group is invited to: • Agree the recommendation that Boards who do not currently operate a Medical Staff Bank mechanism should develop a business case setting out the relative pros and cons for their Board of doing so. • Offer a view as to whether or not the proposed timescale for preparing a business case for medical banks and reporting back to the Task & Finish Group is reasonable.

Author	Project Team
Date	08/03/24

ANNEX A

Staff Bank Recruitment Best Practice Guide

Purpose: The purpose of this guide is to provide a self-assessment checklist for Boards to use when undertaking staff bank recruitment and onboarding. The guide has been developed in consultation with the staff bank managers forum and Deputy HRDs, and has been endorsed by the Supplementary Staffing Task & Finish Group.

Status: The status of this document is advisory and should be used by members of the executive team within Health Boards to inform decision making surrounding the operation of staff banks. It is recognised that boards will be at different stages of readiness to fully satisfy the requirements of the checklist.

Checklist

Advert

	Current practice (Yes/No)	**If No, please outline current practice and likely timeline to achieving**
Bank adverts and recruitment remain open all year round.		
Staff banks are advertised (with direct links to an application form) on a broad range of platforms, including JobTrain, NHS Scotland Careers, FindaJob and staff intranets including HR Connect.		
Appropriate contact information for the bank is readily available (e.g. a designated email address that is regularly monitored).		
The benefits of working for the bank are clearly advertised across platforms (e.g. flexibility of shifts/ locations, pension entitlement and opportunities for career development).		
The Health Board routinely runs targeted recruitment drives for students to encourage them to join the bank.		
The Board uses in-person engagement as a way of advertising staff bank opportunities to substantive staff. This can be done by visiting wards or setting up stalls.		
Targeted recruitment drives are routinely run by the Health Board for specific shifts and/or specific areas (e.g. day shifts or other hard to fill shifts).		

Application

	Current practice (Yes/No)	If No, please outline current practice and likely timeline to achieving
Applications are accessible online and can be submitted electronically.		
An auto-enrol (opt-out) process for new substantive members of staff is adopted.		
A tickbox is included on applications for substantive roles in order to attract all candidates to the Bank.		
A generic email is shared with applicants to thank them for applying to the bank and to set expectations around the timeline for reviewing applications.		
Regular email updates are issued to all applicants, advising the average processing times for applications.		
A simplified application process is in place for all substantive staff in Health Boards (e.g. a tick box exercise which allows the applicant to confirm they are currently working in the Health Board, provision of professional registration details where appropriate, and identification of a senior member of staff for the purposes of securing a reference).		
A simplified application process is in place for staff who hold substantive NHS Scotland posts in other Health Boards (e.g. a tick box exercise which allows the applicant to advise they are currently working in NHS Scotland, provision of professional registration details as appropriate, and provision of contact details for the applicant's most recent line manager for the purposes of securing a reference).		
A simplified application process is in place for students currently undertaking a relevant degree course (e.g. a tick box exercise which allows the applicant to advise they are currently a medical, NMAHP or healthcare science student alongside provision of references from their HEI provider and placement supervising member of staff).		

Selection

	Current practice (Yes/No)	If No, please outline current practice and likely timeline to achieving
Interviews are used to assess suitability of those who don't currently hold a post within NHS Scotland, except where the applicant is a medical, NMAHP or healthcare science student.		

Acceptance on application for substantive staff working within the Health Board, if sufficient reference provided.		
Acceptance on application for applicants who hold a substantive NHS Scotland post in another Health Board, if sufficient reference is provided.		
Acceptance on application for students currently undertaking their medical, NMAHP or healthcare science degree, if sufficient references provided.		

Target completion timescales: 1 week for internal candidates, 3 weeks for external candidates.

Pre-employment checks

	Current practice (Yes/No)	If No, please outline current practice and likely timeline to achieving
Appropriate checks of professional registration details to be completed for substantive members of staff within the Health Board and substantive staff in other NHS Scotland Health Boards.		
PVG checks to be completed for NHS Scotland staff not currently working in the Health Board.		
Reference checks to be completed for current NHS Scotland medical, NMAHP and healthcare science students.		
Reference and PVG checks to be completed for staff who are new to NHS Scotland, following successful interview.		

Target completion timescales: 2 weeks

Onboarding

	Current practice (Yes/No)	If No, please outline current practice and likely timeline to achieving
All corporate induction completed via online portal.		
Occupational Health Checks to be carried out for newly recruited staff.		
Practical in-person moving and handling, management of aggression, control and restraint training for applicants not currently employed by NHS Scotland (where appropriate).		

Turas Learn mandatory and statutory training completed in advance of applicant starting on the bank.		
In person welcome for applicants who don’t currently work within the Health Board, who live within the immediate area (staff member receives ID badge, uniform and is supported to book orientation shifts).		
Staff member invited to complete three induction shifts for sign-off.		

Target completion timescales: 2 weeks (excluding induction shifts).

ANNEX B

National Principles for the Management of Staff Banks

2.1 Introduction

The Health and Care (Staffing) (Scotland) Act 2019 places a duty on NHS boards to provide safe and appropriate staffing for the delivery of high-quality care. Supplementary staffing plays a pivotal role in maintaining appropriate staffing levels where there is either, a deficit in the substantive workforce or an increase in clinical activity.
The engagement and deployment of agency workers, as a component of supplementary staffing, is an option for boards where additional hours, bank and local mitigation has been exhausted.
Exponential growth in the demand for supplementary staffing has seen an increasing demand for agency workers, use of high cost off-framework agency providers and the associated clinical and financial risks. The national principles for the robust management of staff banks, play an essential role in mitigating the risks resulting from high agency use.
The aim of this document is to provide Boards with the principles that they should adopt to best operate and maintain a successful Bank. Embedding these principles across all Health Boards will ensure controls around the use of supplementary staffing are as strong as possible, preventing escalating usage and subsequently costs to the service, while ensuring patient safety standards and safe staffing levels are maintained.
Where agency workers are required engaging them through the *Supply of Nurses, Healthcare Assistants and Operating Department Practitioners to NHS Bodies in Scotland (*NP51018) Framework Agreement (Scottish National Framework (NP510) provides boards with assurance that the agency has:

- recruited to NHS Scotland's Standards
- provide workers to the framework knowledge, skills, and training requirements
- provided indemnity insurance for the worker
- operates under set commercial terms and conditions
- Is externally audited for compliance through NHS National Services Scotland

In recognition that the continued use of off-framework providers increases the clinical, financial, and reputational risks of NHS Scotland Health Boards the principles laid out in this document provide a framework designed to ensure best practice principles are applied when employing all types of supplementary worker.

Following the implementation of principles to control the usage of off-framework providers, this document has been developed to help embed these previous measures. The following activities were undertaken to help reduce reliance on off-framework agencies and agreed by all NHS Territorial Boards:

1. Tranche 1 (April 2023 onwards): implementation of controls to support the success of NHS Board Staff Banks and provide good governance in relation to the assignment of agency workers
2. Tranche 2 (transitional: April 2023 - June 2023): Implementation of controls to reduce the volume and lead time for shifts being sent to off-framework agencies. This creates the conditions whereby it is less attractive for workers to stay with an off-framework agency and signals NHS Scotland's Health Boards intent to no longer use off-framework providers
3. Tranche 3 (June 1st 2023 onwards): The controls to support the principles within this document are in place from the 1st of June whereby agency workers are supplied through the framework only. Where exceptional use of off-framework agency occurs, this will be treated and reported as a breach of the agency principles.

This document has been developed by the Staff Bank Managers Network, with representatives on that network acting on behalf of their respective organisations. The principles have been shared with the Scottish Government and build on previous guidance offered via SGHSC Director Letters on the subject of agency staffing as well as the work of the Supplementary Staffing Task & Finish Group.

3. Working Environment for Bank Staff

1. Environment for Bank Workers			
No.	Principle	Rationale	Benefits / Risks
1.1	All Once for Scotland policies should be applied to Bank workers	National Policy Requirement	Legal requirement, ensures fair and equitable treatment of all Bank Workers.
1.2	All Banks should have local policies and procedures for aspects of A Workforce policy not covered by Once for Scotland policies	Corporate bodies have a duty to provide policies and procedures where there are not national ones already in place.	Legal requirement, ensures fair and equitable treatment of all Bank Workers.
1.3	Whilst on a work engagement it is expected that operational supervision is provided to bank and agency workers as it is for any other member of the team - any issues needing resolved locally should be fed back to the formal line manager in the staff bank.	When on a work engagement, the worker operates under the supervision of the team leader, registrant or identified person in charge. This relationship is not a line management relationship, and any concerns or issues requiring application of line management policy or procedure should be submitted to the staff bank.	Ensures clarity of role and responsibility of each party involved in the management of a Bank worker.
1.4	Bank only workers should have the opportunity for ongoing development	Maintaining standards of practice and competency. Provide opportunity for role development and ability to meet the organisational demands. Ensures they can appropriately expand on their skill and knowledge set. Additional training should be discussed with the Staff Bank Line Manager to approve, as appropriate development for role	Increase the pool of available skills for deployment within the health board. Staff likely to feel more valued if given development opportunities. Improves patient safety and quality of care. Risk: Associated increased costs to organisations as a result of time paid to bank worker for training

4. Recruitment and Retention to Staff Banks

2. Recruiting/Retention to the Staff Bank			
No.	Principle	Rationale	Benefits / Risks
2.1	Bank only workers should be paid to complete their mandatory training	To ensure fair and equitable treatment for bank workers with substantive staff.	This ensures equitable treatment with substantive staff members. Provides assurance of compliance with mandatory training. Risk – May lead to an increase in costs for boards where this is not currently the case.
2.2	Bank workers should be paid for induction and orientation shifts.	To ensure fair and equitable treatment for bank workers with substantive staff.	This ensures equitable treatment with substantive staff members. Provides assurance of compliance with corporate Health and Safety duties. Improving patient safety. Mandatory Risk – May lead to an increase in costs for boards where this is not currently the case.
2.3	Boards should seek to be in compliant with the recruitment best practice guidance issued by SG.	Maximise recruitment and retention opportunities.	Ensuring the bank has sufficient bank workers available to meet the majority of supplementary staffing demands.

5. Software and Systems Usage

3. Software and Systems Usage			
No.	Principle	Rationale	Benefits / Risks
3.1	Boards should maximise the use of electronic systems, as appropriate, that facilitate the Requesting, Booking, and Redeployment of Bank workers, and consider the use of mobile apps when available.	This makes the governance and day to day running of banks substantially easier and more efficient.	Improved governance and efficiency. Improved Bank worker experience. Better Management Information can be made available. Risks: Apps need to have IG clearance Dependant on National rollout and implementation
3.2	Boards should maximise the use of electronic bank system integration with the e-rostering system to support banks in the management and deployment of their workers	Provides the rationale as to whether a bank shift is required or not. This is reliant on the complete rollout of eRostering.	Improved governance and efficiency. Improved Bank worker experience. Better Management Information can be made available. Risks: Dependant on National rollout and implementation
3.3	All bookings should be made through the staff bank, unless in an emergency or Out of Hours situation. All Boards should have a process in place to manage out of hours escalations.	Doing this helps to ensure that potential issues, such as a regular pattern of work leading to the individual developing employment rights, do not occur. This ensures that all bank workers have the appropriate skills and knowledge, have equitable access to available shifts. There is no mutual obligation for a board to offer a shift or an individual to accept one. .	Better control helps to avoid potential employment rights issues. Improved governance and efficiency. Improved Bank worker experience. Better Management Information can be made available.

		Prevent fraudulent activity: False identity and financial activity	
3.4	Electronic systems should have the ability to set warnings and rules to ensure compliance with policy and legislation.	This can help to avoid non-compliance with legislation and/or policy.	Better control helps to avoid potential employment rights issues. Improved governance and efficiency. Better Management Information can be made available. Risks: Ability to override rules & warnings
3.5	Boards electronic booking systems should have Reporting and Audit functionality in relation to Supplementary Staffing.	This allows bank management teams to view usage trends and to monitor compliance with policies and procedures.	Better Management Information can be made available. Improved governance and efficiency.
3.6	The only way to process an invoice should be to reconcile the invoice against both a booked shift and an approved timesheet.	Invoices should be matched and processed against what is booked on the system to provide protection against potential fraud.	Improved governance and efficiency.

6. Organisational Arrangement of Staff Banks

4. Organisational Arrangement of the Staff Bank			
No.	Principle	Rationale	Benefits / Risks
4.1	Boards should have a centralised bank that covers all staff groups and agency engagements, utilising appropriate software and policies.	To ensure correct practices, procedures and governance are followed when engaging supplementary staffing.	Better control helps to avoid potential employment rights issues. Improved governance and efficiency. Improved Bank worker experience. Better Management Information can be made available.
4.2	The Chief Executive of the Board will determine which Director will have ultimate accountability for the Staff Bank as detailed in their local scheme of delegation. . The internal team structure of a bank needs to be appropriate and reflective of the bank workers they are supplying. To that end there should be a professional lead resource identified where large numbers of registrants are engaged. This could be as part of a wider portfolio or deployed solely within the Bank Management Structure.	. As a Staff Bank may cover multiple professionals, it is essential the management structure is tailored to support all disciplines. .	Improved governance and efficiency. Ensures the correct management of any professional issues. Provides professional leadership for regulated bank workers.
4.3	All boards should have an escalation SOP establishing when it is appropriate to access supplementary staffing	Boards should have access to a Ready Reckoner to identify the best value way of filling a given shift and a clear line of escalation through various bank and agency levels to avoid unnecessary expense.	Improved governance and efficiency. Ensures that appropriate organisational oversight of

		Ensuring that staffing gaps are covered in the most appropriate way taking into account all available options.	supplementary staffing usage is in place. Ensuring best value deployment of supplementary staffing resources
4.4	Bank workers will be paid weekly but can opt out to monthly pay if requested.	Supports retention and allows competition with agencies. Allows staff to supplement income.	Improved Bank worker experience. Improves attraction and retention.
4.5	Banks must have a robust process to ensure Bank workers are paid timeously, that areas are aware of timelines for sign-off of shifts to support this, and that Bank workers are aware when payments are due.	Supports retention and allows competition with agencies.	Improved Bank worker experience. Improves attraction and retention.

7. Related Documents

PIN Policies
Agenda for Change Policies
Health Care Staffing Act

FAQs

Under what circumstances will it be acceptable to engage off contract agency supply?
The use of off contract agency supply should be the exception and every off-contract engagement will be reported retrospectively to the Scottish Government.
The Board will require to evidence the clinical scenario / staffing position that necessitated off contract engagement – the Board will need to be able to demonstrate that all other actions had been taken and the only remaining mitigating action was to suspend a clinical service owing to inadequate staffing. This may be either e.g. to close a theatre and cancel elective list or to close beds as at least one Registered Nurse cannot be secured.
In a situation where clinical safety would be breached or a service would have to be suspended, a request to go to an off-framework agency could still be made. This would require escalation to Executive level to approve the use of off-framework agency. This would subsequently be reported to allow identification of areas where targeted assistance may be needed to allow the service to function without recourse to off-framework agencies.

All levels of the Board escalation framework should have been fully exhausted including redeploying resources across the Board estate and redirecting support from other clinical areas.

Q2. Under what circumstances can a Board employ someone who previously worked for an agency?
There would need to be case-by-case analysis of each individual agency's terms to understand what provisions (if any) applied. However, temp-to-temp and finder's fees may be common in agency terms as they enable the agency to benefit from the introduction of the agency worker to a third party or to reflect the loss of the agency worker being engaged via another route. There may be very little a Board can do to negotiate out of these provisions. The existence of an enforceable clause within any contract between the Board and the agency will be a factor as could, for example, the agency's ability to demonstrate that a direct and targeted approach has been made to the individual by the Board. However, it is possible that an agency will seek compensation even in the absence of such factors.

Q3. Are contractors covered by CNORIS?
The situation is not always entirely clear cut when an NHS body engages a third-party contractor to deliver patient care. This is especially true if an independent healthcare provider uses NHS facilities. It's essential to clearly document the responsibilities of

independent contractors. In most cases, independent contractors must bear responsibility for the acts and omissions of staff. They'll need to obtain appropriate insurance and provide an appropriate indemnity to the NHS body.

Q4. Are healthcare professionals opting to work under contracts for services rather than as employees of the NHS covered?
Health boards are vicariously liable for healthcare professionals working under their direction and control. These professionals will be performing services as part of their delivery of NHS patient care.

8. Key Agency Principles and Tranches

Tranche 1	Controls to support the success of NHS Board banks and provide good governance in relation to the assignment of agency workers. These controls are effective from 1st April 2023 and provide a national approach to the provision of agency workers. These principles will continue to apply beyond 1st June 2023			
No.	Principle	Rationale	Benefits / Risks	Comment
1.1	NHS employees or workers **must not** be assigned shifts within their own Health Board via an agency.	This principle supports Health Boards existing flexible options for placing their own staff on to shifts via additional hours, bank or overtime. Allowing employees to work agency shifts in their home board puts the Health Board at financial and reputational risk.	*Benefits*: This principle protects the integrity of NHS Staff Banks as the primary supplementary worker option available to Health Board employees. *Risk*: no risk identified	
1.2	A **six-month** separation period **must** be applied from the date a substantive employee or Bank Worker terminates their contract with a Health Board before they can be assigned	This principle supports protecting Health Boards Staff Banks as the primary method for securing supplementary staff in the Health Board.	*Benefits*: This principle protects the integrity of the Health Boards Staff Banks as the primary supplementary staff provider. *Risk:* Employees and workers will leave the board and work for an	

Tranche 1	Controls to support the success of NHS Board banks and provide good governance in relation to the assignment of agency workers. These controls are effective from 1st April 2023 and provide a national approach to the provision of agency workers. These principles will continue to apply beyond 1st June 2023			
No.	Principle	Rationale	Benefits / Risks	Comment
	within that Health Board through an agency.	This does not restrict the individual's right to work, as they are able to undertake agency work within other Health Boards or private providers during this time.	agency in a private healthcare facility or another Health Board.	
1.3	Bookings **must** be made through the Health Boards Bank Office/system. Departments should not agree shifts directly with the worker or agency.	Local relationships and agreements between agency workers/agencies undermine the escalation controls set out in principle **2.5**.	*Benefit*: Health Boards have assurance that a robust escalation process has been applied. Health Boards have assurance that the best value for money options have been explored. *Risk*: No risk identified.	
1.4	Any amendments or negotiations relating to commercial rates and terms and conditions **must** only be undertaken by the Health Boards Staff Bank in consultation with procurement colleagues.	This principle ensures consistency of practice and processes when negotiating with agencies. This principle ensures compliance with procurement legislation.	*Benefit:* This principle provides good governance and compliance with procurement practices. This principle ensures agencies cannot negotiate rates that adversely affect or undermine the National Scottish. Framework Agreement (NP510) contract arrangements.	

