What has worked well in Scotland?

This has proven to be very flexible but offers lessons to be learned about the need to take an 'insurance-based' approach to building capacity in the pandemic and emergency services.

Opportunity for further resilience

- Whilst bodies reflected on the need to meet initial demand with deployment of staff and/or recruitment of additional staff, the transition back to the 'new normal' presents a risk to the capacity of staff with specific skillsets. A key example cited within the documents provided is clinical skills, where clinical supervisors for non-clinical staff remain in short supply. Organisations also suggested that future planning could consider developing a matrix or system where skills and capability are considered and mapped across potential redeployments in advance, to facilitate the pace at which organisations can respond to changing requirements. Closer work with Higher Education Institutions or education practices might support this.
- Having the time to upskill staff during the onset of the Covid-19 pandemic was clearly a limiting factor. Documents provided noted the fact that certain staff groups were especially impacted in terms of learning and development, for example, with the pausing of clinical placements for AHPs in the first wave. This was exacerbated by the practical challenges of reintroducing placements whilst maintaining social distancing, as well as a lack of patient numbers to support a quality learning experience for students.
- Respondents suggested that the workforce planning exercise was heavily supply-led. The NES and SSSC Recruitment Portals were developed and implemented rapidly through partnerships working across the health and social care sector, which on reflection worked well. Boards, however, did not feel that there was enough focus on aligning efforts to seek temporary or emergency staffing to service needs. At the start of the pandemic, NHS Boards, Health and Social Care Partnerships and Social Care organisations did not know which parts of the workforce would experience the most demand and pressure and consequently, the Portals issued a general invitation to workers across the health and social care sector. This has led to an excess of available staff in the NES and SSSC Portals, for a number of reasons (for example, some of the vacancies were not in required geographical areas or services that Portal registrants wanted to work in and some registrants did not have the required skills that Boards or Social Care organisations needed). Another factor was that as a number of services had temporarily stopped, Health and Social Care Partnerships effectively redeployed staff locally, providing mutual aide to respond to workforce pressures. Going forward, more focus on integrated, flexible, demand modelling will improve efficiency of supply sourcing.

Key takeaways for leaders

- Recognise the value of volunteer staff in freeing up clinical staff to focus on my value-added activities.
- Consider the governance around rapid recruitment when trying to meet peaks in demand.
- Increasing digital provision of care impacts of role automation in workforce plans. Scottish organisations should review workforce requirements over the next 5-10 years considering how the pandemic response may have accelerated this process.
- We can take learnings from the initial waves of Covid-19 around how we can rapidly reconfigure the workforce to direct more staff in service to frontline and emergency response, making use of retirees and returners to provide 'business as usual' services such as ward rounds, which would create additional capacity. Overall, future resilience in relation to workforce requires a holistic view on capacity, rather than filling specific gaps or roles with skills that are temporarily in short supply.