Tranche 1	Controls to support the success of NHS Board banks and provide good governance in relation to the assignment of agency workers. These controls are effective from 1st April 2023 and provide a national approach to the provision of agency workers. These principles will continue to apply beyond 1st June 2023			
No.	Principle	Rationale	Benefits / Risks	Comment
			Risk: No risk identified.	
1.5	Agency workers **must not** be assigned shifts within a Health Board before the pre-employment compliance checks have been completed by the agency and verified by the Health Board.	Compliance checks by the Health Board ensure that the recruitment agency has fulfilled their obligations in recruiting, training, and regulation requirements for the provision of the worker.	*Benefit:* This principle ensures that the agency worker has the appropriate skills and eligibility to fulfil the role. *Risk*: Increased Staff Bank administration burden.	
1.6	NHS Boards **must** have in place processes to identify and review the areas of high agency use to develop exit strategies.	Reducing demand for supplementary staffing is the most effective way of minimising the associated financial and clinical risks.	*Benefits:* This principle ensures Health Boards safely support areas to reduce their agency reliance through a range of workforce and service initiatives. *Risk:* This principle could generate additional process and data burden within NHS Health Boards.	

Tranche 1	Controls to support the success of NHS Board banks and provide good governance in relation to the assignment of agency workers. These controls are effective from 1st April 2023 and provide a national approach to the provision of agency workers. These principles will continue to apply beyond 1st June 2023			
No.	Principle	Rationale	Benefits / Risks	Comment
1.7	Staff Banks **must** have in place a processes to ensure each worker has a **six-month** updated compliance checklist for each agency worker Where a record has not been resubmitted, the worker will be made inactive.	This principle ensures that the agency has met and maintained their contractual obligation as set out in the Scottish Framework Agreement (NP510).	*Benefit*: This principle keeps records of active workers current and minimises the risk of workers being deployed with out-of-date skills and /or eligibility credentials. *Risk:* This principle could generate additional processes within the staff bank. Administration burden	
1.8	**All off-framework workers must evidence indemnity insurance.**	Indemnity insurance is required due to the risk of medical negligence claim. Framework agencies are contractually obliged to have indemnity in place for their workers.	*Risk:* Where indemnity is not in place the health board would be solely liable for the medical negligence of an agency worker.	

Tranche 1	Controls to support the success of NHS Board banks and provide good governance in relation to the assignment of agency workers. These controls are effective from 1st April 2023 and provide a national approach to the provision of agency workers. These principles will continue to apply beyond 1st June 2023			
No.	Principle	Rationale	Benefits / Risks	Comment
1.9	All agency workers **must** only be registered with one agency within a Health Board.	This principle prevents workers from refusing a booking under a framework agency and then securing the same booking at a higher rate with an off-framework agency if escalated.	*Benefit:* This allows Health Boards to have transparent oversight of assigned agency workers under one agency, for compliance purposes. There is less potential for error for the tracking of use and reconciliation of invoices through the systems. *Risk:* There may be a workforce shift in an unexpected direction during this transitional tranche.	

Tranche 2	Controls to reduce the volume and lead time for shift being sent to off-framework agencies. These principles are transitional and will apply up to 1st June 2023 when they should cease to be necessary.			
No.	Principle	Rationale	Benefits / Risks	Comment
2.1	All agency workers **must** only be eligible to work with one agency within a Health Board.	This principle will support the expansion of workers available through the Scottish National Framework (NP510) This principle, in conjunction with the other transitionary measures in tranche 2, will increase access to work through the Scottish National Framework (NP510) for agency workers.	*Benefit:* Bookings through the terms and conditions of the framework agreement provide improved financial and clinical governance for boards This principle will increase agency worker availability through the Scottish National Framework (NP510) agencies. *Risk:* The success of this principle, in conjunction with the other transitionary measures in tranche 2, is dependent on a national approach.	
2.2	Board **must** have a process for reviewing and removing off-framework workers if they have been inactive for over 14 weeks.	This principle supports the removal of inactive off-framework workers without the risk of fees should they wish to return to the board under a framework provider.	*Benefits:* Active removal of inactive workers supports the transition measures in tranche 2 to move to Scottish National Framework (NP510) use only. This principle will support generating a secure and baseline supply of Scottish National Framework (NP510) agency workers. *Risk:* This principle will generate additional processes within Staff banks.	

Tranche 2	Controls to reduce the volume and lead time for shift being sent to off-framework agencies. These principles are transitional and will apply up to 1st June 2023 when they should cease to be necessary.			
No.	Principle	Rationale	Benefits / Risks	Comment
2.3	Boards **must** have a robust risk based tiered escalation framework for agency bookings.	This principle ensures a consistent, risk based, cost effective approach is applied to providing supplementary staffing The application of more stringent controls relating to authorisation level and escalation lead in time will support a risk-based assessment approach and application of cost effective and safe mitigation measures to the management of staffing gaps.	*Benefits:* There is robust assurance that clinical and financial risks have been considered by those in the board authorised to do so. The application of a tiered escalation framework provides rich data on pressures in the system. 14 weeks should ensure that Boards are outside of the period within which they could be charged a temp-to-temp or finder's fee for re-engaging a staff member by a different route than that through which they were originally engaged by the Board. *Risk:* The success of this principle, in conjunction with the other transition measures in tranche 2, is dependent on a national approach. There is a risk that the reduced lead times may reduce the availability of workers through off-framework providers during this transition tranche.	Escalation rules available here.

Tranche 2	Controls to reduce the volume and lead time for shift being sent to off-framework agencies. These principles are transitional and will apply up to 1st June 2023 when they should cease to be necessary.			
No.	Principle	Rationale	Benefits / Risks	Comment
			There is a risk that the increased burden of authorisation on Operational Directors and Executives Directors may result in a weakening of escalation process.	
2.4	Boards **must** have clear mechanisms in place that identify the criteria, processes, and reporting of breaches to the key agency principles within tranche 2.	This principle supports that criteria, process and reporting mechanism is clearly defined and in place for a scenario where the following principles are breached during the transition phase: *Boards must only accept new agency workers through a framework provider. (2.1)* *Boards must have a robust risk based tiered escalation framework for agency bookings* (2.3).	*Benefit:* The mechanisms are in place and clearly defined for securing a worker from off-framework providers in **exceptional** circumstances during the transitional tranche. This principle supports tracking, analysis, and progress review during the transition tranche. *Risk:* There is a risk that Health Boards will view breaches as 'business as usual' during the transitional tranche.	

Tranche 3	Agency workers are supplied through the framework only (Tranche 3 three supersedes controls in Tranche 2)			
No.	Principle	Rationale	Benefits / Risks	
3.1	Boards **must** not use off-framework agencies	This principle is the overarching and primary principle of all agency use. The use of off-framework providers in any capacity will have a negative effect on the workforce marketplace and undermine the provision of agency workers through the Scottish National Framework (NP510) frameworks.	*Benefit:* All agency supply is through the terms and conditions of the Scottish National Framework (NP510) agreement Risk: Scottish National Framework (NP510) supply does not meet the Health Boards demand. Failure in supply lines could result in failure of Health Boards to adhere to the agency principles and achieve significant reduction/elimination of off-framework use	
3.2	Boards **must** have clear Escalation Breach criteria and processes relating to an incidence where an off-framework provider is used	This principle supports that criteria, process and reporting mechanism is clearly defined and in place for a scenario where Principle 3.1 is breached. *Boards **must** not use off-framework agency* (3.1)	*Benefit:* The mechanisms are in place and clearly defined for securing a worker from off-framework providers in **exceptional** circumstances This principle supports tracking, analysis, and progress review during the transition tranche. *Risk:* There is a risk that Health Boards will view breaches as 'business as usual'	Breaches include: • Shift availability escalated to off-framework agency for supply • On boarding of new off-framework agency/agencies • On boarding of new off-framework agency workers
3.3	Boards **must** report use of off-framework	This principle supports Scottish Government in assessing any areas where issues are	*Benefit:* Allows identification of key areas of pressure within the system.	Instructions on reporting arrangements will be issued shortly.

	agencies to Scottish Government	particularly prevalent to see if national interventions could be made to alleviate pressures.		Reporting to SG will not commence until June 2023.

Escalation Breach Criteria: from 1st June 2023

- Shift availability escalated to off-framework agency for supply
- On boarding of new off-framework agency/agencies
- On boarding of new off-framework agency workers

Suggest a standardised reporting framework something along the lines of:

Driver or Trigger of Breach	Breach Descriptor	Planned exit action
e.g completed risk assessment	e.g Out to off-framework agency	e.g Narrative re resolution or future mitigation

9. Risk Based Agency Escalation

Tranche 2	Escalation Tiering (1st April 2023-1st June 2023			
Tier	Agency	Timescale	Authorisation level	Breach Criteria: Breaches can only be authorised by an Executive
Block Bookings	Framework	Where the vacancy gap results in critical staffing level or potential ward closures, identified by Nurse Directors. Up to a maximum of 12 weeks subject to an 8-week review.	Nurse Director	NA
Tier 1	Framework	Shifts can be sent to tier 1 agencies where bank/additional hours and roster changes have been exhausted and there remains a clinical risk	Nurse Director	NA
Tier 2	Off-Framework - 1	<48 hours Evidence provided to demonstrate all avenues have been exhausted and has been discussed at Executive level.	Executive	Breach in time scale. Breach in agreeing new off-framework agency workers

Tier 3	Off-Framework – 2 – Premium Agencies	<6 hours (for night duties in working hours) <14 hours (for next day shift in working hours) Evidence provided to demonstrate all avenues have been exhausted and has been discussed at Executive level.	Executive	Breach in time scale. Breach in agreeing new off-framework agency workers
Tranche three	Framework Only Use from 1st June 2023 (superseded tranche 2 tiering)			
Tier 1 only	Framework Only	Ad-hoc usage **or** Following Risk Assessment up to a maximum of 12 weeks Block Booking subject to an 8-week review.	Executive Nurse Director	Use of any Off-framework provider

MEDICAL LOCUM ENGAGEMENT TASK & FINISH GROUP

Date of Meeting: 3rd April 2024

Purpose: To set out a proposed escalatory framework for the Medical Locum Engagement Task & Finish Group.							
For Decision	X	For Action		For Discussion	X	For information/ To note	

Title	Medical Locum Engagement – Escalatory/Approval Mechanism

Situation	The Medical Locum Engagement Task & Finish Group has indicated that there may be merit in introducing greater consistency in relation to the escalatory/approval measures operated by Health Boards when considering engaging medical locums from external agencies.

Background

Previous guidance was produced by the Scottish Government in 2011 to support the effective commissioning of medical locum capacity, building on the work of a Short Life Working Group established to take account of best practice underway across NHS Scotland.

- **Link to extant CEL 4 (2011) - Supplementary Medical Staffing – Guidance to Boards:** CEL 4 (2011) - Supplementary medical staffing: guidance to boards (scot.nhs.uk)

That guidance set out that best practice for the securing of supplementary medical staff should follow the following escalation process:

Step 1
Identification of a gap in medical staffing

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

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

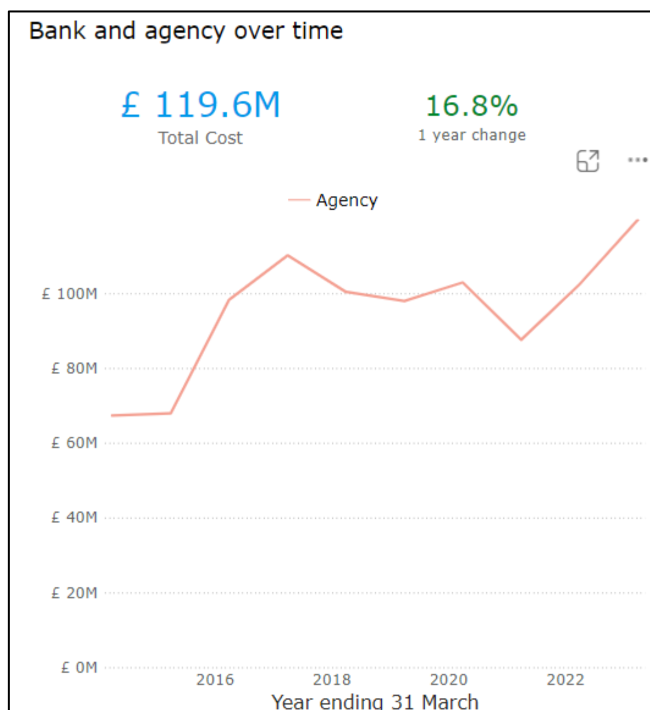
Current Step 4
Consider options for cover by other staff within the department/hospital as a locum

Current Step 5
Initiate process for engaging supplementary medical staff

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

Proposed Step 5
In exceptional circumstances, initiate process for engaging staff from a contract agency as outlined in the new framework agreement.

	The guidance went on to require that NHS boards agree local structures and accountability procedures linked to the operation of staff banks as part of wider supplementary staffing arrangements. This was to include the identification of a nominated executive lead for the strategic oversight of the NHS board's delivery against national guidance, targets and associated recommendations. Boards were advised that in relation to supplementary medical staffing, the Medical Director was recommended as the most appropriate Executive Lead, with delegated responsibilities being devolved to clinical directors through the normal clinical and financial governance routes. Acknowledging the flexibility that was afforded to Health Boards through the above reference guidance, it is understandable that a level of variation has developed in relation to the escalation and approval arrangements being operated for medical locum engagements. Building on prior work undertaken, further activity was delivered between 2016 and 2018 as part of the cross-system Managed Agency Staffing Network (MASNet) in order to strengthen local practices in relation to medical locum engagement. The network supported each Health Board with the development of a strategy to specifically target local issues. It was identified through this work that good practice should involve: 1. The participation of Medical Directors (as Executive Leads) in the regular review of current, short and long term locum requirements in conjunction with key senior representation such as HR, Finance and Clinical Leads. This summary review meeting took place every 2 weeks in some Health Boards to maintain the focus. 2. Regular reviews specifically considered: a. Long term requests – any requirement for a locum from 4 weeks to 13+ weeks required a business case or other local process to be approved by the Medical Director. b. The ongoing need for existing high cost locums, including consideration of the case for re-sourcing alternative candidates at lower rates. c. Recruitment plans for permanent vacancies reviewed with different methods of candidate sourcing developed in conjunction with HR and external agencies (if appropriate). Information gathered as part of a survey exercise conducted by the Medical Locum Project Team in late 2023 indicated that the local arrangements for engaging supplementary medical staff differ significantly across Boards. While some Boards continue to require Executive sign-off in order to proceed with locum engagements, others operate a model whereby responsibility for engagement decisions was devolved to individual service areas to manage. Similarly, while some Boards had consistent administrative processes involving standardised forms to support the approval process, this is not consistent across the country.

Assessment	It is clear that considerable work has already been undertaken over an extended period of time to identify and seek to embed consistent good governance arrangements for the entering into, and continuation of, locum engagements. However, for a variety of reasons these controls have fallen away in some Boards. Consistent with the position in relation to nurse agency usage, data collated as part of the official NHS Scotland workforce statistics shows significant increased reliance on medical locums as the service has sought to recover from the impacts of the Covid-19 pandemic:  This increase coincides with an uptick in sickness absence across the service, with absence rates increasing from 5.44% in 2020 to 6.20% in 2023. While difficult to make any direct link, it is worthy to note that available expenditure data shows a change in trend in relation to locum usage over the lifespan of MASNet. Engagement lengths for supplementary medical staff vary significantly across reporting boards: 7 boards (A&A, Borders, D&G, FV, GGC, Highland & Lanarkshire) predominantly feature short-term engagements of less than 5 shifts, highlighting a preference or need for flexible, brief support. Conversely, 5 boards (Fife, Grampian, Lothian, Tayside & WI) show a majority of engagements exceeding 21 shifts, indicating a reliance on these staff for longer-term roles, suggesting their deeper integration into healthcare teams. Given the significant increase in expenditure in recent years and the wider financial pressures now being managed across the system, it would seem sensible that steps be taken to introduce a consistent sign-off process for

	locum engagements which includes Executive involvement in cases where expenditure is higher. **In line with previous guidance, we believe it continues to make sense for the Medical Director (as Professional Lead for the Board's medical workforce) to act as the Executive Lead in relation to supplementary medical staffing.** **As part of this function, Medical Directors could be asked to take responsibility for considering all locum requests which exceed a defined duration and/or value. It is acknowledged that Boards will require flexibility to respond to short-term staffing gaps caused by e.g. sickness absence and it would seem reasonable that decisions on locum engagements may be delegated in such instances, on condition that the rate of pay does not exceed that provided for through the National Procurement Framework NP50022: Temporary Agency Medical Locum Doctors. However, for engagements which attract higher costs, either due to the rate of pay or because the duration of the contract exceeds a period of 3 days, it may be more appropriate that the Medical Director retains direct responsibility for approval.** **Acknowledging the practical challenges this may present, some flexibility should be introduced which would allow an alternative member of the Board's Executive Team to approve such requests in the Medical Director's absence. A similar approach, whereby Executive approval is required in relation to certain categories of agency nurse engagements, has proven to be effective in ensuring increased rigour in relation to sign-off decisions which in turn has been found to drive reductions in expenditure when delivered alongside other interventions.** **In order so support effective decision-making, a model was promoted under the MASNet approach which involved the production of a business case for any engagements exceeding 4 weeks. Again, there is a strong case for this approach being standardised and potentially mandated going forward. It would seem sensible that any business case includes information on:** **1. The clinical case for engaging locum use.** **2. The options appraisal undertaken to explore alternative staffing solutions, with a preference to utilise substantive staff before considering supplementary medical staffing accessed via banks as well as neighbouring Boards. Only where these options have been exhausted should agency usage be sought.** **3. The proposed timescales for any engagement along with a clear exit strategy which involves a shift to a sustainable staffing solution. Recruitment plans for permanent vacancies should be reviewed as part of this, with different methods of candidate sourcing developed in conjunction with HR and external agencies.** **4. Details of the steps which have been taken to secure best value in relation to any locum engagement. This should**

	include details of market engagement/testing along with confirmation that steps have been taken to secure capacity via an agency which appears on National Procurement Framework NP50022: Temporary Agency Medical Locum Doctors. **The development of an updated business case could also be sought in instances where there is a request to extend existing locum engagements. Finally, Boards could be requested to retrospectively apply these controls to existing locum engagements.** **The above measures have been identified in consultation with representatives from the National Bank Manager's Forum who consider them to be suitably robust and feasible from an implementation point of view. Introduction of the above measures will require lead times on the part of Boards and may benefit from the introduction of standard templates and associated guidance to aid local discussions.**

Recommendation	It is recommended that guidance be prepared for Health Boards requiring: • That Board Medical Directors take on the role of Executive Lead for medical locum engagements and, in this role, assume responsibility for sign-off of any engagements which exceed 3 days in duration and/or attract a pay rate in excess of that set out in the relevant National Procurement Framework. • Members are asked to review the 3 days duration for engagement standard proposed above and to advise if this is the appropriate length of engagement at which to set this control, or if another time period would be appropriate. • In their role as Executive Lead, Board Medical Directors convene and chair a Strategic Oversight Group with involvement of HR, Finance and Clinical Leads to ensure the operation of robust corporate processes for managing locum engagements. • That any medical locum engagements exceeding 4 weeks in duration require to be underpinned by a Business Case to be approved by the Board's Medical Director in consultation with HR, Finance and Clinical Leads. • That Boards retrospectively undertake the development of a Business Case in respect of any ongoing locum engagements exceeding 4 weeks in duration.

Action required	The Group is invited to: • Agree to the recommendations set out above. • Indicate whether they consider it would be helpful to have a standardised business case template developed to aid the consistent adoption of the new controls at a local level.

Author	Project Team
Date	March 2023

Medical Locum Engagement Task & Finish Group
Terms of Reference

Date Published:
Version: v0.3
Document Type: Governance
Review Date:

DOCUMENT CONTROL SHEET

9.1.1 Key Information:

Title:	Medical Locum Engagement Task & Finish Group Terms of Reference
Date Published/Issued:	
Date Effective From:	
Version/Issue Number:	
Document Type:	Governance
Document Status:	Draft
Author:	[redacted]
Owner:	
Approver:	
Approved by and Date:	
Contact:	
File Name:	

9.1.2 Revision History:

Version	Date	Summary of Changes	Name	Changes Marked
0.1	**11/12/2023**	**First Draft**	**[redacted]**	
0.2	**07/03/2024**	**Following first meeting of the group, a number of amendments have been made including additional membership.**	**[redacted]**	
0.3	**04/04/24**	**Changes to text referenced Nurse Agency work**	**[redacted]**	

9.1.3 Distribution:

10. This document has been distributed to:

Name:	Title/Board:	Date of Issue:	Version:
All invitees to Medical Locum Engagement Task & Finish Group	**Medical Locum Engagement Task & Finish Group**	**01/02/2024**	**0.2**

10. Background

It is acknowledged that NHS Scotland's current approach to the use of supplementary staff is not delivering best value. The previously formed Medical Workforce Sustainability Group (MWSG), which met for the final time in November 2023 commissioned the development of an action plan designed to ensure that NHS Scotland Health Boards secure best value when accessing supplementary medical staff. It was agreed that the MWSG be reconfigured to form a Task & Finish Group with the necessary membership to deliver the action plan.

11. Purpose of the Medical Locum Engagement Task & Finish Group

Considerable work has been taken forward to improve NHS Scotland's approach to nurse agency staffing which has resulted in Boards reporting significant progress in reducing reliance on agency nursing staff. The reconfigured Medical Locum Engagement Task & Finish Group will look to make use of applicable learning from this work. In pursuance of this, the group's primary focus will be on the appropriate targeting of locum usage and, where locums are engaged, ensuring Health Boards secure best value when accessing them.

The MWSG endorsed a number of workstreams aimed at addressing the underlying supply deficits across the medical workforce and these being delivered by the NHS Education for Scotland (NES) Medical Directorate, the NES Centre for Workforce Supply and Scottish Government's Health Workforce Directorate. The Task and Finish group will wish to remain apprised of progress with these workstreams given their relevance

12. Scope

The scope includes all locum/agency medical staff engaged directly by NHS Scotland Health Boards, including those accessed via staff banks and those engaged via an agency.

The group will work with key stakeholders to identify best practice and areas for improvement in order to achieve best value whenever NHS Health Boards are accessing supplementary medical staff. This work will include:

- Developing a national approach to guide all Health Boards in ensuring the appropriate use of medical locum agency resource to a proportionate level (to be determined by the Task & Finish Group), while balancing considerations regarding patient safety and staff wellbeing.
- Optimising the use of local staff banks to provide the safest and best value model of resourcing temporary gaps with staff who have knowledge of local procedures and policies, as well as the skills and competencies to contribute effectively.
- Ensuring current work on improving recruitment of substantive medical staff is targeted towards reducing agency locum usage.
- Making use of applicable learning available from the Nursing Supplementary Staffing Task & Finish Group to ensure appropriate use of Medical Locums.

- Achieving the above without compromising quality of care experienced by patients in NHS Scotland.

13. Membership

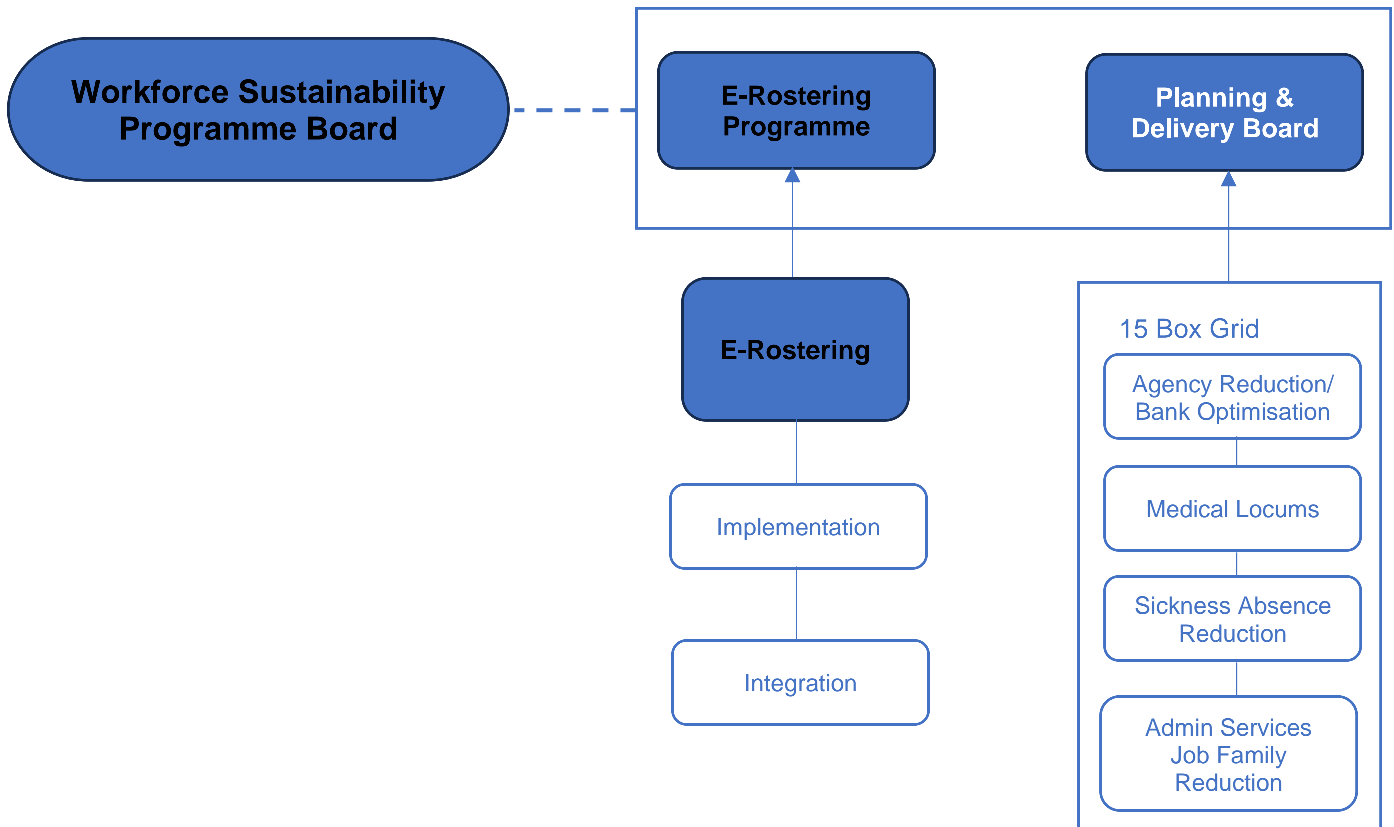
Full membership of the Medical Locum Engagement Task & Finish Group is provided in Annex A. The Group will work in partnership with colleagues from the Scottish Government Health Workforce and Chief Medical Officer Directorates, NES, including NES Centre for Workforce Supply, NHS National Services Scotland (NSS), British Medical Association and other NHS Scotland Health Board colleagues.

Meetings will be co-chaired by Carol Potter, NHS Fife Chief Executive and Gillian Russell, Director of Health Workforce, Scottish Government. Members may nominate a deputy to represent their interests if they are able to attend or to support discussions on a particular matter. Members should make the secretariat aware in advance of the meeting if they are sending a deputy on their behalf.

14. Governance

The Medical Locum Engagement Task & Finish Group will report to both the NHS Scotland Planning and Delivery Board and the newly established Scottish Government Health Workforce Sustainability Programme Board. The latter is a new, Scottish Government led, programme tasked with supporting service development and delivery in the context of the 2024/25 budget.

The Task & Finish Group will maintain connections with the various Executive groups (CE's, HRDs, DoFs, SAMD) via the identified representatives within the membership.



15. Meeting Frequency, Secretariat and Decision Making

The Group will meet monthly, with the first meeting of the group taking place on 29th February 2024. The Co-Chairs may convene additional meetings as deemed necessary and the frequency of meetings will be kept under regular review. Meetings will take place virtually using Microsoft Teams, with ad-hoc correspondence via email as required by the group.

Secretariat support for the group will be provided by the Scottish Government Health Workforce Directorate's Sponsorship and Infrastructure Unit.

Decisions and actions will be recorded within the meeting minutes, and formal approval for these will be sought at the following meeting of the group before they are finalised. Group members are expected to complete actions assigned to them as per the timescales agreed. Any papers will normally be circulated 3 working days prior to the meetings.

The quorum for decision making and carrying out the business of the group will be half of members, and decision making will be by majority. No single member will have a veto, and in the event of a 'split' decision, the Chair will be the final arbiter.

16. Confidentiality

It is likely that information may be of a sensitive or confidential nature. It is vital that all members understand their responsibility to treat as confidential, information that may be available to them, or obtained by them, or that may be derived whilst working in the Group. Authors should be aware and consider that information considered to be Confidential may be required to be disclosed under the Freedom of Information (Scotland) Act 2002 or Environmental Information (Scotland) Regulations 2004.

17. Recordings

The meeting chair must seek informed consent from every member in attendance if a meeting is to be audio recorded. For meetings of the group that are audio recorded, following sign off of the minute/action notes, recordings will be deleted.

18. Lifespan

The group will continue to meet until such times as the desired outcomes are sufficiently achieved. Membership and terms of reference of the group will be reviewed as and when necessary to ensure they remain extant.

Annex A - Membership

Individual	Representing	Role/Responsibility
Co-chair: Carol Potter, Chief Executive, NHS Fife	Board Chief Executives	Chair, provision of advice on key options appraised and support decision making. Provide CE perspective and link with BCE group and Management Steering Group
Co-chair: Gillian Russell, Director of Health Workforce, Scottish Government	Scottish Government Health Workforce Directorate	Chair, provision of advice on key options appraised and support decision making
Caroline Hiscox, Chief Executive, NHS Tayside	Board Chief Executives	BCE perspective and link with BCE Group
[redacted]	Chief Medical Officer and Health Workforce Directorates, Scottish Government	Provision of advice from medical perspective.
[redacted]	SAMD	Providing Medical Director perspective to work and link with SAMD and individual MD's
[redacted]	Board Medical Directors	Providing the perspective of Board Medical Directors and representing their interests
[redacted]	Medical Royal Colleges and Faculties in Scotland	Representing the interests of the Medical Royal Colleges and Faculties in Scotland.
[redacted] [redacted]	NES Medical Directorate	Support with elements relating to doctors in training
Mary Morgan, Chief Executive, National Services Scotland	National Services Scotland	Provide perspective on behalf of NSS and the delivery of national infrastructure
[redacted] [redacted] [redacted] [redacted]	Health Workforce Directorate, Scottish Government	Provide Scottish Clinical Leadership Fellow support to group work program
[redacted] [redacted]	Directors of Finance, NHS Boards	Support financial considerations at Board level
[redacted]	HR Directors, NHS Boards	Support HR considerations at Board level, link with HRD's group and with 'Once for Scotland' Program
[redacted] and [redacted]	NES Centre for Workforce Supply	Support Consultant supply mitigation and communication with Boards

[redacted]	Director of Health Finance, Corporate Governance and Value, Scottish Government	Support the set-up of the work and provide advice and support on behalf of Health Finance
[redacted] [redacted]	Staff Bank Managers	Provide perspective on behalf of Staff Bank Managers
[redacted]	Staff Bank Managers/ West of Scotland Consortium	Provide perspective and advice based on the WoS Consortium
[redacted]	Management Steering Group	Provide links to MSG and the ongoing work in relation to Medical Pay and TCS
[redacted]	Nursing Supplementary Staffing Task & Finish Group	Providing advice based on the work of the Nursing Supplementary Staffing Task & Finish Group.
[redacted]	British Medical Association Scotland	Represent the interests of the BMA
[redacted]	Staffside	Represent staffside interests
[redacted]	SG Health Workforce Recruitment and Capacity Building Unit	Providing SG official support to ongoing work and linking with the relevant SG units
[redacted] [redacted]	SG Pay, Practice and Information Governance Division	Represent the interests of the Pay team within SG
[redacted] [redacted]	NSS National Procurement	Supporting work on bank vs agency; best value
[redacted],[redacted]	NES Digital	Data and analytic support
[redacted]	SG Health Workforce Sponsorship and Infrastructure Unit	Providing SG official support to ongoing work and linking with the relevant SG units
[redacted]		Taking actions and minutes at formal meetings. Issuing key papers and agenda ahead of formal meetings

OFFICIAL SENSITIVE

MEDICAL LOCUM ENGAGEMENT TASK & FINISH GROUP

Date of Meeting: 9th May 2024

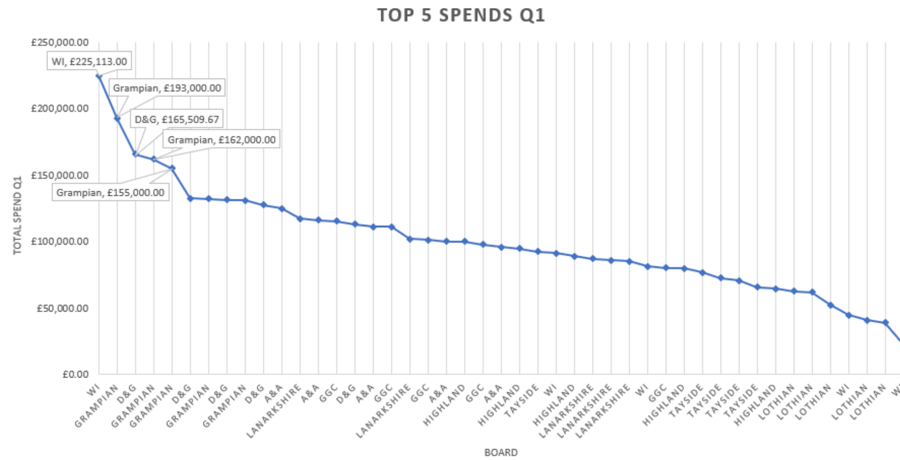
Purpose: To set out a proposed approach to benchmarking pay rates for medical locum engagements across NHS Scotland Boards. The aim of this paper is to provide members with a basis for discussion and the opportunity to feed back, before any decisions in relation to the recommendations are implemented.							
For Decision	X	For Action		For Discussion	X	For information/ To note	

Title	Medical Locum Engagement – Benchmarking pay rates

Situation	The Medical Locum Engagement Task & Finish Group has indicated that it would like to explore the potential merits associated with the introduction of a mechanism to support Boards in assessing the value for money being obtained through medical locum engagements.

Background	Initial evidence gathered to support the Medical Locum Task & Finish Group's work demonstrates that, whilst there is relative consistency in commission rates paid by Boards in order to access supplementary medical staff via agencies, there is significant variation in the rates of pay offered to locums engaged through this route: Average of Commision rate and Average of Hourly Rate by Board Average of Commision rate / Average of Hourly Rate Board: Forth Valley 12 / 144; Highland 11; Borders 10 / 157; Tayside 10 / 159; Lothian 10 / 105; Orkney 10 / 107; D&G 9 / 129; Grampian 9 / 180; A&A 8 / 124; Lanarkshire 8 / 144; Fife 165; GGC 135; WI 130 0 50 100 150 2 Average of Commision rate and Average of Hourly Rate Data collected from the SG Supplementary Medical Staffing Survey conducted in October 2023 The above data concerns the period April to June 2023 and is not currently collated on a recurring basis. Variation can be expected depending on the spread of vacancies/gaps, for example if there are a greater number of gaps within a Board's junior doctor workforce, then the average rates will be lower compared to a Board with greater Consultant gaps.

In addition to the above, evidence was gathered as part of that same one-off exercise in order to better understand the highest rates of pay offered by Boards in relation to individual locum engagements via agencies:



Data collected from the SG Supplementary Medical Staffing Survey conducted in October 2023

Finally, evidence gathered by SG Health Finance via Board Directors of Finance is currently used to support financial benchmarking using *Discovery*, NHS Scotland's online management information system that provides approved users with access to a range of comparative healthcare information. That data is then used to produce a scorecard which offers an assessment of the relative performance of Boards from a financial perspective against key areas of spend / cost pressure:

Indicator	Allied Health Professional Agency	Consultant Agency	Consultant Bank	Consultant Permanent	Junior Doctor Agency	Junior Doctor Bank	Junior Doctor Permanent
							Pay
Average % of YTD budget	-	12.2%	2.6%	62.1%	1.9%	1.5%	30.8%
NHS Ayrshire & Arran	-	4.7%	0.6%	70.7%	0.3%	1.6%	29.5%
NHS Borders	-	7.8%	0%	70.7%	0.6%	0.1%	24.8%
NHS Dumfries & Galloway	-	18.9%	0%	61.3%	8.3%	0.9%	21.9%
NHS Fife	-	14.9%	0%	70.6%	2.1%	0%	25%
NHS Forth Valley	-	3.9%	3.7%	68%	1.5%	0.1%	25.7%
NHS Golden Jubilee	-	1.3%	0%	55.4%	0.7%	5.3%	22.2%
NHS Grampian	-	6.8%	0%	66.5%	2.4%	0%	31.9%
NHS Greater Glasgow & Clyde	-	1.7%	0.5%	63.5%	0.4%	3.9%	29.2%
NHS Highland	-	14.1%	0%	69.2%	3.8%	0%	17.4%
NHS Lanarkshire	-	5.9%	0.1%	69.7%	1.3%	1.2%	26.4%
NHS Lothian	-	0.6%	1.3%	69.7%	0.4%	1.5%	30.4%
NHS Orkney	-	18.4%	0%	90.1%	6.4%	0.2%	10.8%
NHS Shetland	-	17.7%	8.3%	81%	0.1%	0%	13.3%
NHS Tayside	-	5%	0.2%	66.4%	0.2%	0.1%	30.9%
NHS Western Isles	-	61.6%	6.1%	44.6%	0.7%	1.1%	9.5%

Discovery NHS Scotland Finance Dashboard, Directors of Finance Scorecard

As part of the assessment delivered through the above scorecard, Boards are afforded a RAG rating on their expenditure profile. This is based on a comparison across Boards who are comparable in terms of size and geography.

Assessment

It has generally been acknowledged that the data collation exercise taken forward as part of the initial evidence gathering to support the work of the Medical Locum Task and Finish Group has been helpful in building an understanding of medical locum usage across the country. Subsequent discussions within the Group suggested that regular collation and distribution of such data would be helpful, not only in informing potential national interventions designed to drive best value but also to support robust local decision-making.

Building on the above, a number of options have been identified in relation to the benchmarking of medical locum expenditure and, in particular, rates of pay. The intention would be for data to be collated and reported on a monthly basis.

Option 1 – Do Nothing (*Discovery* Scorecard)

	Under this option, no additional benchmarking data would be collated. However, some information on overall medical locum spend, presented as a proportion of overall medical workforce spend, would continue to be available via the *Discovery* spending scorecard described above and it would be possible to share this with the Medical Locum Task and Finish Group on a quarterly basis. This approach has the benefit of mitigating the requirement for Boards to collate and submit additional information at a time when resources are already stretched. In terms of disadvantages, this option would not provide Boards with the granular analysis of spend that would be possible under other options explored and, in particular, would provide no intelligence in relation to individual pay rates (currently understood to be a key area of variation which is reflected in outputs of the Supplementary Medical Staffing Survey). <u>Option 2 – Discovery Scorecard, monthly monitoring of average/median agency locum rates</u> Option 2 would involve the continued collation of data to populate the *Discovery* spending scorecard, supplemented by the monthly collation of data from Boards on rates of pay for locums accessed via agencies. As outlined earlier in this paper, there are likely to be a relatively small number of instances within Boards where significantly higher rates of pay are offered to locums due to market factors and the need to maintain the viability of services which may not be able to function in the absence of a temporary staffing solution. These engagements have the potential to inflate any calculation of average locum pay, meaning it is unlikely to be representative of pay rates for a majority of locums accessed by the Board via an agency. Accordingly, it may be helpful to supplement any reporting on average pay rates with details of the median rate of pay for locums over the reporting period. The suggestion would be for both the average and median pay rates to be reported as hourly rates. In terms of the benefits associated with this option, enhanced reporting on average and median pay should provide the Medical Locum Task & Finish Group with an up-to-date understanding of how the medical locum market is operating. It should also allow informed decisions to be taken about which national and local interventions have the potential to deliver the greatest financial impact. Finally, a decision to routinely share this information across Boards may usefully inform local decision-making about the relative value for money being obtained through individual local engagements. The key disadvantage of this approach is the introduction of an additional reporting burden for Boards at a time when staff/the service is already managing significant pressures. Anecdotal feedback suggests that Boards did not find it straightforward to collate information of this nature when it was sought as part of the initial survey/evidence gathering exercise conducted on behalf of the Medical Locum Task and Finish Group.

	However, the Group may consider it a necessity that appropriate systems and processes be adopted within Boards for the collation and consideration of such information as part of enhanced governance arrangements surrounding the use of locums. Option 3 – *Discovery* Scorecard, monthly monitoring of average/median agency locum rates, and reporting on high-value locum engagements (by specialty). Option 3 involves the introduction of all those reporting arrangements described under option 2. In addition, it would involve the introduction of a requirement for Boards to routinely report on pay rates for their highest cost locum engagements, presented as an hourly rate. Boards would also be asked to confirm the specialty to which the locum engagement relates. There is evidence that a number of Boards are currently being charged significantly inflated pay rates in order to access the workforce required to sustain fragile services. At a system level, steps are being taken to consider how such fragile services can be reconfigured in order to ensure their long term viability, underpinned by sustainable workforce solutions. In the meantime, it remains important that Boards are supported to assess the extent to which they are securing best value in relation to the engagement of locums within these services. The routine collation and sharing of details amongst Boards regarding pay rates for these engagements is likely to help in this regard. In keeping with the methodology adopted for the recent survey, it may be that the Task and Finish Group sees merit in requesting routine reporting of the hourly rate for the **5** most expensive locum engagements in a Board area. This method of identifying the highest locum spends could be revisited after a few reporting months and once a data set has been established, to determine whether or not it's the most appropriate metric. In terms of disadvantages, this option (much like option 2) involves the introduction of an additional reporting burden for Boards at a time when staff/the service is already managing significant pressures. However, the Group may consider that this cost is outweighed by the benefits described above. **Reporting and Dissemination** All of the above options involve some collation of relevant data pertaining to locum use. Irrespective of which approach is supported by the Task & Finish Group, it is felt that the routine presentation of available data at national and local level will be of benefit. With this in mind, the project team would propose preparing a monthly report summarising available data for submission to the Task & Finish Group and dissemination to nominated leads within Boards for their local consideration. The project team will also engage with Scottish Government colleagues leading on the Health and Care Staffing Act to understand the potential for integrated reporting.

Recommendation	Given the increased focus on medical locum expenditure and the feedback regarding the value derived from initial evidence gathering to support the work of the Task & Finish Group, It is recommended that a new benchmarking process focussed on assessing medical locum pay rates be implemented in line with option 3. Specifically, this would involve the monthly collation, analysis and distribution of: • information on overall medical locum spend, presented as a proportion of overall medical workforce spend. • Details of average and median pay rates for medical locums accessed via agencies, reported as hourly rates. • reporting of the hourly rate for the 5 most expensive locum engagements in each Board area. Reporting of the above dataset would be incorporated into any wider reporting arrangement being developed to support an improved understanding of locum usage.

Action required	The Group is invited to: • Note the options set out above and indicate whether they support the recommendation to introduce new benchmarking arrangements in line with option 3.

Author	Project Team
Date	April 2024

MEDICAL LOCUM ENGAGEMENT TASK & FINISH GROUP

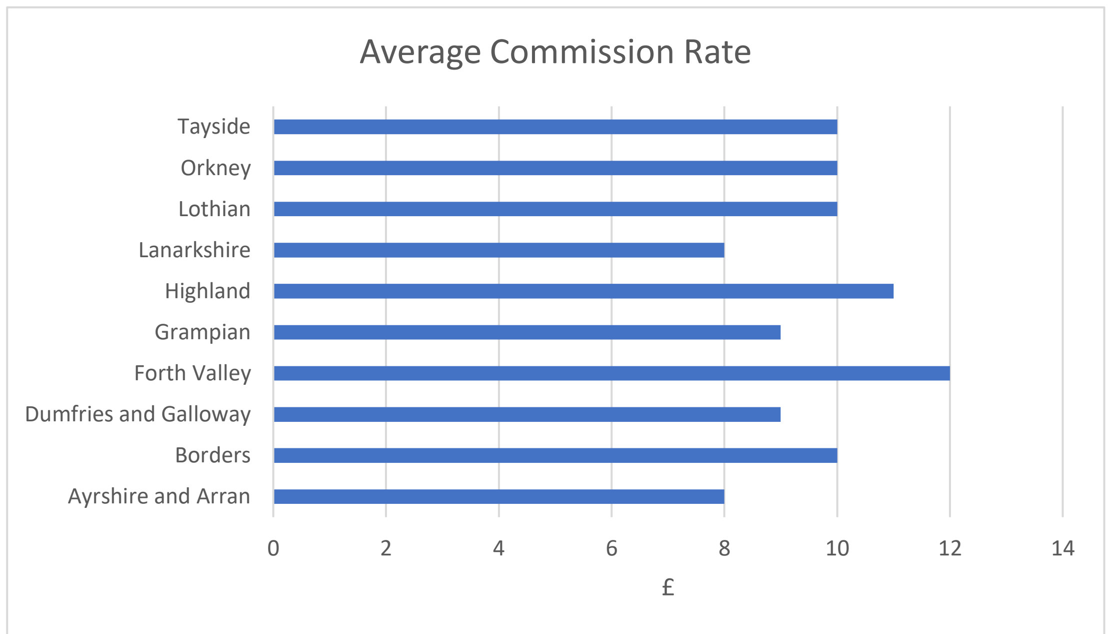
Date of Meeting: 9th May 2024

<table>
<tr><td colspan="8">Purpose: To explore the potential benefits associated with reviewing the commission structure for long-term locum engagements, with a view to negotiating lower hourly commission rates for long-term locum engagements. The aim of this paper is to provide members with a basis for discussion and the opportunity to feed back, before any decisions in relation to the recommendations are implemented.</td></tr>
<tr><td>For Decision</td><td>X</td><td>For Action</td><td></td><td>For Discussion</td><td>X</td><td>For information/
To note</td><td></td></tr>
</table>

Title	Medical Locum Engagement Task & Finish Group – Commission Rate Review

Situation	The Medical Locum Engagement Task & Finish Group has indicated that there may be merit in reviewing the commission structure for long-term locum engagements, with a view to negotiating lower hourly commission rates for long-term locum engagements.

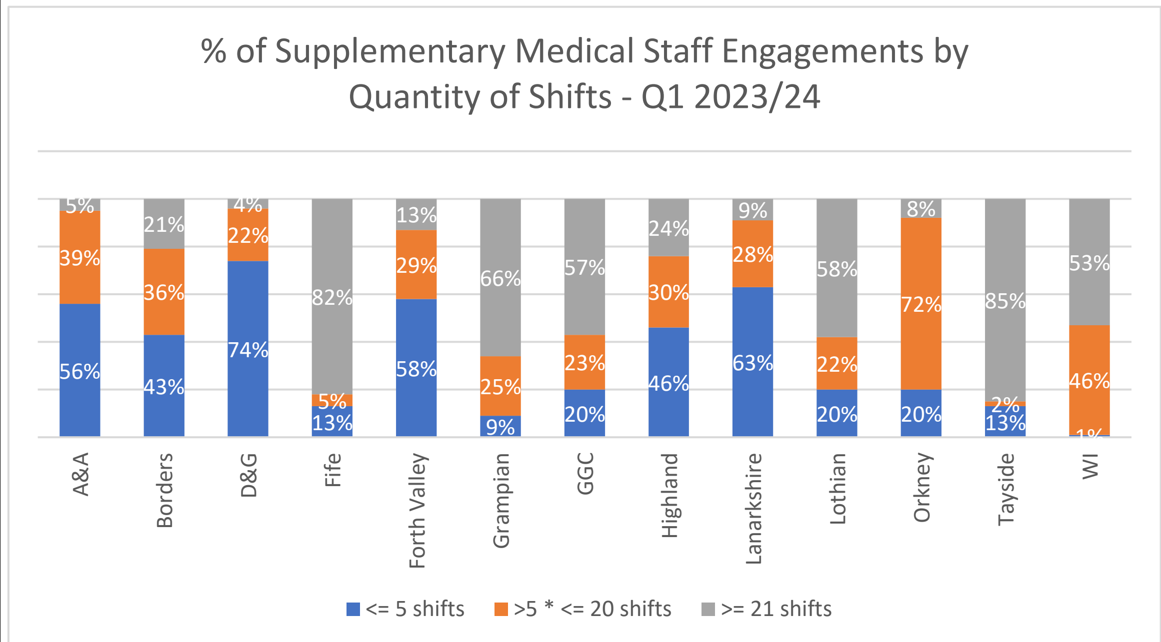
<table>
<tr><td>Background</td><td>The outputs of the Supplementary Medical Staffing survey, issued to all Boards in October 2023, suggest that the average commission rate paid by Boards for locum engagements ranges between £8 and £12 an hour.



*Average commission rate not available for Fife, GGC or Western Isles

Despite the consistency in commission rate across Health Boards, the survey found that the length of supplementary medical staff engagements differs significantly across Boards. According to the data, which covered Q1 2023/24, 6 Health Boards reported that the majority of their engagements lasted 5 shifts or less, while another 6 Health Boards reported that 50% or more of their shifts related to engagements lasting 21 days or more. 1 Board reported that 72% of their engagements were greater than 5 shifts, but</td></tr>
</table>

less than or equal to 20 shifts. NHS Shetland did not provide a response to the survey and therefore are not included in the data reported in this paper.



With a view to reducing the costs associated with locum usage, it is important to consider the potential for Health Boards to negotiate a reduced commission rate for long-term locum engagements.

Due to the nature of long-term locum engagements, they offer both the agency and worker greater employment and financial security, which places Boards in a strong negotiation position when it comes to agreeing the commission and pay-rate for such engagements.

Accessing medical locums via the N5002 Temporary Agency Medical Locum Doctors National Framework gives Health Boards greater control around commission rates, as well as guarantees around indemnity insurance, which helps support the provision of high quality, safe patient services.

It is also worth noting that the current framework has a cap on commission based on Grades (irrespective of engagement duration), with many suppliers providing a rate which is lower than the cap and this has historically provided savings for NHS Scotland.

Assessment

In order to determine the most optimal solution for maximising the potential savings associated with reviewing the commission structure and negotiating lower rates, a number of options have been identified and are set out below.

Option 1 – Set a National Commission Rate
This option would involve setting a national commission rate for all engagements in all Health Boards. As the survey outputs suggest, there is already relative consistency in terms of commission rate, however given the unique nature of each engagement within the framework, it would be challenging to establish one singular pricing structure for the whole of Scotland. Setting a national commission rate is also likely to limit the negotiation flexibility Boards have, as power dynamics can

	vary considerably across engagements due to their unique and specific requirements. There is a risk that this option could increase commission costs for Boards whose current commission rate is lower than the national rate. In this situation, agencies may see the opportunity to request the national rate when they have previously agreed to a lower rate for specific engagements. For example, if a national commission rate was set to £10, then any Boards who are currently agreeing commission rates below £10 would likely faced increased costs and in effect cancel any potential savings that had been made nationally. <u>Option 2 – Agree Once for Scotland Percentage Discount for Long-Term Engagements</u> Under option 2, Boards would agree on a national basis that a specific percentage discount would be sought for any engagements over a certain duration. The current terms and conditions of the NP5002 Temporary Agency Medical Locums Doctors National Framework state that "*Where the Participating Authority requires an Agency Worker to be supplied in the provision of the Services for a continuous period of 4 weeks or more, the Framework Participant shall offer to the Participating Authority a discount on the Agency Worker Rate of Pay and/or the commission.*" It seems sensible to tie the definition of long-term engagements to the 4 week period which is set out in the framework. As such, this option would request that all Boards agree to seek a percentage discount for any engagements lasting 4 weeks or more. Whilst the framework does stipulate a reduction in commission for long-term engagements and provides Health Boards with a way to negotiate with suppliers, there is no further guidance defining what the reduction should be and how this would be applied to the agreed rates. In the event that a supplier rejects the request for discount, Boards do have the opportunity to escalate the request to NSS national procurement who can engage with the supplier. In this situation however it is unlikely that Procurement would have sufficient leverage to force the agency to provide the reduction, given Boards are likely to be reluctant to cancel the contract for the worker if the discount is rejected. In addition, this would take additional time to secure an engagement, which Boards may require urgently. National procurement have confirmed that the current framework expires on 1st November 2025, however there is scope for a 2 year extension to 1st November 2027. At the point of retendering, in 2027, the inclusion of a consistent step down rate for engagements more than 4 weeks in duration will be discussed with stakeholders and the Commodity Advisory Panel for consideration in inclusion in the tender. By agreeing a national discount percentage for locum engagements lasting 4 weeks or more in advance of this date, Health Boards would benefit from a reduction in commission rates in the meantime, until the retendering exercise has taken place and step down rate agreed. There is however a risk that the competition for locums remains too high and Boards drift from the agreed rate, depending on circumstance, in order to secure the engagement.

	In order to estimate potential cost savings this option could generate, an assumption has been made that any shifts reported by Boards as lasting 21 days or more in Q1 2023/24, also lasted at least 4 weeks. Assuming an average commission rate of £10/hour for a 12 hour shift , then a 25% discount rate for engagements lasting 4 weeks or longer would equate to a saving of £30 per shift. Focussing on the Boards who reported the greatest percentage of engagements lasting 21 days or more during Q1 2023/24, the following savings could be made:

Board	Number of engagements >= 21 in Q1 23/24	Potential Savings (per quarter)
Tayside	45	£1,350
Grampian	67	£2,010
Fife	74	£2,200

As suggested in the table above, it is unlikely that option 2 would generate significant financial savings for Boards. A significant level of national procurement resource would also be required to support this option, in order to define a national step down rate in advance of the retendering exercise in 2027, given the number of suppliers and renegotiations that would need to take place.

Option 3 – Make Boards Aware of the Opportunity to Negotiate
This option would involve drafting correspondence to all Health Boards to highlight that they have the opportunity to negotiate lower commission rates as part of the Framework terms and conditions, but leaving the decision as whether or not to do so, to individual Boards.

As outlined in response to option 2, it appears that, according to the Q1 2023/24 survey data, the majority of engagements tend to be short-term. This option would allow Boards the opportunity to make an informed decision about whether or not negotiating reduced commission rates would be beneficial. By leaving the decision to Health Boards, they can weigh up the potential costs associated with negotiation and whether or not these outweigh the potential savings to be made. Where Boards choose to pursue the negotiation of discounted rates, an arrangement could be put in place to share intelligence regarding the outcome of said negotiations across NHS Scotland in order to inform activity in other Boards.

Recommendation	Each Board is likely to be in a slightly different position with regards to the leverage they have in the negotiation of step-down rates for long term locum engagements. Their relative negotiation powers will be influenced by a number of factors, including the criticality of the locum engagement and the extent of their relationship with particular agencies. With this in mind, we recommend: • That communication is drafted to make all Health Boards aware that, as part of the Framework terms and conditions, they have the opportunity to

	negotiate reduced commission rates for engagements lasting 4 weeks or more. • That each Board pursues its own negotiations with its suppliers. • That Boards share details of the outcome of those negotiations via the Task & Finish Group who will then consider the case for further benchmarking of rates across Scotland, in advance of the framework retendering. • That NSS be asked to define and introduce step down rates as part of a revised framework at the earliest possible date.

Action required	The Group is invited to: • Note the options set out above and indicate whether they support the recommendations proposed, in line with option 3.

Author	Project Team
Date	April 2024

Medical Locum Engagement Task & Finish Group
Terms of Reference

Date Published:
Version: v0.3
Document Type: Governance
Review Date:

DOCUMENT CONTROL SHEET

10.1.1 Key Information:

Title:	Medical Locum Engagement Task & Finish Group Terms of Reference
Date Published/Issued:	
Date Effective From:	
Version/Issue Number:	
Document Type:	Governance
Document Status:	Draft
Author:	[redacted]
Owner:	
Approver:	
Approved by and Date:	
Contact:	
File Name:	

10.1.2 Revision History:

Version	Date	Summary of Changes	Name	Changes Marked
0.1	**11/12/2023**	**First Draft**	**[redacted]**	
0.2	**07/03/2024**	**Following first meeting of the group, a number of amendments have been made including additional membership.**	**[redacted]**	
0.3	**04/04/24**	**Changes to text referenced Nurse Agency work**	**[redacted]**	

10.1.3 Distribution:

11. This document has been distributed to:

Name:	Title/Board:	Date of Issue:	Version:
All invitees to Medical Locum Engagement Task & Finish Group	**Medical Locum Engagement Task & Finish Group**	**01/02/2024**	**0.2**

19. Background

It is acknowledged that NHS Scotland's current approach to the use of supplementary staff is not delivering best value. The previously formed Medical Workforce Sustainability Group (MWSG), which met for the final time in November 2023 commissioned the development of an action plan designed to ensure that NHS Scotland Health Boards secure best value when accessing supplementary medical staff. It was agreed that the MWSG be reconfigured to form a Task & Finish Group with the necessary membership to deliver the action plan.

20. Purpose of the Medical Locum Engagement Task & Finish Group

Considerable work has been taken forward to improve NHS Scotland's approach to nurse agency staffing which has resulted in Boards reporting significant progress in reducing reliance on agency nursing staff. The reconfigured Medical Locum Engagement Task & Finish Group will look to make use of applicable learning from this work. In pursuance of this, the group's primary focus will be on the appropriate targeting of locum usage and, where locums are engaged, ensuring Health Boards secure best value when accessing them.

The MWSG endorsed a number of workstreams aimed at addressing the underlying supply deficits across the medical workforce and these being delivered by the NHS Education for Scotland (NES) Medical Directorate, the NES Centre for Workforce Supply and Scottish Government's Health Workforce Directorate. The Task and Finish group will wish to remain apprised of progress with these workstreams given their relevance

21. Scope

The scope includes all locum/agency medical staff engaged directly by NHS Scotland Health Boards, including those accessed via staff banks and those engaged via an agency.

The group will work with key stakeholders to identify best practice and areas for improvement in order to achieve best value whenever NHS Health Boards are accessing supplementary medical staff. This work will include:

- Developing a national approach to guide all Health Boards in ensuring the appropriate use of medical locum agency resource to a proportionate level (to be determined by the Task & Finish Group), while balancing considerations regarding patient safety and staff wellbeing.
- Optimising the use of local staff banks to provide the safest and best value model of resourcing temporary gaps with staff who have knowledge of local procedures and policies, as well as the skills and competencies to contribute effectively.
- Ensuring current work on improving recruitment of substantive medical staff is targeted towards reducing agency locum usage.
- Making use of applicable learning available from the Nursing Supplementary Staffing Task & Finish Group to ensure appropriate use of Medical Locums.
- Achieving the above without compromising quality of care experienced by patients in NHS Scotland.

22. Membership

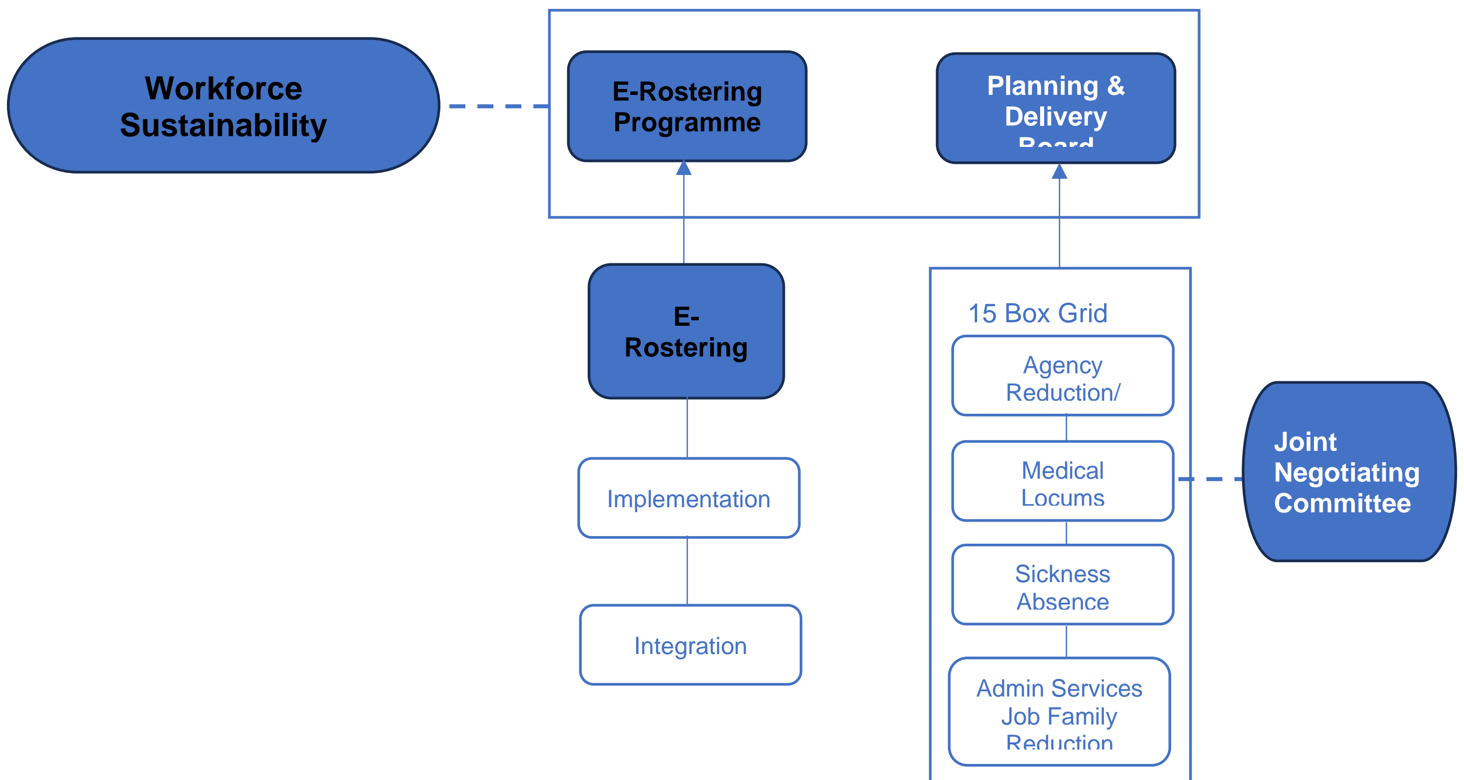
Full membership of the Medical Locum Engagement Task & Finish Group is provided in Annex A. The Group will work in partnership with colleagues from the Scottish Government Health Workforce and Chief Medical Officer Directorates, NES, including NES Centre for Workforce Supply, NHS National Services Scotland (NSS), British Medical Association and other NHS Scotland Health Board colleagues.

Meetings will be co-chaired by Carol Potter, NHS Fife Chief Executive and Gillian Russell, Director of Health Workforce, Scottish Government. Members may nominate a deputy to represent their interests if they are able to attend or to support discussions on a particular matter. Members should make the secretariat aware in advance of the meeting if they are sending a deputy on their behalf.

23. Governance

The Medical Locum Engagement Task & Finish Group will report to both the NHS Scotland Planning and Delivery Board and the newly established Scottish Government Health Workforce Sustainability Programme Board. The latter is a new, Scottish Government led, programme tasked with supporting service development and delivery in the context of the 2024/25 budget.

The Task & Finish Group will maintain connections with the various Executive groups (CE's, HRDs, DoFs, SAMD) via the identified representatives within the membership.



24. Meeting Frequency, Secretariat and Decision Making

The Group will meet monthly, with the first meeting of the group taking place on 29th February 2024. The Co-Chairs may convene additional meetings as deemed necessary and the frequency of meetings will be kept under regular review. Meetings will take place virtually using Microsoft Teams, with ad-hoc correspondence via email as required by the group.

Secretariat support for the group will be provided by the Scottish Government Health Workforce Directorate's Sponsorship and Infrastructure Unit.

Decisions and actions will be recorded within the meeting minutes, and formal approval for these will be sought at the following meeting of the group before they are finalised. Group members are expected to complete actions assigned to them as per the timescales agreed. Any papers will normally be circulated 3 working days prior to the meetings.

The quorum for decision making and carrying out the business of the group will be half of members, and decision making will be by majority. No single member will have a veto, and in the event of a 'split' decision, the Chair will be the final arbiter.

25. Confidentiality

It is likely that information may be of a sensitive or confidential nature. It is vital that all members understand their responsibility to treat as confidential, information that may be available to them, or obtained by them, or that may be derived whilst working in the Group. Authors should be aware and consider that information considered to be Confidential may be required to be disclosed under the Freedom of Information (Scotland) Act 2002 or Environmental Information (Scotland) Regulations 2004.

26. Recordings

The meeting chair must seek informed consent from every member in attendance if a meeting is to be audio recorded. For meetings of the group that are audio recorded, following sign off of the minute/action notes, recordings will be deleted.

27. Lifespan

The group will continue to meet until such times as the desired outcomes are sufficiently achieved. Membership and terms of reference of the group will be reviewed as and when necessary to ensure they remain extant.

Annex A - Membership

Individual	Representing	Role/Responsibility
Co-chair: Carol Potter, Chief Executive, NHS Fife	Board Chief Executives	Chair, provision of advice on key options appraised and support decision making. Provide CE perspective and link with BCE group and Management Steering Group
Co-chair: Gillian Russell, Director of Health Workforce, Scottish Government	Scottish Government Health Workforce Directorate	Chair, provision of advice on key options appraised and support decision making
Caroline Hiscox, Chief Executive, NHS Tayside	Board Chief Executives	BCE perspective and link with BCE Group
[redacted]	Chief Medical Officer and Health Workforce Directorates, Scottish Government	Provision of advice from medical perspective.
[redacted]	SAMD	Providing Medical Director perspective to work and link with SAMD and individual MD's
[redacted]	Board Medical Directors	Providing the perspective of Board Medical Directors and representing their interests
[redacted]	Medical Royal Colleges and Faculties in Scotland	Representing the interests of the Medical Royal Colleges and Faculties in Scotland.
[redacted] [redacted]	NES Medical Directorate	Support with elements relating to doctors in training
Mary Morgan, Chief Executive, National Services Scotland	National Services Scotland	Provide perspective on behalf of NSS and the delivery of national infrastructure
[redacted],[redacted], [redacted], [redacted]	Health Workforce Directorate, Scottish Government	Provide Scottish Clinical Leadership Fellow support to group work program
[redacted] [redacted]	Directors of Finance, NHS Boards	Support financial considerations at Board level
[redacted]	HR Directors, NHS Boards	Support HR considerations at Board level, link with HRD's group and with 'Once for Scotland' Program
[redacted] [redacted]	NES Centre for Workforce Supply	Support Consultant supply mitigation and communication with Boards
[redacted]	Director of Health Finance, Corporate Governance and Value, Scottish Government	Support the set-up of the work and provide advice and support on behalf of Health Finance

[redacted] [redacted]	Staff Bank Managers	Provide perspective on behalf of Staff Bank Managers
[redacted]	Staff Bank Managers/ West of Scotland Consortium	Provide perspective and advice based on the WoS Consortium
[redacted]	Management Steering Group	Provide links to MSG and the ongoing work in relation to Medical Pay and TCS
[redacted]	Nursing Supplementary Staffing Task & Finish Group	Providing advice based on the work of the Nursing Supplementary Staffing Task & Finish Group.
[redacted]	British Medical Association Scotland	Represent the interests of the BMA
[redacted]	Staffside	Represent staffside interests
[redacted]	SG Health Workforce Recruitment and Capacity Building Unit	Providing SG official support to ongoing work and linking with the relevant SG units
[redacted] [redacted]	SG Pay, Practice and Information Governance Division	Represent the interests of the Pay team within SG
[redacted] [redacted]	NSS National Procurement	Supporting work on bank vs agency; best value
[redacted], [redacted]	NES Digital	Data and analytic support
[redacted]	SG Health Workforce Sponsorship and Infrastructure Unit	Providing SG official support to ongoing work and linking with the relevant SG units
[redacted]		Taking actions and minutes at formal meetings. Issuing key papers and agenda ahead of formal meetings

MEDICAL LOCUM ENGAGEMENT TASK & FINISH GROUP

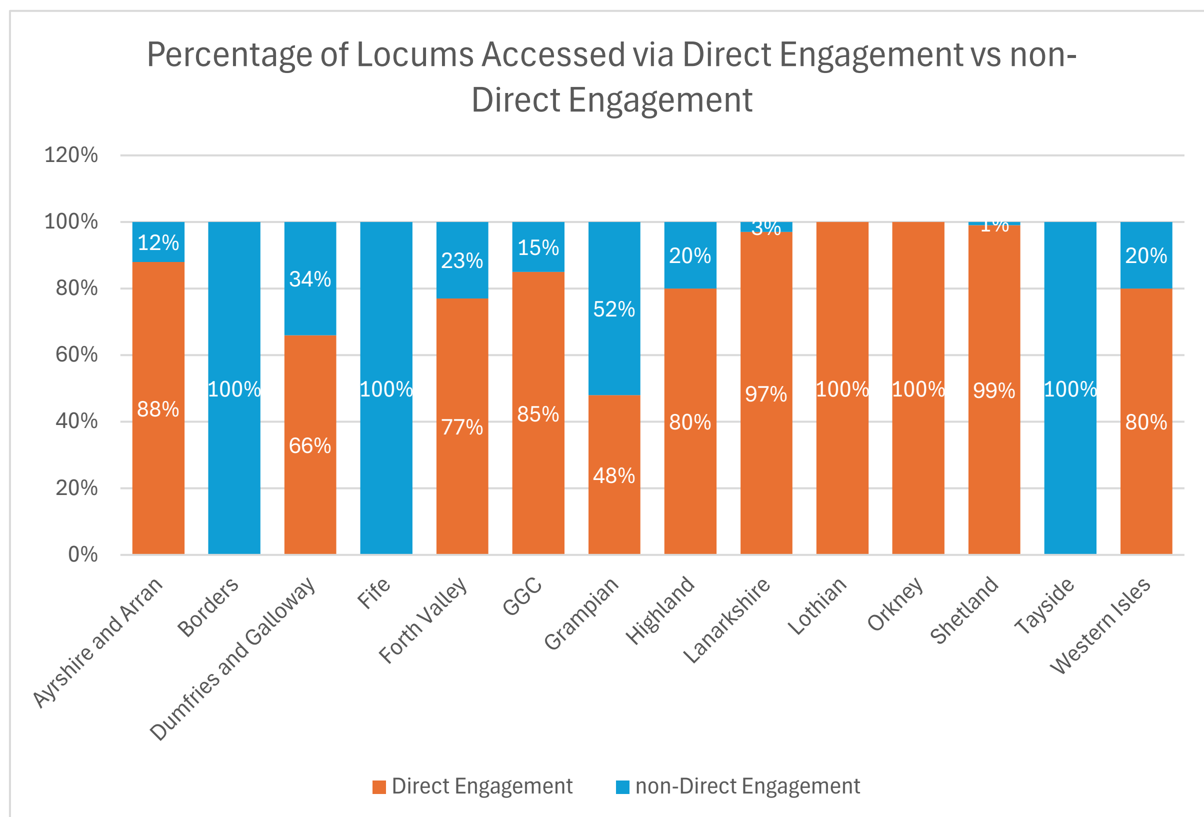
Date of Meeting: 6th June 2024

Purpose: To set out the benefits associated with accessing medical locums via a direct engagement method and propose the inclusion of reporting on direct engagement within monthly financial returns in order to measure uptake and associated savings across Boards.							
For Decision	X	For Action		For Discussion	X	For information/ To note	

Title	Medical Locum Engagement Task & Finish Group – Direct Engagement
Situation	The Medical Locum Engagement Task & Finish Group has indicated that there may be merit in reviewing the uptake of the direct engagement model for accessing medical locums across Health Boards, with a view to introducing regular reporting and understanding where additional financial savings could be made.

Background	Engaging medical locums via the traditional recruitment route requires a VAT payment of 20% on the total cost of the engagement (commission and hourly rate). However utilising a direct engagement model, whereby a Health Board sets up an employment contract with the agency worker and pays them directly via payroll, means VAT is not attracted. In a direct engagement scenario, Health Boards pay commission directly to the supplier with the appropriate VAT payment added on. This means they are not required to pay VAT on the hourly rate of the locum engagement. Agency / Trust / Worker — Introduction as agent contract; Worker is registered with the agency; Agency has a contract as an introducer; Under control and direction of the trust for contract term; Contract of employment or contract for services (compliant as per the Adecco case); Trust pays worker; Standard VAT on agency commission only **Direct Engagement** Agency has contract with trust **to introduce** the worker, Trust contracts with worker and pays worker. Worker under control and direction of the Trust. Agency / Trust / Worker — Supply contract; Agency pays workers; Worker has contract with Agency only; No worker/trust contract but under Trust control and direction for assignment; This is a supply of staff and VAT is chargeable **Traditional Recruitment** Agency has contract with trust to **supply worker**, agency contracts with worker and pays worker. Worker under control and direction of the Trust. NHS National Services Scotland Buyer's Guide - Commercial Improvement Opportunity Medical Locum Direct Engagement Payment efficiency was one of the main pieces of work explored by the Managed Agency Staffing Network (MASNet) Programme. At the programme's conclusion in 2018, it was identified that all Boards were in the process or had completed the roll out of direct engagement and were reporting a reduction in costs associated with locum spend. According to data gathered from the Supplementary Medical Staffing survey in October last year, the use of direct engagement across Health Boards is varied. Lothian and Orkney reported that all of their medical locum engagements during Q1 2023/24 were accessed via direct engagement models. A further 7 Health Boards reported that the majority of their engagements were via direct engagement and Grampian reported that just less than half of their engagements were. Borders, Fife and Tayside reported that, at the time of the survey, they were not currently facilitating a direct engagement model for medical locums within their

Board. However both Borders and Fife indicated support for the direct engagement model and advised that work was underway within their Boards to put this into place.



Data collected from the SG Supplementary Medical Staffing Survey conducted in October 2023

The above data demonstrates that there is still scope for potential savings to be made in Boards who are not yet adopting the direct engagement model or have not fully utilised this approach for accessing medical locums.

Financial Savings

In order to quantify the potential savings involved with accessing medical locums via a direct engagement model, a calculation has been carried out based on the costs associated with a 12 hour locum shift, a commission rate of £10/ hour and pay rate of £140/hour[1].

	Hourly Pay	Hourly Pay VAT (20%)	Commission Rate	Commission Rate VAT (20%)	Total Cost to Board
Traditional Recruitment	£1680 (£140/hr)	£336	£120 (£10/hr)	£24	£2160
Direct Engagement	£1680 (£140/hr)	-	£120 (£10/hr)	£24	£1824

The above example demonstrates a potential saving of £336 for one 12 hour locum shift. Data provided by the survey highlights that during Q1 2023/24, NHS Fife had 90 locum engagements, of which all were accessed via non-direct engagement. To determine the total

[1] These were the average commission and pay rates across all Health Boards who responded to the supplementary medical staffing survey

	potential saving within Q1 2023/24 for Fife, achieved by utilising the direct engagement model over traditional recruitment, the figure of £336 has been assumed as a saving for all 90 engagements. On this basis, the total estimated saving for Fife in one financial quarter would be c.£30,000. Given that both the commission and hourly rate for the above scenario are averages, and a number of Boards reported hourly and commission rates higher, it is likely that the financial savings associated with adopting direct engagement are likely to be greater. Forth Valley, who use an in-house developed provision for direct engagement, reported savings of over £250,000 last year. It is worth noting that when the direct engagement model began pre-auto enrolment, the NHS employers pension contribution rate was 14.9%. This has now increased to 22.5% and so if an individual chooses not to opt out of the scheme, then the total cost for accessing the locum via direct engagement may be greater than traditional recruitment (where the Board is only required to pay 20% VAT on hourly rate and not pension contributions). Boards currently using direct engagement for the majority of their shifts haven't identified this as a significant issue, noting that a number of locums choose to opt out of the pension scheme. NHS Lanarkshire, who reported a direct engagement compliance of 97% during Q1 2023/24, advised that medical locums accessed via direct engagement do not access to the NHS pension scheme. <u>Reporting</u> As part of the initial survey, a number of Boards indicated that while a direct engagement model is always preferred, there are certain circumstances where the Board are required to access a non-direct engagement locum. The majority of these Boards reported that gaps within hard to fill specialities, such as Psychiatry, were the cause of non-direct engagement. It would be beneficial to gain an updated picture of direct engagement use across the country, to see how usage has changed from last year. By asking Boards to routinely report their direct engagement usage, via the monthly Finance Performance Returns (FPR), the task and finish group will be able to see where direct engagement is not being used to its full extent in order to understand the reasons constraining its use. If necessary, it may also provide the group an opportunity to support Boards in taking up this approach. The suggested addition to the monthly FPRs is included in Annex A and asks Boards to report on whether or not they are utilising direct engagement, the percentage of engagements arranged via direct engagement for that month, the associated savings and the reasons direct engagement isn't being fully utilised (if appropriate). At the meeting of the task and finish group on 9 May, members agreed that it would be beneficial to collect financial and usage data in relation to medical locums. As part of this discussion, members highlighted that utilising the direct engagement approach to access locums would make it easier for Boards to report their usage and spend. The direct engagement data received each month would be collated alongside the monthly locum usage reports and presented to the group each month.

Recommendation	It is likely that, based on the outputs of the initial survey, each Board has a differing level of direct engagement compliance. We therefore recommend:

	• That Health Boards who are not yet using direct engagement as a method of accessing medical locums undertake the necessary work to implement this approach where this is expected to deliver financial benefit. • That Health Boards who are using direct engagement, but not for all locum engagements, seek to maximise the use of it where possible and financially beneficial. • That direct engagement reporting is added to the monthly FPRs to allow the group to monitor uptake and the associated savings.

Action required	The Group is invited to: • Offer comment on the recommendations above and indicate whether they would be supportive.

Author	Project Team
Date	May 2024

Annex A – Suggested Addition to Finance Performance Return (FPR)

	Direct Engagement Status	If partial indicate %	YTD Saving achieved(£000)	Forecast Saving (£000)	Why is direct engagement not being fully used?
Medical Locum Direct Engagement Update	No	CONDITIONAL FORMAT based on B27			
AHP Direct Engagement Update	Partial	CONDITIONAL FORMAT based on B28			

Medical Locum Engagement Sign-Off Checklist

Purpose: The purpose of this guide is to provide Health Boards with a consistent approach to the approval of medical locum engagements.

Status: The status of this document is advisory and local Health Board policies should aim to account for the steps included in the checklist. It is acknowledged that Boards may operate additional sign-off steps to the ones set out below.

Checklist

Following the identification of a gap within medical staffing, Health Boards should:

	Current practice (Yes/No)	**Comments**
Review the need to cover the medical staffing gap.		
Explore options for covering without engaging additional medical staff capacity.		
Consider options for cover by existing Board staff on the same rota/work pattern.		
Initiate process for engaging staff through the relevant NHS staff bank (including the use of staff working in the specialty area in another Board where this can be facilitated).		
If required, initiate the process for engaging staff from a contract agency as outlined in the National NP50022 Temporary Agency Medical Locum Doctors Framework. It should be noted that Boards have the opportunity to negotiate reduced commission rates for engagements lasting 4 weeks or more. All agency bookings must be made through a central booking process within the Board unless a regional arrangement has been implemented with neighbouring Boards.		
In exceptional circumstances, where framework agencies and substantive or bank staff are unable to provide suitable cover, escalate to off-framework agency. All agency bookings must be made through a central booking process within the Board unless a regional arrangement has been implemented with neighbouring Boards.		
An appropriate Executive Lead(s) identified by the Chief Executive as accountable officer should sign off any new engagements that attract a pay rate in excess of £126.29 an hour.		
An appropriate Executive Lead(s) identified by the Chief Executive as accountable officer should sign-off any engagements which exceed 2 weeks in duration.		

OFFICIAL-SENSITIVE

Produce a business case*, to be approved by an appropriate Executive Lead(s) identified by the Chief Executive as accountable officer in conjunction with HR, Finance and Clinical Leads, for any medical locum engagements exceeding 6 weeks in duration.		

*Within the business case, it may be helpful to outline:
1. The clinical case for engaging locum use.
2. The options appraisal undertaken to explore alternative staffing solutions, with a preference to utilise substantive staff before considering supplementary medical staffing accessed via Banks as well as neighbouring Boards. Only where these options have been exhausted should agency use be sought.
3. The proposed timescales for any engagement along with a clear exit strategy which involves a shift to a sustainable staffing solution. Recruitment plans for permanent vacancies should be reviewed as part of this, with different methods of candidate sourcing developed in conjunction with HR and external agencies.
4. Details of the steps which have been taken to secure best value in relation to any locum engagement. This should include details of market engagement/testing along with confirmation that steps have been taken to secure capacity via an agency which appears on *National Procurement Framework NP50022: Temporary Agency Medical Locum Doctors.*

MEDICAL LOCUM ENGAGEMENT TASK & FINISH GROUP

Date of Meeting: 16th August 2024

Purpose: To consider the interventions being explored by NHS England in relation to reducing the costs associated with medical locum engagements and determine whether there would be merit in pursuing these in NHS Scotland.							
For Decision	X	For Action		For Discussion	X	For information/ To note	

Title	NHS England Medical Locum Engagements

Introduction	The Medical Locum Task & Finish Group Project team recently met with representatives from the Temporary Staffing Workforce Team within NHS England to discuss their approach to the engagement of medical locums. While the meeting was initially scheduled to discuss the impact of introducing price caps for agency engagements, the NHS England team shared details of a number of further interventions that have been / are being explored, with a view to reducing the costs associated with accessing medical locums and driving down reliance on this workforce group. The Task and Finish Group is invited to consider the interventions set out below to determine whether there would be merit in pursuing these further in NHS Scotland.
	INTERVENTIONS **Price Caps** When finalising the content of the initial workplan for the Medical Locum Task & Finish Group, it was agreed that work would be undertaken to explore the merits of introducing price caps covering medical locum engagements. Such price caps have been a feature of NHS England's approach for a number of years. In a 2015 impact assessment paper prepared for NHS England by Monitor, which is now part of NHS Improvement, a number of considerations are set out in relation to the introduction of price caps. The paper highlights that the costs, benefits and risks of setting price caps for agency staff depend on a number of factors, including: • The level(s) at which they are set: if set too low, they may encourage staff to exit the market and lead to shortages of staff; if set too high, they may 'anchor' prices upwards, perhaps even increasing costs rather than reducing them. Indeed, there is a general risk that price caps will, in fact, become the default prices in each market affected.

	• The elasticity of supply of agency staff: i.e. the precise trade-offs that agency staff will make between work at different levels of pay and other uses of their time. • Whether there are any exemptions/arrangements for trusts to overrule the price caps, e.g. allowing them to pay more to avoid (temporary) service closures because of a lack of the necessary staff. • The level of Health Board compliance with the caps (which may be affected by all of the above). NHS England subsequently implemented price caps for medical locum engagements, with caps calculated on the basis of average market rates at the time. This work was undertaken by an internal economics team on behalf of NHS England. NHS England report that the impact of price caps has been negligible, with price cap compliance having never exceeded 16% of agency engagements. It has been suggested that the introduction of caps effectively set a floor for pay rates. Based on this, we do not see any immediate case for replicating this approach in Scotland. **Capping Commission** Learning from their experience in applying price caps focussed on rates of pay, colleagues in NHS England have now turned their attention towards the capping of commission rates nationally for medical locums. By capping commission via direct engagement, this simplifies any negotiation, with the hourly rate becoming the sole focus. Anecdotal evidence from NHS Scotland Health Boards suggests that locums from outwith Scotland will travel here to access locum work. If actions are taken to impede locum pay, then locum doctors may no longer choose to come to Scotland to work. By capping commission rates rather than impeding locum pay, there is a reduced risk that locums are driven away from working in NHS Scotland. It is worth noting that as part of the NHS Scotland National Framework for Temporary Agency Medical Locum Doctors, there is a commission cap and only suppliers who bid below this are awarded onto the framework. According to the data provided by Boards in the medical supplementary staffing survey, based on Q1 2023/24, there is not significant variation in commission rates across NHS Scotland, with the majority of rates between £8-£12 per hour. The Task and Finish Group previously considered the case for re-visiting NHS Scotland's approach to commission rates and signalled that steps should be taken to explore the potential introduction of step-down rates for longer term engagements. Beyond this, the project team do not consider there to be a strong case for the introduction of additional commission caps at this stage.

	Data NHS England collect monthly data from Trusts in relation to their locum usage, including the top 10 highest paid and top 10 longest serving locums. Collation of this data allows Trusts to target the longest and most expensive engagements. A dashboard has been created for systems to identify insights in order to drive down costs via Power BI. The project team are currently piloting a similar data collation exercise for NHS Scotland. The expectation is that the data will be used to identify aspects of current practice which may benefit from review and improvement as well as assessing the impact of national and local interventions taken forward to ensure appropriate locum usage. **Agency Commissioning: Central Co-ordination Hub** NHS England colleagues advised of examples where several NHS England Trusts work together to co-ordinate locum engagements in an effort to more effectively manage the market. One such example involves the operation of a procurement hub in Hertfordshire. All participating Trusts within the area who wish to use an agency must seek approval and sign off from the procurement hub. The procurement hub holds knowledge and experience of the market, so can challenge agencies who are offering a specific rate to one Trust and a different rate to another. By having a central hub, agencies are unable to cold call providers directly and they must instead get in touch with the central hub to be added to the agency cascade. The arrangement therefore allows Trusts to work together to drive the best rates. Adopting a Scottish regional or national hub model – responsible for all locum and bank engagements – is something that will be considered as part of the medical staff bank options appraisal, as the Task and Finish Group have previously acknowledged that this would be beneficial. **Off-framework Locum Engagements** NHS England colleagues advised that, as part of cost-saving measures, it had proven effective to ask Trusts to focus solely on reducing off-framework agency usage (that is agencies who do not appear on the relevant national procurement framework) in the first instance, rather than in conjunction with other interventions aimed at reducing overall usage. As a result of this approach, NHS England have successfully reduced their off-framework agency usage, with significant associated recurring savings. It is worth noting that while not directly comparable, the Supplementary Staffing Task and Finish Group, responsible for a reduction in NHS Scotland nurse agency usage, implemented a similar approach by targeting off-framework usage in the first instance.

	As well as proving effective in reducing spend, driving a reduction in off-framework agency usage can also improve the quality of care being delivered to patients. This is because framework agencies will usually be subject to certain conditions concerning the training and qualifications of their workers. The same safeguards do not necessarily apply to off-framework agency staff. A recent change in escalation process requires that all off-framework locum engagements in NHS England receive Chief Executive sign-off and all off-framework usage must be reported on a weekly basis. The NHS England team advised that this control has been particular successful in reducing usage. By way of comparison, the proposed sign-off checklist for NHS Scotland suggests that all agency locum engagements (both framework and off-framework) longer than 2 weeks in duration require sign-off by the Medical Director. Finally, NHS England have introduced frequent reporting on off-framework agency use, whereby Trusts must report on a weekly basis the number of off-framework locum engagements. Under the Task & Finish Group's proposed approach, all NHS Scotland Boards will report on off-framework agency usage on a monthly basis. **Chief Executive Sign Off** In NHS England, any locum engagements costing £100 an hour or more require Chief Executive sign off. NHS England previously set a threshold for £120 an hour, however as a result of the level of scrutiny surrounding this control, all spend above this was removed in a year, and therefore the threshold was adjusted to £100 an hour. At a previous meeting, the Task and Finish Group agreed that a consistent sign-off process for accessing medical locums would be beneficial. In an initial draft shared with the group, it was determined that any locum engagements exceeding rates set out in the national procurement framework should be signed off by a Board's Medical Director. Following our discussion with NHS England colleagues, the project team have developed a further version of the checklist, to include that any locum engagements costing £126.29 an hour or more be signed off by a Board's Medical Director, or relevant deputy. This figure reflects the definition of high cost agency, agreed to by Ministers, within the Health and Care Staffing Act. It is worth noting that according to the data provided by Boards in the supplementary medical staffing survey last year, 10 Health Boards reported an average hourly rate greater than £120 an hour, with the highest average rate of pay being £180 an hour. While the average hourly rate doesn't provide an accurate representation of the typical hourly rate within a Board, it is expected that the majority of locum engagements will exceed £120 an hour.

	Restrictions NHS England colleagues suggested that while it is not always possible to control pay rates for agency workers, it is possible to control the number of shifts or days that a locum works. As a result of this, they are looking at whether it would be possible to limit off-framework agency locums who may have worked for (for example) 5 days over a defined period, to only 2 or 3 day engagements in subsequent periods. Trusts could then signal that, in order to increase their take home pay, locums would need to take up remaining shifts with a framework agency or via the Bank. While not directly comparable, there has been success in applying restrictions across the NHS Scotland nursing workforce, whereby NHS employees or workers must not be assigned shifts within their own Health Board via an agency. A six-month separation period must also be applied from the date a substantive or bank employee terminates their contract with a Health Board before they can be assigned within that Health Board through an agency. These principles have been successful in encouraging agency workers to apply for substantive posts or Bank positions. However, it is accepted that the composition of the medical workforce and the willingness of medical locums to travel significant distances for work opportunities is somewhat different from the nursing workforce, meaning such a step may not be as effective in this context. **Direct Engagement** While NHS England don't mandate direct engagement for locum engagements, they do encourage Trusts to carry it out correctly where it is done and to maximise compliance as much as possible. The direct engagement approach allows Trusts to see more easily what workers are being paid and this can allow Trusts to identify the lowest rates being offered in order to aid negotiations with agencies. The direct engagement approach also makes it possible to see and monitor the commission rates being paid to agencies. This approach mirrors the one agreed by the Task and Finish Group. **Medical Staff Banks** NHS England have done a significant amount of work to ensure they have the necessary medical bank infrastructure in place to support the shift of agency staff onto NHS contracts. At the same time, it is acknowledged that securing staff on substantive part-time contracts will often be preferable to relying on Banks to supply staff. Accordingly, if an individual is working the same banks shift patterns every week, NHS England are encouraging Trusts to seek to understand why the individual isn't on a substantive part-time contract.

	In support of the above objective, NHS England are trying to challenge the pervading culture that in order to work part time or more flexible hours, staff must either join the bank or access shifts via an agency. This default assumption results in a number of individuals leaving to work for an agency, having asked to reduce their hours and been told this is not possible. By attempting to challenge this culture, NHS England believe progress has been made to encourage individuals to move to substantive part-time contracts. **<u>Building Relationships</u>** NHS England have pointed towards a number of Trusts having success in transitioning agency workers to either substantive posts or the medical bank as a result of engaging locums in meaningful conversations with a Trust's Medical Director. Finding out why an individual wants to work for an agency and where they see themselves in the future can help understand an individual's situation and the reasons they may have for working as a locum rather than substantive member of staff. While often the decision to work for an agency will be driven by pay (which is hard to influence), NHS England have found that it can also be a result of training, development and non-financial rewards, all of which are easier to influence.
Conclusion	NHS England colleagues have agreed to share the outcomes and any future learning from each of the above interventions, to allow us to make decisions as to whether or not there is merit in adopting any of them within NHS Scotland. NHS England colleagues have also shared the link to NHS England's agency rules, which set out all the controls which Trusts are expected to apply/adhere to.

Action required	The Task & Finish Group are encouraged to consider each of the above listed interventions and consider where there is merit in undertaking more detailed scoping with a view to supporting their implementation across NHS Scotland.

Author	Project Team
Date	July 2024

MEDICAL LOCUM ENGAGEMENT TASK & FINISH GROUP

MEDICAL STAFF BANK: OPTIONS APPRAISAL

1. Situation

The Medical Locum Task and Finish group, which aims to ensure more appropriate locum usage across NHS Scotland, has indicated that there is merit in improving the consistency of NHS Scotland bank structures for the medical workforce. Currently there is significant variation in medical bank structures and maturity across the country, partly contributing to a high level of agency spend. Banks can play a substantial role in the reduction of higher cost supplementary staffing options, particularly in Boards who do not have an established medical bank.

2. Background

A number of Health Boards already have an established medical bank, although the structures and operational processes to run those banks differ significantly. A survey issued by Scottish Government in October 2023 identified that a range of medical bank structures exist across NHS Scotland Boards, including:

- A single centralised bank with provision for all professions and roles, including medical
- No bank in-house, but access to services via the West of Scotland Consortium run by Greater Glasgow and Clyde
- The operation of small informal banks, occasionally managed within individual service areas and sometimes with no active recruitment
- The operation of a locum desk to manage agency engagements but no access to formal bank provision.

Following a paper shared with the Medical Locum Task and Finish Group on 3 April 2024 which highlighted examples of local bank structures, as well as the regional approach taken in the West of Scotland, there was broad agreement from the group that it would be beneficial to improve the level of consistency in approach to medical staff banks. The group also signalled an initial preference for a regional or national model, rather than 14 or 22 separate Health Board banks, to facilitate the movement of medical staff across the country.

In addition, members of the Task and Finish group agreed that any regional or national approach to medical banks should factor in the merits of operating a central hub for all agency engagements, with a view to hosting a team with market knowledge and experience, as well as negotiation capabilities.

In response an options appraisal has been developed to fully assess each potential option and the associated benefits and drawbacks. Those options and associated assumptions about their key features are set out in full below.

3. Option Assumptions

Options	Option 1 – Do nothing / Status Quo	Option 2 – Target Operating Model	Option 3 – Regional Banks	Option 4 – National Bank
Hosting Arrangements	A proportion of Boards run their own medical banks, while others work on a collaborative basis, and some have no access to a formal bank provision.	Each individual Health Board runs its own medical bank in line with an identified target operating model based on best practice.	Regional banks are run by one lead Health Board responsible for overseeing bank functionality on behalf of participating neighbouring Boards.	National bank is run by one lead territorial or National Board.
Financial Arrangements	The majority of Boards who have their own medical bank will fund this service themselves. In Board areas with no formal provision, each service funds their bank worker costs.	Each individual Health Board funds its own bank service.	Bank service and utilisation are funded via charge back arrangements (lead Health Board charge participating Boards for use of the service).	Bank service and utilisation are funded via charge back arrangements (lead Health Board charge participating Boards for use and maintenance of the service).
Recruitment Process	Boards who have their own medical bank will oversee their own recruitment and onboarding of bank staff. Currently there are some Boards who do not undertake bank recruitment. For some	Each Health Board recruits and onboards all their own bank doctors. Central guidance is provided on recruitment best practice, including the provision of shared marketing assets. Central bank worker contract template provided	Lead Health Board is responsible for the recruitment, contracting and onboarding of all bank doctors.	Lead Health Board is responsible for the recruitment, contracting and onboarding of all bank doctors.

	Boards who do not have formal bank recruitment, individual services are responsible for the recruitment and onboarding of medical bank workers.	as part of target operating model.		
Statutory and Mandatory Training	Each Health Board with its own medical bank is responsible for ensuring the statutory and mandatory training for bank staff is completed and kept up to date. For staff who wish to work across multiple Board banks, they are required to undertake separate statutory and mandatory training in each Board they wish to work in. This duplication is expected to reduce with the introduction of a staff training passport. For Health Boards with no formal bank provision, individual services are responsible for ensuring statutory and mandatory training for bank medical	A level of consistency would be expected in respect of statutory and mandatory training, linked to the staff training passport which would allow doctors to move freely between Board banks which is currently in the early stages of development.	Statutory and mandatory training would be undertaken in the lead Health Board, however localised inductions would take place when doctors choose to work outwith the lead Board.	Statutory and mandatory training would be undertaken in the lead Health Board, however localised inductions would take place when doctors choose to work outwith the lead Board.

	workers is completed and kept up to date.			
Agency Engagement	Each Health Board is responsible for engaging its own agency locums. Discrepancy in both pay and commission rates are experienced as a result of this. Direct engagement compliance varies across Health Boards. Competition for agency workers between Board areas can inflate costs further.	Each individual Health Board is responsible for engaging its own agency locums. Direct engagement model of accessing medical locums, as well as consistent pay and commission rates, would be encouraged as part of the target operating model. In keeping with the NHS Lothian direct engagement model where direct engagement compliance is 100%, the Target Operating Model would set out arrangements to limit pension entitlement for agency locums.	Lead Board has responsibility for coordinating the engagement of all medical locums on a Direct Engagement basis. The lead Board would also have the ability to set pay and commission rates to reflect regional requirements. This option should be done without the aid of a neutral or master vendor. In keeping with the NHS Lothian direct engagement model where direct engagement compliance is 100%, arrangements would be put in place to limit pension entitlement for agency locums.	Carried out by central hub/ lead Board with national market knowledge and negotiation capabilities. Engagements would be on a Direct Engagement basis as a default. The central hub/ lead Board would also set the pay and commission rates. This option should be done without the aid of a neutral or master vendor. In keeping with the NHS Lothian direct engagement model, arrangements would be put in place to limit pension entitlement for agency locums.

Pay	Health Boards operating a medical bank pay bank staff directly from payroll and have access to pension via this Board. Health Boards without a formal bank also pay medical bank workers directly from payroll and provide access to pension via the Board. Boards have varying processes in place to mitigate fraud risks arising from the payment of medical bank workers.	Each individual Health Board is responsible for paying their medical workers. Rates of pay should be in line with MSG rates for medical bank workers. Each Board area is responsible for ensuring appropriate financial governance mechanisms to mitigate fraud risks arising from the payment of medical bank workers.	Bank doctors are paid directly via the lead Board's payroll and have access to pension via this Board. All financial transactions are subject to a consistent set of financial control mechanisms.	Bank doctors are paid via the lead Health Board's payroll and have access to pension via this Board. All financial transactions are subject to a consistent set of financial control mechanisms.
Shift requests	Health Boards with their own medical banks upload shifts to their bank IT system. The process is varied, with some being managed via a central desk, while others are managed locally within services. In Boards without a centralised bank, individual services are responsible for communicating the	Each individual Board processes their own shift requests. Utilisation of national shift/ rostering systems would be encouraged as part of the target operating model. Utilisation of national IT system/ app for the communication and booking of available shifts to medical bank workers would be encouraged as	Participating Boards upload their own shift requests to the regional bank IT system, which is overseen by lead Board. The regional bank IT system will require to interface with individual Health Board rostering mechanisms.	All Health Boards upload their own shift requests to the national bank IT system, which is overseen by lead Board. National Bank IT System will require to interface with local health board rostering mechanisms. Communication and booking of available shifts to medical bank workers via National IT system/app or agreed single process.

	availability of, and the booking/recording of shifts to their known bank workers.	part of the target operating model.	Communication and booking of available shifts to medical bank workers via regional IT system/ app or agreed single process.	
Performance Metrics	Some boards are unlikely to have consistent performance metrics at a corporate level.	Each Board monitors their own bank performance, with monthly MI data being provided to the Scottish Government.	Weekly and monthly shift reports are shared with participating Board Executive team including Medical Directors, HR Directors, Directors of Finance and Workforce Planning colleagues as well as Scottish Government.	Weekly and monthly shift reports are shared with participating Board Executive team including Medical Directors, HR Directors, Directors of Finance and Workforce Planning colleagues, as well as Scottish Government.
Professional Governance arrangements	Health Boards with their own medical banks often have named professional leads to deal with professional governance matters. Health Boards without a centralised medical bank are unlikely to have a named professional lead for medical bank worker governance.	Each Board ensures their own arrangements / provisions for professional governance matters related to medical bank workers. Guidance could be provided as part of a Target Operating Model.	Lead Board would have responsibility for ensuring appropriate professional governance arrangements for all medical bank workers.	Lead territorial or National board would have responsibility for ensuring appropriate mechanisms are in place between them and each Health Board area for professional governance arrangements.

Legal	Each Board area is responsible for legal governance arising from contracting of medical bank workers.	Each Board area is responsible for legal governance arising from contracting of medical bank workers.	Lead Board would be responsible for legal governance arising from contracting of medical bank workers. Agreement as per Doctor in Training lead employer model used to clarify line management of medical bank workers and route of addressing legal claims by medical bank workers.	Lead territorial/national Board would be responsible for legal governance in relation to medical bank workers. Agreement as per Doctor in Training lead employer model used to clarify line management of medical bank workers and route of addressing legal claims by medical bank workers.
Resource requirements	Each Board area responsible for the resources required to support the operation of their medical bank provision.	Each Board area responsible for the resources required to support the operation of their medical bank provision.	Lead Board responsible for the resources required up front to support the operation of the medical bank provision. Costs associated with this are funded by charge back arrangements as part of the service charge.	Lead territorial/National Board responsible for the resources required to support the operation of the medical bank provision. Costs associated with this are funded by charge back arrangements are part of the service charge.

4. **Options**

Options	Description	Advantages (Strengths and Opportunities)	Disadvantages (Weaknesses and Threats)
Option 1 - Do Nothing / Status Quo	Existing bank arrangements remain in place. The level of bank provision and structures continues to be varied across the country.	Services continue to deliver the level of bank provision currently available. Allows for specific local requirements / circumstances for supplementary staffing to be responded to in a tailored approach, reflective of local demand and need. Does not require additional funding from either Health Boards or the Scottish Government.	Medical bank processes and maturity levels differ significantly between Boards. A number of Health Boards do not currently have a centrally managed medical staff bank and therefore do not actively recruit medical workers, nor are they able to offer clinical services a coherent and cost effective bank provision, therefore encouraging locum usage. Locum agency spend was £129.6 million in 2023/24. The discrepancy in approach to accessing medical agency across Scotland is contributing to the differing rates of pay and commission across Boards.
Option 2 – Target Operating Model	Utilise best practice identified across the country to develop a target operating model for adoption across Boards.	Allows Boards the autonomy to make their own decisions as to how to implement the model and take actions specifically tailored to their local situations/need.	Lack of consistency amongst Boards as they may choose to implement the model in different ways. A lack of consistency may lead to discrepancies in governance and bank processes and inconsistent adoption of best practice.

		Boards can choose whether to work collaboratively with other Boards for all or specific specialities.	Potential inefficiencies associated with duplication of bank administration / management functions across Boards. Increased costs due to competition for agency workers between Boards. Initial outlay of funding required to achieve single rostering, training and education, and booking systems.
Option 3 – Regional Banks	Develop North, East and West regional bank models.	Health Boards have access to a larger pool of staff and there is greater consistency in the approach to medical banks and agency locum engagement compared to options 1 and 2. Bank doctors are able to work more flexibly across neighbouring Board boundaries. Clarity and consistency of approach for managing professional, legal and financial governance risks. Current example of this approach working in the West of Scotland. More cost-effective than running individual banks, this approach is likely to attract a larger pool of workers who could see the benefits from working in neighbouring boards closer to home.	Larger, more central Boards may benefit from this approach the most. Smaller, less central Boards may not achieve the same fill rate under the regional approach. Potential inefficiencies associated with duplication of bank administration / management functions across regions. Bank doctors may not be able to work flexibly across regional boundaries. Board areas constrained in their ability to meet specific local requirements. The interface of different IT Systems and administrative processes at each Board area may result in inefficiencies and may create the requirement for increased resource requirements either at a regional or local Board area level.

			Initial outlay of funding required to achieve single rostering, training and education, and booking systems.
Option 4 – National Bank	Develop a national staff bank responsible for overseeing all NHS Scotland medical bank and agency supply.	Health Boards theoretically have access to a larger pool of staff. Complete consistency in the approach to medical staff banks and accessing medical agency for all Health Boards. Doctors are able to work flexibly across all NHS Scotland Board banks to fill short term gaps. Clear and consistent approach for managing professional, legal and financial governance risks. Agency negotiations are carried out by one team who have market knowledge and experience so can drive the best rates. More cost-effective than running regional banks, this approach is likely to attract a larger pool of workers who could see the benefits from working in neighbouring boards closer to home.	Similar to a regional approach, larger, more central Boards may again benefit the most from this approach. Smaller, rural Boards may not achieve the same fill rate. Doctors may not choose to travel Scotland-wide for bank work and therefore operating one single national bank may not deliver benefits in fill rate beyond those offered via a regional bank model. A move to a national bank which assumes responsibility for all attraction and recruitment activity could potentially limited the scope of tailored activity to reflect the workforce needs of individual Boards. The interface of different IT Systems and administrative processes with individual Board areas may create the requirement for increased resource requirements either at a regional or local Board area level. Initial outlay of funding required to achieve single rostering, training and education, and booking systems.

5. Assessment Criteria

In order to assess and score the options set out above, a number of assessment criteria have been agreed by the subgroup:

a) Attraction – the extent to which each option will be able to satisfy the attraction and recruitment needs of participating Boards.
b) Staff Experience – the extent to which each option promotes a good experience for staff who are part of/ wish to join the bank, as well as the effect these potential options will have on existing staff working locally within the staff bank admin teams, if a regional or national solution is implemented.
c) Flexibility – the extent to which each model can support flexible deployment of staff across Board boundaries.
d) Governance – the efficiency of the respective governance arrangements and the extent to which the interests and legal obligations of individual Boards can be satisfied through each model.
e) Systems – the level of work required to either existing or new technical systems in order to implement each option.
f) Financial Impact – the cost of each option, both for individual Boards and for the system as a whole, taking into account both cost and spend.
g) Fill Rate – the extent to which the model is likely to achieve the greatest fill rate for available bank shifts.
h) Implementation timescale – the length of set up time required for each option to enable realisation of proposed benefits.

6. Scoring

		Raw Scores				Weighted Scores			
Assessment Criteria	**Weight**	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Attraction	**3**	1	3	3	3	3	9	9	9
Staff Experience	**2**	2	3	4	3	4	6	8	6
Flexibility	**2**	1	2	4	4	2	4	8	8
Governance	**2**	3	4	3	3	6	8	6	6
Systems	**1**	3	4	3	3	3	4	3	3
Financial Impact (Cost vs. Spend)	**3**	2	3	3	2	6	9	9	6
Fill Rate	**3**	1	3	3	3	3	9	9	9
Implementation Timescale	**2**	4	3	3	1	8	6	6	2
					Total Weighted Scores	**35**	**55**	**58**	**49**

Score Key	
1	Poor
2	Limited
3	Average
4	Effective
5	Highly Effective

We have weighted each of the criteria, based on 1-3 and will calculate the weighted scores based on a multiplication of the raw score with the weight assigned to each assessment criteria.

7. Narrative

The subgroup met on 27th September to discuss and score options. In order to reach a final score for each option against each of the assessment criteria, it was agreed that members would submit their individual scores and an average score would be calculated.

Attraction

Due to the variance that currently exists in terms of Board medical staff banks, option 1's ability to satisfy the attraction and recruitment needs of NHS Scotland Health Boards is limited and it offers a low level of assurance around the adoption of best practice consistently across the country.

The recruitment needs of a Board are best understood at a local level, with activity tailored to reflect the needs of the Health Board at any given time. With that in mind, option 2 and 3 should score the highest in terms of attraction because they offer the implementation of a target operating model at either local or regional level. The benefit of these options beyond the national model is that they allow for locally tailored solutions in terms of the timing and focus of recruitment activity.

Option 2 can provide national reach in terms of recruitment, because all Boards have access to Job Train and so are able to advertise posts on a national basis, in line with local need.

Option 4 was considered beneficial in terms of potential efficiencies that could be made in relation to recruitment practices, but the group felt that on balance, this would score slightly lower in terms of attractiveness. However, it was acknowledged that it would be appealing to those Boards who currently have no medical bank provision. There is a risk that under a national bank model some Boards, particularly the smaller Boards, will be deprioritised at the expense of larger Boards where attraction is considered critical, however the group did not feel that these potential challenges were insurmountable.

Staff Experience

When discussing each of the options in relation to staff experience, the group were mindful to consider both staff who are working on/ looking to join a bank and those who work to service and provide administrative support to the bank itself.

The staff experience associated with option 1 (to do nothing and retain the status quo) should score low given the variation amongst Boards currently, which means that some staff have limited access to a bank facility and others are deployed through less formal bank structures.

With regards to option 2, the adoption of a target operating model based on best practice would improve the experience of staff accessing shifts through the bank while also allowing the quick resolution of any issues, queries or questions that may arise. Option 2 would also support relationship building and the establishment of lines of accountability and responsibility within a Board, which is key to workforce

management. The availability of local intelligence, offered by a locally managed target operating model, would allow for informed decision-making based on pressure points and priorities, specific to the Board. Option 2 may still however allow for variation in implementation of the target model, which may impact negatively on staff experience.

The consistency afforded by option 3 and 4 in terms of the ability for staff to work flexibly across Board boundaries would promote good staff experience for those who work on medical staff banks, by allowing them to work in different Boards across the country without having to undertake several recruitment processes. In terms of drawbacks associated with these options, it is important to acknowledge that a number of bank staff will also hold substantive contracts and, where this is the case, Options 3 and 4 could result in these individuals holding multiple contracts of employment serviced by HR teams within different organisations. This has the potential to introduce confusion for this workforce.

The significant work required to establish either a national or regional bank will have a greater impact on staff responsible for the running of staff banks and therefore when considering the staff experience of this specific staffing group, options 3 and 4 would score lower than option 2. In particular, the implementation of option 3 or 4 would introduce uncertainty around the future role of those staff currently employed to deliver local Bank services and this should also be factored in.

Flexibility

In terms of flexibility, a move towards a single bank structure should maximise the opportunities for flexible working across Board boundaries in a way not possible through Board-led bank models (such as option 1 and 2) and therefore the group were in agreement that options 3 and 4 should score higher.

It was acknowledged that there is already an example of a regional approach within NHS Scotland which works well. The West of Scotland approach, which is run by Greater Glasgow and Clyde Health Board, is responsible for providing over 500 shifts a month to other Boards in the region, including Ayrshire and Arran, Dumfries and Galloway, Golden Jubilee and Lanarkshire. The model allows staff to work across a number of Boards within the West region and allows smaller Boards to achieve higher fill rates by accessing a larger pool of staff.

While the group were in agreement that both options 3 and 4 should score the highest in terms of flexibility, it was noted that flexibility will be, to an extent, limited by the willingness of staff to travel and it is more likely that they will choose to travel in regional clusters rather than across the entire country.

Governance

The group considered this assessment criteria from slightly different perspectives and so there was a notable variation in suggested scores.

From a local governance perspective, it is likely that the most efficient and straightforward models are those which involve direct employment of bank staff by

the Boards who are deploying them. There was a suggestion that option 2, (locally adopted Target Operating Model) would provide the best level of assurance around governance in all forms, including clinical, systems and financial.

However there are already several examples of medical staff being deployed across Boards who are not their primary employer, demonstrating that any additional complexity associated with staff governance in the operation of regional or national models should not be insurmountable.

When work to explore the delivery of shared bank infrastructure was considered previously in 2006, Boards were unable to agree appropriate joint governance arrangements in relation to the training and the movement of staff and this proved a key barrier to implementation. Accordingly, it is critical not to underestimate the importance of governance and the value in having full endorsement from Boards if a regional or national approach is implemented.

Systems

There is a level of commonality across all Boards in terms of the systems used to support the operation of banks and it was agreed that this technology should benefit the implementation of all of the options covered as part of the appraisal. However it is important to acknowledge that current disconnects between certain nationally adopted systems can and do cause challenges at local level, leading to variation in their application.

There is a recognition that the move to a regional or national approach would require a greater volume of work with regards to systems compared to option 1 or 2, but that the basic technical infrastructure is available to support implementation of any option. Implementation of option 3 or 4 would require the purchase of an additional product called Cloudstaff and this should be factored into discussions at a future stage if either of these options are preferred.

Financial Impact

Overall it was challenging to score the financial impact because this will be largely determined by the approach taken to implementation of the various options. The more effective and efficient NHS Scotland's Bank infrastructure is, the more scope there is to deliver financial savings to offset costs associated with the set-up and delivery of banks. The sub-group agreed that, in order to fully understand the potential return on investment, a detailed cost analysis would have to be carried out.

Notwithstanding the above, it is reasonable to assume that there will be significant scope for economies of scale as a result of moving to a regional or national model. However it is not entirely clear what the setup costs for those models would be.

It was agreed that option 1 should score low against this criterion because despite no additional financial resource being required to implement this option, Boards would continue to operate inefficient systems which place too much reliance on agency staffing which is a drain on resource.

OFFICIAL-SENSITIVE

It was noted that the current financial climate is extremely challenging and it may be difficult to secure the level of investment required for a regional or national approach.

In conclusion, the group agreed that it would make sense to narrow down the options to a shortlist of two before requesting permission from the Task & Finish Group to undertake a more detailed cost-benefits analysis.

Fill Rate

The ability of Boards to be able to achieve a high fill rate will be determined by a number of factors, including attraction, flexibility, staff experience and eligible pools. To an extent fill rate will also be affected by workforce availability, taking into consideration the number of new graduates, those retiring and those returning to the service.

When considering option 1, it was determined that continuing to operate existing bank structures would provide little value to fill rate, especially in Boards where no medical bank arrangements currently exist.

Options 3 and 4 offer the flexibility and freedom of movement which should in theory boost fill rates, by providing staff with a consistent straightforward joining process and improving overall staff experience. These options may also remove some of the competition experienced between Boards to secure staff. However with a national model, fill rate may be limited by bank workers' willingness to travel outwith their regional cluster or indeed the Board area in which they hold a substantive post.

Additional consideration would also need to be given to the policy on payment of travel and accommodation costs for bank doctors and, indeed, the sub-group signalled support for such a piece of work irrespective of the outcome of options appraisal. The variation in current practice, whereby some Boards choose to cover these costs and some don't, introduces an element of competition in the current locum market. In addition, it is important to acknowledge the likely impact on fill rates should a national position be adopted on this issue which is less favourable than that currently offered by some Boards.

Implementation Timescale

Option 1 will take the least amount of time to implement, followed by option 2 which can build on existing systems, structures and best practice. It is however important to consider that option 2 may take significantly longer for those Boards who don't currently operate a medical staff bank.

There are already examples of regional bank models in place, meaning there is a potential target operating model for option 3, which can be replicated across Boards. This option may also take less time than option 2 for Boards without an existing bank structure in place because it allows for collaboration and the sharing of best practice.

Option 4 is expected to take the longest to implement.

8. Conclusion

There was agreement that whilst option 1 would require the least amount of resource to implement, it would result in Boards continuing to operate inefficient and inconsistent systems. On this basis, it scored low in every assessment criteria, apart from implementation timescale. It is therefore proposed that option 1, to retain the status quo and do nothing, should be ruled out as a preferred option.

Option 4, to develop a national medical staff bank, scored highly in attraction, fill rate and flexibility, however it scored low in implementation timescale and financial impact, as the group acknowledged that a significant amount of time and resource would be required to develop and implement a bank model of this scale. Overall, option 4 ranked as the second lowest scoring option.

Option 2, to develop and implement a target operating model based on best practice, was the second highest scoring option. The group recognised that this option would offer a greater level of consistency than currently available across NHS Scotland Health Boards and that it would provide the best level of assurance around governance in all forms. It did however score lower than option 3 in staff experience and flexibility criteria, as it was felt that a regional model would allow for the movement of staff across Board boundaries more easily and provide those working on the bank with a more straightforward, consistent joining process.

Option 3 (regional bank model) was the highest scoring option overall, scoring the highest in staff experience and flexibility, and equalling option 3 in terms of attraction, financial impact, fill rate and implementation timescale.

The subgroup proposed that before a final preferred option be agreed, the two top scoring options should undergo a cost-benefit analysis in order to quantify the full financial impact of each.

9. Recommendation & Next Steps

The group is invited to comment on the detail provided in the paper and offer a view as to whether they would be content to request a full cost-benefit analysis be undertaken on option 2 and option 3, before a final decision on which option be endorsed is made.

Once this work has been completed, it is the intention to share the final two options in detail with relevant stakeholders, including Board Chief Executives, HR Directors, Medical Directors and directors of Finance.

OFFICIAL-SENSITIVE

From:[redacted]<[redacted]@gov.scot>
Sent: 19 April 2024 20:47
To: Cabinet Secretary for NHS Recovery, Health and Social Care <CabSecforNRHSC@gov.scot>
Cc: DG Health & Social Care <DGHSC@gov.scot>; Director of Health Workforce <Directorofhealthworkforce@gov.scot>; Deputy Director of Health Workforce, Planning and Development <DeputyDirectorHWPD@gov.scot>; Deputy Director of Health Workforce Pay, Practice and Partnership <Deputydirectorhwppp@gov.scot>; Deputy Director of Leadership, Culture and Wellbeing <DeputyDirectorofLeadershipCultureandWellbeing@gov.scot>; [redacted]<[redacted]@gov.scot>;[redacted]<[redacted]@gov.scot>;[redacted]<[redacted @gov.scot];[redacted]<[redacted@gov.scot];NursingOfficer<CNO@gov.scot>;[redacted]<[redacted]@gov.scot>;[redacted]<[redacted]@gov.scot>;[redacted]<[redacted]; [redacted]<[redacted]@gov.scot>;[redacted]<[redacted]@gov.scot>;[redacted]<[redacted] @gov.scot>;[redacted]<[redacted]@gov.scot>;[redacted]<[redacted]@gov.scot>; [redacted]<[redacted]@gov.scot>
Subject: Ministerial Advice - Supplementary Staffing - 19 April 2024

PS / Cabinet Secretary,

Please find attached a submission providing the Cabinet Secretary with advice on progress to reduce NHS Scotland's reliance on high-cost agency staffing and to describe the interaction between this activity and other key workforce developments, including implementation of Agenda for Change (AfC) reforms and commencement of the Health & Care (Staffing) (Scotland) Act 2019.

The advice is primarily for noting although officials would of course be happy to meet to discuss these issues further if Mr Gray would find that helpful.

Thanks

[redacted]

[redacted]
Recruitment and Capacity Building - Sponsorship and Infrastructure Unit
Health Workforce Planning and Development
Scottish Government

Email: [redacted]
mobile: [redacted]

From: [redacted]
Health Workforce Directorate

19 April 2024

Cabinet Secretary for NHS Recovery, Health & Social Care

SUPPLEMENTARY STAFFING

Priority and Purpose

1. To provide the Cabinet Secretary with advice on progress to reduce NHS Scotland's reliance on high-cost agency staffing and to describe the interaction between this activity and other key workforce developments, including implementation of Agenda for Change (AfC) reforms and commencement of the Health & Care (Staffing) (Scotland) Act 2019.

Recommendation

2. Recommends that you note:

    - progress being made to reduce reliance on high-cost agency staff and to optimise the operation of staff banks;
    - possible risks to future delivery of further reductions in high-cost agency usage due to the cumulative impact of other policies currently being pursued, notably the introduction of the Health & Care (Staffing) (Scotland) Act 2019 and implementation of the reduced working week being delivered as part of wider reforms to Agenda for Change.
    - The offer of a meeting with officials should you wish to discuss these matters further.

Context and Issues

3. It is recognised that there is an aspiration to sustainably eradicate the regular use of high-cost agency staffing across NHS Scotland's medical, nursing and AHP workforces. Two programmes of work have therefore been established to improve the system's approach to the use of supplementary staffing.

Nurse Supplementary Staffing

4. Reliance on nurse agency staffing has increased in recent years, with spend totalling £169.7 million in 2022/23 compared with £32.1 million in 2019/20. At least some of this increase can be attributed to a decision to relax controls surrounding the use of agency nursing as part of wider efforts to increase service capacity as part of the Covid-19 pandemic response. However, the trend in expenditure accelerated further in 2022/23, perhaps in part linked to efforts on the part of Boards to support the recovery of services.

5. In response to the above trend, a Supplementary Staffing Task & Finish Group was established to drive improvements in relation to nurse agency spend and as a result increase the level of assurance around care quality. Chaired by the Chief Nursing Officer and the Chief Executive of NHS Lothian, the Group oversaw the introduction of new controls from 1 June 2023 which prevent (in all but exceptional circumstances) Boards from using staff supplied via nurse agencies who do not feature on the relevant national procurement framework. Those 'off-framework' agencies are not subject to the same charging regime or recruitment standards as agencies who appear on the framework and there is clear evidence of excessive rates having been charged for the provision of staff via this route in recent years. There are also concerns about the impact on quality of care when such arrangements are pursued.

6. New reporting arrangements were introduced to coincide with the introduction of the above controls. Data submitted by Boards as part of that reporting regime suggests that the controls are having a positive impact, with the number of off-framework agency shifts reducing significantly from 12,671 in May 2023 to 115 in February 2024, representing a c.99% overall decrease. Over the same period, we have seen a c. 42% reduction in overall agency usage, driven by the consistent implementation of additional measures designed to introduce improved rigour around decision-making. As a result, current expenditure forecasts for the 2023/24 financial year suggest a potential £13 million reduction in nurse agency spend. However, spend is still too high.

7. Noting the above, the Task & Finish Group has committed to further action to drive down agency spend. Initially this will involve the introduction of additional controls to end the use of agency staff for Band 2 to 4 (unregistered) shifts. Health Boards have been working to prepare for the cessation of unregistered agency use from 1 April this year. As with the off-framework agency use, we will continue to monitor Boards' unregistered agency usage.

8. More significantly, the Task & Finish Group are now proposing an end to all nurse agency use, except in exceptional circumstances, with staffing gaps being filled by either substantive staff or those who work on the staff bank. The intention is to implement this new arrangement from 1 October, with a set of enabling measures being implemented on a gradual basis from 1 April. Reporting arrangements have been established to allow officials to monitor the impact of these changes on service resilience.

9. The effective operation of staff banks as an alternative source of supplementary staffing will be key to ensuring resilience and enhancing quality of care going forward. With that in mind, officials are taking forward a programme of work to review and improve aspects of staff bank operations including governance and oversight arrangements, marketing/attraction activity and recruitment/onboarding processes. The work to establish a staff training passport as part of implementation of Agenda for Change reforms will also create new opportunities for bank staff to work across Board boundaries.

Medical Supplementary Staffing

10. Expenditure on medical locum engagements has also increased in recent years, although not as starkly as is the case for nursing (spend has risen from £102.9 million in 2019/20 to £119.6 million in 2022/23).

11. Our approach to driving down spend in this area has been shaped in discussion with Medical Directors who have emphasised the need for work to address underlying supply challenges for the medical workforce. With that in mind, a Medical Workforce Sustainability and Value Group (MWSG) was established in early 2023 with a particular focus on measures designed to improve the sustainability of the medical workforce via initiatives such as the geographic redistribution of doctors in training, targeted recruitment support and other strategies aimed at addressing the underlying supply challenges in relation to medical staffing.

12. Taking into account the extended nature of medical training timelines, immediate support is now being put in place for our most fragile services, with psychiatry identified as a specialty of focus. Psychiatry currently experiences critical shortages – at September 2023, the number of vacant consultant posts for all Psychiatric specialties accounted for almost a quarter of the total consultant vacancies across Scotland - 98.7 WTE vacant posts. The NHS Scotland Centre for Workforce Supply (CWS) have therefore scoped the viability of providing recruitment, supply, transformation, and sustainability initiatives designed to support Boards in addressing current workforce gaps, reduce locum use, and ensure a more robust, sustainable Psychiatry workforce over the next 3 – 5 years. Building on this, CWS propose taking forward bespoke direct support to one or two of the most challenged Boards as tests of change. Through this approach CWS would help Boards test out a range of immediate, practical solutions based on their own unique context, and then write up case studies to help spread good practice to other Boards.

13. Alongside the above measures, consideration is now being given to the introduction of new measures designed to ensure Health Boards are securing best value whenever locum engagement is required. Membership of the previous MWSG has been revised to reflect this new remit and will now be chaired by Carol Potter, Chief Executive, NHS Fife, and Gillian Russell, SG Director of Health Workforce.

14. Initial evidence gathering on the part of the Group points towards considerable variability in current practice across Boards when it comes to medical locum engagement as demonstrated through:

    - Lack of a consistent approval framework across Boards for accessing medical locums.
    - Variability in medical staff bank structures, with some Boards operating a fully centralised bank covering all roles and others operating a small bank with no active recruitment. Some Boards have no medical bank at all.

15. The newly established Task & Finish Group has now met on two occasions and will be taking forward the development of detailed proposals for implementation over the coming months with a view to ensuring appropriate, cost-effective engagement of medical locums going forward. Examples of potential interventions include:

    - The introduction of a consistent approval framework for adoption by all Boards engaging medical locums.
    - The introduction of new information sharing arrangements across Boards to allow for benchmarking of locum rates.
    - A review of the commission fee structure for long-term agency locum engagements.
    - Analysis of the case for introducing staff banks, potentially on a regional or national basis.

16. It should however be noted that addressing the issue of medical locum usage is more complex than is the case for other categories of agency staff. This is in large part because examples of extended high-cost locum usage are often driven by the need to sustain fragile services due to substantive recruitment challenges. In such circumstances, the only alternative to locum cover would be closing or reducing services. This is particularly pertinent in rural areas. Any action will therefore need to drive forward solutions while balancing these risks. It is particularly worth noting that locums falling into this category are often highly mobile and sought after, and can therefore command a premium.

Interaction with other policy interventions

17. It is important that the work underway to improve our approach to supplementary staffing is not viewed in isolation given the range of related policies which have the potential to impact on our rate of progress.

18. In particular, it is important to understand the interaction between the use of agency staffing and the commencement of the Health & Care (Staffing) (Scotland) Act 2019. That Act places a new duty (and related legal obligations) on Boards to ensure appropriate staffing. A specific duty has also been introduced requiring Boards to report quarterly on the use of high-cost agency workers (agency workers costing more than 150% of an equivalent substantive member of staff) and the reasons for this. Another duty requires Scottish Ministers to publish (as they consider appropriate) information from Health Boards on the amount spent on all agency workers.

19. At this stage, it is not clear what the direct impact of these new duties will be on staffing capacity across the system. There is the potential that Boards will seek to increase their rostered workforce in some services in order to assure themselves of compliance with the new legal requirements. Alternatively, Boards may seek to engage in dialogue regarding service reconfiguration as a way of adopting more efficient staff deployment models. In circumstances where Boards require to access additional staff through means other than additional hours, they are required (by the Scottish Government) to seek to secure that capacity

through the staff bank in the first instance. Only where this is not possible should Boards seek to access staff via agencies.

20. In addition, it is important to consider the impact of implementing reformed terms and conditions for AfC staff and, most notably, the planned reduction in the working week.

21. As part of the 2023/24 Pay Deal for AfC staff, it was agreed that we would explore the feasibility of reducing working hours with the overall aim to reduce to 36 hours. As the first stage of this, from 1 April 2024 full time hours for Agenda for Change staff should reduce to 37 per week (pro rata for part time staff), without loss of earnings. If, due to service pressures, safety or wellbeing issues determined within Boards, it is not possible at that time for a staff member or group of staff to receive their 30 minute reduction (pro rata number of minutes for part time staff), they will be recompensed accordingly until such times as the reduction can be accommodated.

22. Both employers and staffside partners agree that this change should be implemented in a way which is meaningful for staff. In practical terms, this means that the reduction should likely be taken as a block of time. This has the potential to result in rota gaps which Boards will require to fill through accessing additional staff capacity, be that in the form of additional hours from substantive staff, capacity accessed via the staff bank or capacity accessed via agencies in exceptional circumstances. This additional factor requires to be managed at a time when Boards are under pressure to make savings which could in turn dampen willingness to recruit staff on a substantive basis. These issues are being considered as part of a newly established AfC Board Capacity and Delivery Oversight Group led by Gillian Russell, Director of Health Workforce, and Jane Grant, Chief Executive of NHS Greater Glasgow and Clyde.

23. When considering the cumulative impact of the above listed interventions, it is also important to consider other initiatives currently being delivered with the aim of improving productivity across the system, including work underway to improve NHS Scotland's position in relation to sickness absence. NHS Scotland currently has an overarching sickness absence target of 4%, with the annual sickness absence rate ranging between 4.8%-6.2% for the years 2013-2023. Sickness absence rates have been increasing since 2014 and have increased further post pandemic. Most Health Boards consistently remain above the 4.0% target. If we reduce sickness absence rates overall by 0.7% by March 2025, this will save the NHS up to 2.1 million hours annually.

24. We are seeking to support boards to reduce sickness absence rates through setting an interim target back to 2019/2020 levels by end of March 2025. As a longer-term measure, we are intending to work with employers to develop a framework to set an upper limit sick absence rate for NHS Scotland rather than a target. This upper limit will be informed by national public and private sector comparators, industry standards and cross-UK comparisons.

25. As part of this work, we will also take steps to better understand key drivers for sickness absence which should in turn allow us to better target future wellbeing

interventions. Clearly, any reduction in sickness absence supports the overall aim to reduce reliance on supplementary staffing as it reduces the need to back fill shifts.

Options Considered and Advice

26. It is clear that concurrent implementation of each of the above policies could have a potentially significant cumulative impact on workforce capacity.

27. Commencement plans for the Health & Care (Staffing) (Scotland) Act 2019 have been the subject of extensive assurance activity, with the Act having now come into force. Similarly, a decision on implementation of the AfC reforms has been taken by the Cabinet Secretary in light of official advice and following engagement with staffside representatives. There is therefore no scope to adjust plans in either of these areas.

28. Ministers continue to maintain some flexibility around timescales for the introduction of further restrictions concerning the use of both medical and nursing agency staffing, with any such decision expected to take account of wider service resilience as well as advice provided through the above referenced Task and Finish Groups. The operation of regular reporting on supplementary staffing fill rates will be crucial in helping us to understand service resilience over the coming period.

29. In addition, continued investment in targeted capacity building activity will enable us to develop bespoke solutions for resourcing fragile services and supporting key professions. This includes (but is not limited to):

    - Investment in attraction activity in line with emerging recommendations from the Nursing and Midwifery Taskforce.
    - Continued investment in the NHS Centre for Workforce Supply which will play a critical role in supporting the development of local resourcing strategies to address key workforce gaps across both nursing and medicine.
    - Continued investment in accelerated training opportunities in order to facilitate the deployment of additional staff across key services, including planned care and diagnostics.
    - Ongoing consideration of the opportunities associated with workforce diversification, including but not limited to the potential future role that Medical Associate Professionals can play in augmenting our traditional medical workforce.

Assessment of Options

30. Taking account of the above, we would advise that Ministers note the outlined programme of activity relating to supplementary staffing on the grounds that it forms an important element of Board savings plans. Further, a reduction in supplementary staffing is expected to deliver improvements in both patient safety and quality of care if delivered correctly. This is on the basis that substantive

staff and staff accessed via Banks will be more familiar with local systems and processes for the delivery of care.

31. That said, it will be important to keep under review the feasibility of reducing supplementary staffing spend in light of the impact that other policies may have on service resilience as outlined above. We therefore advise that robust reporting and monitoring arrangements continue to be operated in relation to supplementary staffing and that evidence gathered through that process is considered alongside emerging detail on the impact that implementation of other key policies is having on workforce capacity.

32. Alongside this, we would advise that work continues to be taken forward to develop and deliver policy intended to build additional workforce capacity as a way of off-setting the anticipated reduction in productive capacity across the service.

Bute House Agreement Implications

33. There are no implications for the Bute House Agreement.

Financial and Legal Considerations

34. Officials believe there is potential to derive significant financial savings from the programmes of work targeted towards supplementary staffing. For illustrative purposes only, a reduction in spend on agency nurse staffing to 2019/20 levels could result in the release of approximately £137 million although at least some of this money would likely be required to contract bank and/or substantive staff to fill critical roster gaps, albeit at a lesser rate of pay. Even accounting for this, it is believed that a reduction in agency usage will create an opportunity for Boards to reduce their forecast overspends.

35. The Cabinet Secretary will also wish to note the possibility that the cumulative impact of other ministerial commitments as detailed in this submission has the potential to slow or even reverse recent progress in relation to agency usage, thereby introducing additional cost into the system at a time of significant financial challenge.

Sensitivities

36. The usage of agency staff has attracted parliamentary interest in recent months, with concerns being raised about the scale of the increase in expenditure on nurse agency staffing in particular. Ministers have responded to criticism by pointing towards the establishment of dedicated workstreams to address this challenge. A decision to slow activity in this space would likely be the subject of criticism going forward.

37. Should the cumulative impact of the changes detailed in this advice be such that there is a notable impact on the delivery of patient facing services, this would similarly drive increased public and parliamentary scrutiny. To illustrate, a decision to prioritise a reduction in supplementary staffing at the expense of

recovering planned care services would likely attract considerable criticism given the priority Ministers have attached to reducing waiting times.

Quality Assurance

38. This Submission has been approved by Gillian Russell, Director of Health Workforce, and Anne Armstrong, Chief Nursing Officer.

Conclusions and next Steps

39. The Cabinet Secretary is invited to note the work underway to implement further reductions in usage of high-cost agency staffing alongside ongoing work to implement Agenda for Change reforms and commencement of the Health & Care (Staffing) (Scotland) Act 2019. Officials will provide bi-monthly updates on progress in relation to supplementary staffing alongside an assessment of any emerging risks. Officials would be happy to meet to discuss these issues further should the Cabinet Secretary consider this would be helpful.

[redacted]
Health Workforce Directorate

Cabinet Secretaries and Ministers Copy List	For Action	For Information Portfolio interest	For Information Constituency interest	For Information General awareness
Cabinet Secretary for NHS Recovery, Health and Social Care	X			

Officials Copy List
DG Health & Social Care Gillian Russell, Health Workforce [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] Chief Nursing Officer [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted]