Contents

About the Symposium ........................................................................................................................................ 4
Executive Summary ........................................................................................................................................... 5
Chapter One: Challenges and Myths regarding the Medical Workforce .............................................. 7
Chapter Two: Workforce Sourcing ............................................................................................................. 13
Chapter Three: Workshop ........................................................................................................................... 15
Chapter Four: Medical Workforce, the Role of Education .......................................................................... 19
Chapter Five: Alternative models Physician Associates ........................................................................... 22
Chapter Six: Workshop ............................................................................................................................... 24
Summary ..................................................................................................................................................... 26
Conclusion .................................................................................................................................................... 27
Appendix One ............................................................................................................................................... 28
**Foreword**

During the past year, the organisation has been under significant external scrutiny and this has included the suggestion that a robust Medical Workforce Plan for Secondary Care is required. The rationale is that this enables the opportunities/challenges and risks around the medical workforce to be shared and discussed across the organisation.

The aims of this Symposium is to engage Senior Doctors on medical workforce planning and to develop a shared understanding. For this to occur a broader understanding of the medical workforce demographics are required.

When the programme pack for this symposium was distributed to all delegates on arrival a Secondary Care Medical Workforce profile has been included. This includes detail for all specialties apart from Acute Medicine and Medical HDU which are currently inappropriately coded within our local workforce information systems.

A medical workforce profile includes: headcount; WTE (whole time equivalent); age; gender and whole/part-time working and explores potential opportunities/risks in terms of medical workforce demographics.

The Symposium is an opportunity for us to understand the challenges and opportunities for the medical workforce in Grampian. As Doctors in Training and Career Grade doctors are potentially attracted by working at a Tertiary teaching hospital and teach at a Medical School plus come to work with colleagues deemed as experts in their field. Other reasons for doctors to come here are research opportunities and to work with University colleagues.

The output of this Symposium is this report which includes detail on the presentations as well as themes from two workshops. This is an important step in engaging and developing a Secondary Care Medical Workforce plan.
About the Symposium

The Secondary Care Medical Workforce Symposium event occurred in Spring 2015 at the Med Chi, Foresterhill and was attended by nearly sixty delegates (see Appendix One).

The aim of the Symposium was to improve the sustainability of the medical workforce through engaging Senior Doctors; identifying risks and developing opportunities; informing medical workforce planning; developing actions and working collaboratively to resolve our challenges.

The programme was introduced by Dr Nick Fluck Medical Director, before a presentation by Dr Annie Ingram Director of Workforce on “Challenges and Myths regarding the Medical Workforce” and is detailed in Chapter One. The second presentation was by Susan Coull, Head of HR on “Workforce Sourcing” and is detailed in Chapter Two.

The next section of the Symposium programme was Workshop One: “What can NHS Grampian do to improve our reputation and support our Workforce supply?”

The delegates were spilt into five groups and the output of this workshop is detailed in Chapter Three.

The next presentation was by Dr Richard Coleman on “Medical Education – role of education” and is detailed in Chapter Four. Thereafter a presentation by Dr Philip Crockett Consultant Psychiatrist and Jane Lawson Physician Associate and on “Alternative models: an example in Practice” which is detailed in Chapter Five.

The next section of the programme was Workshop Two: “With the Challenges we face what should the future medical workforce look like? - 3 practical actions”

The Symposium was then concluded and summarised by Dr Annie Ingram.
Executive Summary

The Secondary Care Medical Workforce symposium started with a presentation by Dr Annie Ingram, Director of Workforce on the overall medical workforce profile for NHS Grampian. There is a headcount of 467 consultants which equates to 450 WTE. The age profile and gender split of the Career Grades and Doctors in Training medical workforce was outlined.

Information on the UK medical workforce profile is now starting to become available from the GMC which reports increasing feminisation; a change in workforce supply with less international medical graduates and a loss of over 65s.

Analysis of the Doctors in Training workforce intelligence suggests a lack of retention of Aberdeen medical school graduates in the North of Scotland. Factors that influence retention include friends and family alongside the views of their peers. The latest GMC survey on the view of Doctors in Training indicates that there is room for improvement.

Other significant medical workforce risks include the current expenditure on medical locums and the pending Shape of Training review. Consultant challenges include the completion rate for job planning and Consultant recruitment.

A focus on workforce sourcing i.e. medical recruitment was outlined by Susan Coull. This includes: social media; attendance at career fairs and potentially utilising network opportunities more.

The role of education in supporting the medical workforce was outlined by Dr Richard Coleman, Director of Medical Postgraduate Education and this is to train the next generation of the medical workforce. A range of skill mix is required to enable this to happen. Alternative models of delivery of service are potentially required and this was outlined by Dr Philip Crocket and Jane Lawson who have been involved in the development of the Physician Associate role in mental health. Such models are potentially required to maximise the skill mix of Physician Associates/Scientists and their contribution.

Themes were forthcoming from all delegates and these included: marketing our unique selling points; creating an alumni database; enhancing culture via positive training and department experience; creating added value to working in Grampian via research and University links; team working and a sense of belonging; development of clinical attachments; knowledge of those STs about to CCT; utilisation of networks via social media; meeting GMC Standards; robust implementation of the GMC Recognition and Approval of Trainers work-stream; maximise the capabilities of Physician Associates and Scientists; cultural aspects of seven day working requires further discussion; utilisation of in-house Doctors in Training or Career Grades rather than locums; development of a locum bank and organisational development work in terms of integration.

Next steps will include a discussion with each clinical specialty to consider the medical workforce profile for each specialty as detailed in the Secondary Care Medical Workforce profile.

There will be an opportunity to discuss the individual specialty actions that would dovetail with an overarching action plan for Secondary Care Medical Workforce that creates resilience.

This will also enable the organisation to produce an overall robust Medical Workforce Plan.
**Chapter One: Challenges and Myths regarding the Medical Workforce**

This chapter details the presentation by Dr Annie Ingram Director of Workforce which was titled: “Challenges and Myths regarding the Medical Workforce.”

The aims of this presentation are to: engage senior doctors; identify sustainability of the medical workforce; identify risks and opportunities; inform medical workforce planning and work collaboratively work together to resolve our challenges.

**Medical Workforce Profile**

The Secondary Care Medical Workforce Profile for NHS Grampian that was handed out on arrival at the Symposium illustrates the following. There is a headcount of 467 consultants with a WTE of 450. There is a headcount of 108 SAS doctors with a WTE of 81.3. 37 GPs work in secondary care but predominantly part-time as there is a WTE of 11.7.

The Doctor in Training workforce for NHS Grampian has a headcount of 195 FY1 and FY2 and likewise there is a headcount of 392 Specialist Trainees, Core Trainees and GPSTs (GPs in training).

Currently 20.3% of our Consultant workforce is over the age of 55 with 37.9% over the age of 50. Potentially 95 Consultants could retire in the next 5 years (assuming a retirement age of 60).

The age profile of the SAS doctors indicates that 30 (28%) SAS doctors are over the age of 55.

The gender split of the medical workforce is 50.5% male and 49.5% female. The Consultant workforce is predominantly male at 66%. SAS doctors are predominantly female and account for 69% of the SAS workforce.

Doctors in Training also have a high proportion of women, with 47% of Specialist Trainees and 55% for Core Trainees female suggesting that the gender bias is increasing towards a female workforce.

**UK Medical Workforce Profile**

The GMC is now producing information on the medical workforce at a UK level. These reports are highlighting increasing feminisation of the medical workforce especially under the age of 30. For example, Scotland has the highest proportion of female doctors. Obviously, this has implications as women possibly sometimes have different expectations from men.

Women are under-represented in General Surgery, Trauma Orthopaedics and remain under-represented in Specialty Training with the highest proportion working in General Practice. Although there is evidence that this is changing, the Royal College of Physicians are reporting that the number of women in Speciality Training has increased by 18%.

The increasing number of women in the workforce has implications for the future delivery of services. Women work differently from their male counterparts, suggesting that if numbers continue to increase and women remain under-represented in the
craft specialities, this could have implications for sustainability of services in the future.

The GMC are also reporting a change in the supply into the UK medical workforce. This is apparent from the GMC register. There is a loss of over 65s due to the introduction of the Licence to Practice in 2009 and the removal of the exemption fee. Alongside, this there are less International Medical Graduates (IMGs) due to the changes in immigration rules however, although there has been a reduction in the number of IMGs this group remains a substantial proportion of all registered doctors in the UK at 26%.

There is evidence that IMGs have different speciality preferences than UK Graduates and there are higher numbers working in Anaesthetics, Obstetrics and Gynaecology, General Adult Psychiatry and Histopathology. Each of these specialities is experiencing recruitment challenges; however with the new immigration rules the workforce profile could change and therefore there is a need to ensure that UK graduates are attracted to these hard to recruit disciplines.

Doctors in Training

There are 41,422 medical students in the UK, with 5156 (12%) studying in Scottish Universities\(^2\). Of all 29 medical schools in the UK and those from Queens University, Belfast 85.4% of medical graduates is likely to remain in their local area. The University of Glasgow is second in the UK at 68.6% of graduates who go on to train within the local deanery. The University of Edinburgh is 24\(^{th}\) with 36.2% of graduates retained; Aberdeen is 25\(^{th}\) with 34.9% and Dundee who has the lowest retention rate in the UK of 20.6%. The GMC expects that graduates will complete foundation and specialty training in their local deanery thereby contributing to delivering health services in these regions. The reality is somewhat different.

35% of graduates from the University of Aberdeen will progress their training in a North of Scotland (NoS) deanery post with 24% of the University of Aberdeen graduates progressing their training in the West of Scotland deanery; 12% in the South East and 29% in all other deaneries. It is therefore important that NHS Grampian collaborate with the University of Aberdeen and the NoS deanery to better understand why graduates move away from Grampian so that we can encourage them to stay within the area in the future.

Evidence from the StART initiative\(^3\) from NHS Education Scotland (NES) suggests that the most influential factors for graduates is friends and family alongside the views of their peers.

Of the 5540 Doctors in Training in Scotland, 799 (14.4%) are training in the NoS deanery, which equates to 1.3% of the total Doctors in Training workforce in the UK. With only a very small proportion of the overall Doctor in Training workforce exposed to Grampian training we will need to work extremely hard to encourage young doctors to come to Grampian and to stay in Grampian for the long term.

The most recent General Medical Council (GMC) survey\(^4\) on the views of doctors who train in Grampian indicated room for improvement in the Doctors in Training

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\(^2\) This excludes medical students at St Andrews, who are included in the numbers for the University of Manchester
\(^3\) NHS EDUCATION FOR SCOTLAND 2013 Strategy for Attracting & Retaining Trainees [www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk)
\(^4\) GENERAL MEDICAL COUNCIL 2014 National Training Survey Results [www.gmc-uk.org](http://www.gmc-uk.org)
experience. Various domain factors such as clinical supervision are compared and contrasted across training programmes in the UK. All the results are derived from a comparison between a score generated by a smaller group of respondents (a report group in our case NHS Grampian) and a score generated by a larger group of respondents.

A green flag, the score for the indicator is significantly above the national score in the benchmark group. A red flag, the score for the indicator is significantly below the national score in the benchmark group. There are a number of red flags, for a number of domain factors across the specialties for NHS Grampian. Dr Annie Ingram’s vision is for the majority of the flags to be green.

The Scottish Government Reshaping Medical Workforce work-stream has drawn to a conclusion. The aim was to increase the proportion of the service delivered by Career Grade doctors and reduce the proportion of service delivered by Doctors in Training.

For Doctors in Training, the reshaping project has reduced the number of available training posts, although the reductions have been small. Since 2009 the North of Scotland deanery has reduced by 25 training posts. The Reshaping the Medical Workforce has been blamed for many challenges in the training grade workforce many of the challenges relate to vacancies in training programmes and hard to fill posts. This can impact upon the sustainability of the training programme as a whole. It is therefore vital that NHS Grampian retains training programmes, particularly small training programmes which are operated on a national level.

**Shape of Training**

The GMC established a review to consider the Shape of Training, which was published on 29th October 2013. This review makes proposals for a significant change in the way that doctors are trained and the future shape of the service. Many of the changes are projected to start over the next 5 years and will have an impact on the way services are delivered.

The main recommendations include a requirement for doctors who are able to provide general care in a broad range of settings, with: full registration at graduation from medical school and two year foundation programmes in fewer places, but with the opportunity to follow patients for their entire patient pathway.

There will also be a requirement for 4-6 years broad based specialty training, where specialities are themed together and trained with generic capabilities and the ability to look after acutely ill patients with multiple morbidities; longer training placements, with supervisors and apprenticeship based models.

The exit point of training will be Certificate of Specialist Training (CST) which replaces CCT and enhanced training for specialist and subspecialty training through formal and quality assured training programmes leading to credentialing.

The above changes will bring a degree of flux to services and could impact on the ability to deliver service change at the same time. Therefore NHS Grampian needs to

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consider how the changes will affect services, particularly in tertiary specialities and how, where service remain reliant on Doctors in Training, that NHS Grampian are able to deliver the 24/7 approach to services that each of the UK health authorities have proposed.

**Consultant Issues**

At Consultant level, the job planning approach promoted by NHS Scotland was introduced to provide a higher level of clinical facing time by ‘new’ consultants. This has had a number of unintended consequences including acting as a disincentive for those out with Scotland coming to work here and reducing the time that new Consultants devote to ‘professional’ activities, including supervising training, which if unaddressed will undermine our role as a teaching Board. Even in a Board which has not been overly prescriptive in the approach, there has been a disadvantage locally.

There are issues in relation to reward, including distinction awards and discretionary points and the perception that doctors are not valued. Other external factors such as the HMRC restrictions on the amount any individual can build towards a pension, with the benefit of tax relief have had a particular impact on many of our senior clinicians. Whilst we do not have a figure for the number affected, there is anecdotal evidence that a proportion of the most recent retirals of Consultants have cited this as a reason, with some retiring and then returning on reduced hours or commitments.

There are a number of areas where the Health Boards in the North struggle to recruit to Consultant posts. Some of the areas are recognised at national and UK level while others are particular to the North of Scotland.

The areas that are of particular concern within secondary care include: Clinical and medical oncology, psychiatry, paediatrics, radiology (both clinical and interventional radiology), emergency medicine, histopathology, renal medicine, gastroenterology, geriatric medicine and acute medicine. There are also challenges in recruiting more generalist clinicians for the specialities in Dr Gray’s Hospital.

**Seven Day Services**

A key Scottish Government policy is to improve diagnostics and interventions at weekends and in the evening, to support a more effective seven day service. The aim is to improve 24/7 provision and enhance local services in key areas including major trauma, critical care, acute surgery, acute medicine, coronary care, maternity and neonates.

**Medical Locums**

NHS Grampians’ expenditure in relation to medical locums has increased by 30% over the last two years, following a period when this had been reducing. In 2012-13, NHS Grampian spent £4.3m in locum doctors across all grades, which had increased from £3.3m in 2010-11. In the current year, to the end of September the expenditure was £3.4m and if the upward trend continues, it is projected that the end of year outturn figure could be £6.7m. The most significant spends in the first six months of the year are in women and children, complex care and musculoskeletal/neurosciences, with 56% of spend at Consultant grade and 27% at Specialist Trainee.
The use of locums is unavoidable in some areas if service levels are to be maintained, but it is recognised that services delivered by locums may be less safe and the extent of spend will undermine our ability to be financially resilient.

Currently NHS Grampian faces a number of challenges in securing the appropriate medical workforce at all levels.

**Living in Aberdeen – The geographical challenge**

The cost of moving to Aberdeen and cost of living here is becoming more of a recruitment issue for all staff in Grampian. As a recent BBC report highlighted:

“Two cities in the UK - one is a centre of commerce, has runaway house prices, and welcomes a constant stream of overseas property buyers. The other is London.

“House prices in and around Aberdeen have more than doubled in the past 10 years, according to data from the Nationwide Building Society. That increase is only matched by the trendy north London borough of Islington, and by Westminster in the heart of the capital of the UK. Recent figures show that Scotland's third city is recording a fresh surge in property prices. One estate agent describes the area as a property force field.”

The high cost of housing in Aberdeen is often mentioned by Doctors in Training and others, such as Nurses, as a disincentive to moving to Grampian. In the past, the NHS used to offer an excess rent allowance, which has been removed by changes to terms and conditions. This was based on a calculation of the costs of housing in Aberdeen relative to the place of origin of an appointee. It was paid in full for five years and then phased out over the next four years.

There is pressure from staff across Grampian, including our partnership colleagues, to seek authorisation for an Aberdeen Weighting, or an allowance such as described above, or even ‘golden hello’s’. NHS Grampian is currently collecting evidence on these issues. However the national frameworks were established in Scotland to ensure equality and therefore NHS Grampian is unlikely to succeed. There is little understanding in other parts of the country of the extent of the economic bubble that exists linked to the vibrant economy in Aberdeen.

In a recent exit interview with one young Consultant, the Director of Workforce was told: ‘the reality is that when I was a trainee in Glasgow, I could buy more for my money than when I became a Consultant in Aberdeen.’

Scotland is rightly proud of the economic powerhouse centred on Aberdeen but this needs to be supported by a world class health service and for the reasons above, this could be at risk.

**Summary**

In summary the risks and opportunities include: an ageing workforce especially for our SAS medical workforce; an increasing female medical workforce and implications for recruitment of Consultant posts now and in the future.

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6 [www.bbc.co.uk/news](http://www.bbc.co.uk/news) 7th October 2013
The requirement is for NHS Grampian to improve our reputation to attract and retain our Doctors in Training. Medical locum costs have increased and there is necessity in reducing the locum spend and in addition to support innovative approaches to compensate for the high cost of living.
Chapter Two: Workforce Sourcing

This chapter details the presentation by Susan Coull Head of HR which was titled: “Workforce Sourcing.”

NHS Grampian has a recruitment 2020 vision which is for NHS Grampian to be viewed as an employer of choice and requires the organisation to continue to develop the employer brand i.e. how the organisation is perceived externally. This requires us all to work together to provide a number of different solutions.

NHS Grampian is successful at marketing the organisation, but alongside this there is a need to develop the employee value proposition, which is the definition of whether an individual’s engagement is matched by an organisation.

There have been a number of actions to date in relation to recruitment and employee value proposition these include various campaigns and events. NHS Grampian has attended careers fairs and schools to promote medicine as a career. There is also a “earn while you learn” scheme which is being marketed across NHS Grampian where medical students can register to work as a healthcare support worker whilst studying medicine in Aberdeen.

A small team from the Workforce Directorate attended the British Medical Journal (BMJ) conference in London last October to promote NHS Grampian to the nearly 2000 delegates who attended. In addition, there was attendance at the Scottish Medical Training (Scot MT) event in Glasgow which promoted medical careers in Scotland to Doctors in Training and medical students and attendance at the Acute Medical Conference in London.

At these events, there were various promotional materials for NHS Grampian which included pop-ups, banners and posters. Alongside, this there have been specific marketing materials developed including specific flyers, business cards and printed adverts.

There is a focus on social media including Linkedin, Facebook, Twitter and our webpage in relation to recruitment and marketing Grampian as a place to live and work.

In terms of medical recruitment, there is a requirement to market our unique selling points. These are that we are a teaching hospital with excellent opportunities to be involved in research; the lifestyle is both urban and rural with a buoyant economy. Grampian is often rated highly in the surveys as the best place to live. There is also a relocation package to support doctors relocating here.

Hopefully, Senior Doctors can use networking opportunities more; these include using business cards at events and conferences. There is the possibility of identifying champions for each specialty and using the extensive list of contacts from being a teaching hospital to assist with networking and recruitment opportunities.

Further work is required on headhunting by using Linkedin, Social Media and by using relevant agencies.

All of the aforementioned requires a culture change to exploit our networks, to be better at matching our vacancies to current Doctors in Training. For us to use blogs, podcasts and our own webpage to market our vacancies and to promote our
employer brand. Each speciality maybe needs to sell itself by defining the employer brand and developing the employee value proposition.

Useful links include: Linkedin, follow NHS Grampian, and connect to Susan Coull and Tracey Hicks. On Facebook: follow facebook.com/NHS.grampian.scotland and on twitter follow: @NHSGrampian.

Useful websites include: www.nhsgrampianjobs.org and www.aberdeenieinvestlivevisit.co.uk
Chapter Three: Workshop

Introduction

Following on from the first two presentations, a workshop was held and attended by all delegates. Workshop 1 was under the broad theme of:

“What can NHS Grampian do to improve our reputation and support our Workforce supply?” Each of the five groups explored a different theme under this heading.

Group 1 explored retention, Group 2 explored employer brand, Group 3 explored employee value proposition, Group 4 explored workforce profile challenges and Group 5 recruitment.

Group One

Group One was tasked with discussing:

What can NHS Grampian and Partners do to improve our retention from Medical School into FY1/FY2 thereafter into Core Training?

Group one discussed that Specialty Training has to become more attractive, that it would be beneficial to facilitate visits to Grampian from abroad and make it easy for those interested to come to the area. It was identified that there should be more focus on rotas, study leave, people interaction and flexibility to ensure attractive training programmes.

Group one suggested a requirement to highlight medical education selling points and to emphasise the positive and outstanding elements within different specialties. This requires better publicity out-with Grampian. It was identified that there is also a need to personalise the management of Doctors in Training and for NHS Grampian to promote a feeling of belonging to the team, department and specialty. In addition there is a requirement for a process for Doctors in Training to be able to air their ideas and opinions. This includes support for issues outside work and enabling Doctors in Training to talk through such issues. Focussing on these elements will provide a positive experience that will encourage them to stay.

It was acknowledged that the system can be potentially completely swamped with work, so vacancies and forward planning has to be better. Communication to departments could be improved and in particular in relation to forthcoming maternity leave, so that better planning can be undertaken.

It was identified, that there is a need to engage at undergraduate level to give good experience of departments from the outset and that word of mouth is important to improve reputation of services. Other important elements include comfort factors for example office space and facilities for refreshments and likewise first impressions have to be improved for example: Ashgrove house and car parking.

Organising Fellowship and secondments abroad which keep links here to Grampian, although this has the risk of Doctors in Training, not returning to Grampian. The contact details of all doctors who have worked in Grampian should be retained on an alumni database. This is a long term investment and to develop University Links to publicise what is available, in relation to research.
Group Two

Group Two was tasked with discussing:

Employer Brand: What can NHS Grampian do to improve our reputation, improve our image and support our workforce supply?

Group two highlighted that there has to be a focus on the culture of the organisation, recognition of HIS Report as learning for the future and for the organisation to move on. This requires a common purpose/ set of values and processes to improve our reputation.

Group two discussed the importance of providing a sense of belonging to the organisation and for appropriate staff support where required. This would enable employees to feel valued by the organisation.

It was identified that issues should be contained and managed internally first. There is possibly a requirement for better communication and engagement between medical and managerial staff. This requires exploration and reinforcement of the organisational values that we have at the present: caring, listening and improving. Thereafter by learning from the past and truly delivering these values. Overall culture and values should enable doctors to develop their roles as individuals in the future but particularly within multi-disciplinary teams.

Group Three

Group Three was tasked with discussing:

Employee Value Proposition: what NHS Grampian has to offer, understand what future employees’ value and what would persuade them to join?

Group three highlighted the potential to change how training is delivered; have more protected time for teaching and have stronger collaboration with the Universities. There should be a continued commitment in Grampian to high quality research and publication of papers in high profile journals.

Group three suggested that there is a requirement for NHS Grampian to market the uniqueness of specialities in Grampian i.e. innovative working /academia and hold national conferences. This could be supported by establishing international partnerships with departments in other countries and give trainees and consultants the opportunity to swap roles with overseas colleagues and gain experience abroad for defined periods of time.

It was identified that there is a need to promote the lifestyle in Grampian and to ensure an attractive relocation package for Consultants. Difficulties were identified with the recruitment process. The process appears to be ‘drawn out’; advertising is not timely and difficulties with red tape. There was discussion as to whether there could be a ‘Fast Track’ recruitment process for Consultants.

It was acknowledged that the following challenges exist for Doctors in Training: difficulties with centralised recruitment; little control over which trainees come to Grampian and unable to influence potential candidates.
One possible opportunity for Consultant recruitment is to headhunt at Medical Conferences UK wide. Obviously it is flattering to be headhunted, however competition is out there and sometimes by the time the process is complete, the potential candidate has successfully applied elsewhere and is lost to NHS Grampian.

**Group Four**

**Group Four was tasked with discussing:**

**Workforce profile challenges in the context of what NHS Grampian can do to improve our reputation and support our workforce supply?**

Group four discussed that the philosophy of the NHS is consistent across the UK. So Aberdeen and NE specific factors such as cost implications and geography will potentially mitigate against successful workforce supply. However the counter balance to this is the strength of Aberdeen as a tertiary centre with medical school. However that there is a financial counterbalance e.g. relocation, but local Doctors in Training have no access to this, so they may be offered incentives to go elsewhere. Local thoughts on such issues have included the difficulty of implementing a higher cost of living supplement due to the challenge of national frameworks and financial constraints.

It was identified that training and department experience has to be a focus to ensure NHS Grampian is as supportive and engaging place to work as possible. Psychology research indicates that money is not the number one factor.

Autonomy, relationship, belonging, connection and contribution are recognised as the more important factors for employees to be retained according to research. It was acknowledged that the balance is difficult, as focusing on negative, external constraints means it’s more difficult to foster feelings of autonomy, belonging and control over the workplace environment.

Group four discussed the importance of the training of medical students and to encourage links to hospital during the duration of training. Reputation and the management of the reputation are important factors.

Group four thought that a framework for feeding back ideas into the organisation and therefore the value of an event like this, would be beneficial and how ideas can be taken forward. However the size of structure means that sometimes decision making is difficult.

It was agreed that a support structure for Doctors in Training where a speciality cannot resolve specific issues independently would be beneficial and to build on working relationships with the management and team are critical.

Clinical attachments and a recognised process for this would be useful in promoting and improving our workforce supply.
Group Five

Group Five was tasked with discussing:

Recruitment in the context of what NHS Grampian can do to improve our reputation and support our workforce supply?

Group five stated that there should be more sessions like today and alongside this promote ARI blueprint session information i.e. the positive developments around the new hospitals. There is a need to offer support to applicants and to value new employees by undertaking better communication around the following areas: induction; supporting current staff; engagement; sense of belonging; catering and doctors’ mess.

It was identified that there is a need to better promote the use of social media by organising drop in sessions and develop champions in this area and utilize social media for the consideration of head hunting.

It was acknowledged that Relocation/Retention packages should be available as appropriate to support international medical graduates and to better develop links with other Universities (Glasgow & Edinburgh) as well as Aberdeen.

Networks at TPD level could be better utilized to identify potential ST trainees about to CCT (be aware of those CCT’ing in next 6 months, invite candidates to visit/meet Consultants).

Summary of the workshop

The workshop discussed the broad themes of: “What can NHS Grampian do to improve our reputation and support our Workforce Supply?”

Key themes included: marketing our unique selling points; creating an alumni database; enhancing culture via positive training and department experience; creating added value to working in Grampian via research and University links; team working and a sense of belonging; development of clinical attachments; knowledge of those STs about to CCT and utilisation of networks via social media.

Such actions require discussion with each individual clinical specialty.
Chapter Four: Medical Workforce, the Role of Education

This chapter details the presentation by Dr Richard Coleman Director of Postgraduate Medical Education which was titled: “Medical workforce, the role of Education”.

Dr Coleman’s presentation began with an introduction to the role of Director of Medical Education. Most territorial health boards have one Director of Medical Education (DME). The role of the DME is to provide oversight on medical education within a Local Education Provider (LEP), in this case NHS Grampian.

Dr Coleman highlighted that NHS Grampian has two Directors of Medical Education, one for postgraduate and one for undergraduate medical education. Dr Richard Coleman undertakes this role on behalf of NHS Grampian for postgraduate medical education and Mr Kim Ah-See for undergraduate medical education.

The structure of medical education is different between postgraduate and undergraduate medical education. Postgraduate medical education includes liaising with the divisions of the Acute Sector, Dr Gray’s and Mental Health and Undergraduate medical education involves working with the University of Aberdeen and utilising their internal structures such as co-ordinator block leads.

Dr Coleman explained that the definition of a Local Education Provider requires explanation in that NHS Grampian is the provider of local medical education training for Doctors in Training. The concept of educational governance is to ensure that the organisation has oversight in the delivery of medical education and where required can be held accountable. The statutory regulator for educational governance is the General Medical Council and the Director of Medical Education role is to ensure that the Local Education Provider meets regulatory standards in relation to medical education and training.

NHS Education for Scotland has a key role in this education governance framework especially for post-graduate medical education. NES was created in 2002 and is a non-territorial health board. There were four deaneries across Scotland until 2014: West of Scotland; South East of Scotland; East of Scotland and North of Scotland. There is now only one single deanery following an internal re-organisation within NES.

Dr Coleman alluded to the fact that there is an element of change and this has been described as doing more for less or maybe different for less. The common response is that everyone would like improvements to the delivery of patient care and to their service, but that change is the element that everyone experiences as difficult. Although, the reality is that probably continuous change is here to stay.

Dr Coleman discussed that all staff should receive support, development and training and that there are specific requirements for medical staff due to GMC being the statutory regulator. The GMC are approaching this from two perspectives: one is the work-stream entitled GMC Recognition and Approval of Trainers’ and the second is the new draft GMC Standards for proving an education governance framework.

7 GENERAL MEDICAL COUNCIL 2012 Recognition and Approval of Trainers www.gmc-uk.org
The GMC Recognition and Approval of Trainers work-stream is to ensure that all medical education trainers’ are recognised and approved. The implementation plan was launched by the GMC in 2012. For this process there are four defined roles.

For undergraduate there are those who are responsible for overseeing students’ progress at each medical school and a separate role for the lead co-ordinators at each LEP. For postgraduate there are two roles: named educational supervisors and named clinical supervisors. Named clinical supervisors are not the same as supervising clinicians.

Dr Coleman discussed that within the framework of the GMC Recognition and Approval of Trainers, the Local Education Provider has a responsibility to work with education organisers such as medical schools and deaneries (NES). The Local Education Provider role is to identify trainers, ensure sufficient trainers and support trainers in their job plans, appraisal, revalidation and addressing concerns/remediation.

For the support of this overall education governance framework there will be new GMC Standards to support such a framework. These new standards are currently in draft form and will create a single framework for undergraduate and postgraduate medical education.

Dr Coleman in his presentation went on to highlight that the role of medical education is to train the next generation of the medical workforce. There is a balance to be struck between service and education. The right ratio of trainers to Doctors in Training is required so that Doctors in Training have access to high quality education and training. Often the introduction of more Doctors in Training is not the answer, as the quality of training could be harder to deliver.

Dr Coleman went on to discuss why the quality of training is important. The morale, reputation, recruitment and retention are dependent on the quality of training. So how do we achieve quality, there is a requirement to: focus on Doctors in Training; focus on the curriculum; focus on the training environment and focus on feedback data.

For the balance of training and for medical education to support the medical workforce there is a requirement to ensure the skill mix is right. This includes utilising the following possible posts: Locums for Service (LAS) posts; International Training fellows; Specialty Doctors, Physician Associates, Advanced Nurse Practitioners and maybe more Consultants.

One possible suggestion from Dr Coleman is for an innovative scheme that promotes Specialty Doctors for training. This would require a CESR route to enable them to register. Another possible innovation is to explore Edinburgh’s Clinical Development Fellows.

Dr Coleman concluded his presentation by discussing the future of medical workforce and the role of education. One theme was NES and the impact of the Single Deanery on us here in Aberdeen. A second theme was that a new NHS Grampian Medical Directorate is being proposed that will include Associate Medical Directors with one post having particular responsibility for workforce, education and training. A third
theme on the horizon is Greenaway the “Shape of Training” review on medical education\textsuperscript{8}.

\textsuperscript{8} GREENAWAY D 2013 Shape of Training: Securing the future of excellent patient care October 2013, \texttt{www.gmc.uk.org}
Chapter Five: Alternative models Physician Associates

This chapter details the presentations by Dr Philip Crockett and Jane Lawson on the role of Physician Associates in Mental Health.

The first presentation was by Dr Philip Crockett a Consultant Psychiatrist. He explained the current staffing difficulties in Mental Health and how these had promoted exploring alternative models of service provision. One of these was to explore the possibility and role of a Physician Associate in Mental Health.

The definition of “a Physician Associate is in that they are a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.”

Dr Crockett highlighted that in essence Physician Associates work within the medical model under supervision from a Consultant/GP and can undertake team or individual work. The profession originated in the United States in the 1960s.

The second presentation was by Jane Lawson who is currently working as an intern year Physician Associate in Mental Health. Her presentation was titled: “Alternative Models: Physician Associates”.

Jane Lawson subsequently discussed the route of how to become a Physician Associate. Entry is mainly by undertaking a previous undergraduate degree, in her case Neurosciences. The Physician Associate course is a two year post-graduate programme. The first year includes lectures, teaching and clinical skills with the second year consisting of eleven four week clinical placements.

Currently, thereafter there is an optional intern year, although it is likely that this is likely to become mandatory in the future. The abilities of a Physician Associate include clerking/medical histories; physical examinations; request and interpret diagnostic tests; diagnose and formulate treatment plans and a range of clinical skills as summarised in the Ritsema and Paterson census.

The next section of Jane Lawson’s presentation was on the PA role within Mental Health and this has included working in three areas. The first area has been the outpatient eating disorders clinics; the second area being acute adult inpatient ward and the third area slow stream rehabilitation.

The outpatient eating disorders clinic includes supporting the physical monitoring clinic, the triage of assessments and being involved as part of a multi-disciplinary team. The Acute adult inpatient ward includes providing continuity of care to patients in the ward environment, the clerking/initial assessment of patients, mental state assessments and physical monitoring. The slow stream rehabilitation facility currently has a lack of clinical input, so there is more responsibility for the Physician Associate who is part of the multi-disciplinary team and undertakes daily tasks under Consultant supervision.

9 UKAPA 2015 http://www.ukapa.co.uk/general-public/faqs/index.html
10 RITSEMA TS, PATERSON KE. 2012 Results of the Second Annual UK Physician Associate Census London, England, United Kingdom
The conclusion of Jane Lawson’s presentation was the benefit of the Physician Associate career in terms of facilitating life-long learning, being a rewarding career and for her as an individual continuously developing and expanding. She is looking forward to the summer of 2015 when the Faculty of Physician Associates within the Royal College of Physicians is being established.
Chapter Six: Workshop

Introduction

After the presentations on Medical Workforce: Role of Education and Alternative Models Physician Associates, a second workshop was held and attended by all delegates. Workshop 2 was under the broad theme of:

“With the challenges we face what should the future Medical workforce look like? – 3 practical actions”

Each of the five groups explored a different theme under this heading. Group 1 explored education, Group 2 explored alternative models, Group 3 explored seven day services, Group 4 explored medical locums and Group 5 explored integration.

Group One

Group One was tasked with discussing:

“What should the future medical workforce look like in terms of medical education – 3 practical actions?”

Group One was tasked with the aforementioned remit and outlined three practical themes. One theme was to ensure that there was adequate resource and time for Trainers. A second theme was that NHS Grampian has to meet the GMC Standards for educational governance. The third theme was that to support the delivery of medical education, there is a requirement for a more diverse workforce to create resilience to allow protected time for training.

Group Two

Group Two was tasked with discussing:

“What could the future medical workforce look like in terms of alternative models – 3 practical actions?”

One theme from this group was to ensure that the role and capabilities of Physician Associates and Scientists were maximised and up-skilled. This includes enabling them to work at the higher end of their capabilities and within appropriate guidelines to support medical staff. Such a role could include Out of Hours at night or working within Community Hospitals and support for admission/discharge processes. This would require a development plan that enabled this to happen. There would also be benefit in including a watching brief on regulation of prescribers for both Physician Associates and Scientists.

Another theme was for better and more frequent joint working across the system. One aspect of this was for closer relationships with Social Care Services at the time of discharging patients. Another way of improving relationships could be by introducing a centralised advice centre that enables staff to ask medical staff for advice in relation to patients in a timely way.

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A third theme was that processes for medical staff are often not well understood in terms of the added value at each stage. There could be benefit in scoping processes for medical staff and removing any element which does not add value. This would have the potential benefit of freeing time for medical staff to supervise/advise.

**Group Three**

**Group Three was tasked with discussing:**

“Seven day services what could the future medical workforce look like in terms of seven day services – 3 practical actions

There was alas no consensus in terms of practical actions from this Group around the themes of seven day services, just a discussion around potential issues, an emotional reaction and possible advantages/disadvantages.

There was an emotive response, with this described as potentially being “horrible” and would require buy-in from the Consultant body.

A number of issues were discussed by this group. There was a debate as to whether seven day working is necessary. There was a discussion about the fact that there is higher mortality at weekends. The Group considered as to whether the financial implications had been considered and the fact that there is sometimes a struggle to provide emergency cover at the moment could seven day working increase the stress on the service?

There was a view as to whether the proposal to develop seven day working had considered the difference between emergency and elective treatment. There was also discussion about whether Primary Care colleagues were ready and prepared for seven day working. In addition, there is a requirement for downtime to enable theatres to undertake maintenance and housekeeping.

The advantages of seven day working were viewed as the following: reduce waiting times; reduce DNA’s; flexibility offered to changing population expectations/requirements and increasing capacity to offer a flexible service.

The disadvantages of seven day working were viewed as the following: there is potentially limited senior medical workforce availability at weekends; the potential cost of paying locums to cover the weekend; financially detrimental to the organisation, for example paying additional enhancements; undervalue the wellbeing of staff and the feminisation of workforce i.e. child care often not available at weekends.

**Group Four**

**Group Four was tasked with discussing:**

“What could the future medical workforce look like in terms of locums – 3 practical actions?”

There were a number of themes identified by this discussion. First, there was improving recruitment processes by sharing good practice of vacancy management in certain specialties and maybe by ensuring that there is a co-ordinator role in the department that helps to ensure that gaps are covered.
The other aspect of recruitment management is the issue of the recruitment process not starting until after the notice period has been completed. However, as soon as the resignation letter has been formally accepted the recruitment process can start. This should be communicated widely across NHS Grampian.

Another theme was whether it was possible to use in-house trainees instead of locums. This requires pro-active management whenever possible by the clinical lead to fill gaps. In-house trainees are preferable to externally sourced locums. Maybe there is a question as to whether to look at the pay rate which could be awarded for in-house trainees to ensure that it is financially attractive.

Encourage the local development of a clinical attachment database to fill gaps, i.e. those who have been in NHS Grampian on clinical attachment and might potentially be interested in a locum position. This could also be associated with a local Locum Bank and requires a conversation with service to explore alternatives to external locums.

**Group Five**

**Group Five was tasked with discussing:**

“What could the future medical workforce look like in terms of integration – 3 practical actions?”

The flow of patients between primary and secondary care requires further work, especially in terms of discharge. This is not just about shifting the bed blockage, but should be a focus of integration.

There are differences in cultures/language/roles between the different stakeholders involved in integration. This requires management and clarity and enhanced awareness in relation to joint reporting.

For the processes of integration to work, improved understanding of roles and what people do/contribute are required.

**Summary**

The workshop discussed the broad theme of “With the challenges we face what should the future medical workforce look like – 3 practical actions?”

Key themes included: meeting GMC Standards; robust implementation of the GMC Recognition and Approval of Trainers work-stream; maximise the capabilities of Physician Associates and Scientists; cultural aspects of seven day working requires further discussion; utilisation of in-house Doctors in Training or Career Grades rather than locums; development of locum bank and organisational development work in terms of integration.

Such actions require discussion with each individual clinical specialty.
Conclusion

The Secondary Care Medical Workforce Symposium has heard five presentations on medical workforce planning; workforce sourcing; the role of medical education and alternative models. The focus of the symposium has been to engage senior doctors; identify how to sustain the medical workforce; identify opportunities and risks and how to work collaboratively to solve them.

The presentation by Dr Annie Ingram provided information on the workforce profile of the Secondary Care medical workforce across Grampian. This information is included in the workforce profile for each specialty and there are potential opportunities/risks within each specialty’s workforce profile which requires further exploration.

Two workshops were held: one on improving our reputation and supporting our workforce supply and the second on with the challenges we face what should the future medical workforce look like.

From the first workshop, key themes included: marketing our unique selling points; creating an alumni database; enhancing culture via positive training and department experience; creating added value to working in Grampian via research and University links; team working and a sense of belonging; development of clinical attachments; knowledge of those STs about to CCT and utilisation of networks via social media.

From the second workshop, key themes included: meeting GMC Standards; robust implementation of the GMC Recognition and Approval of Trainers work-stream; maximise the capabilities of Physician Associates and Scientists; cultural aspects of seven day working requires further discussion; utilisation of in-house Doctors in Training or Career Grades rather than locums; development of locum bank and organisational development work in terms of integration.

Due to the proactive themes suggested as above and the potential opportunities/risks within each specialty’s workforce profile. A series of individual meetings will be initiated with each clinical specialty to assess the opportunities/risks around gaps in funded establishment and individual specialty actions required to provide service resilience.

Themes will emerge from these individual clinical specialty meetings that will support the progression of actions locally by Senior Doctors and corporately across the organisation in partnership with the Workforce Directorate.

This workshop report summarises the Symposium and identifies a number of themes for Senior Doctors and the Workforce Directorate to progress in partnership.
# Appendix One

Secondary Care Medical Workforce Symposium

**Thursday 26th March 2015**

**08.30 – 13.00**

**Med Chi, Foresterhill**

**Aberdeen**

## ATTENDANCE LIST

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Mr Ifran Ahmed</td>
<td>Consultant HPB Surgeon</td>
<td>Attended</td>
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<tr>
<td>Mr Kim Ah-See</td>
<td>ENT/Director of Undergraduate Medical Education</td>
<td>Attended</td>
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<tr>
<td>Dr Umesh Basavaraju</td>
<td>Speciality Registrar, Gastroenterology</td>
<td>Attended</td>
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<tr>
<td>Sean Berryman</td>
<td>Unit Operational Manager</td>
<td>Attended</td>
</tr>
<tr>
<td>Mr Pragnesh Bhatt</td>
<td>Consultant, Neurosurgery</td>
<td>Attended</td>
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<tr>
<td>Morag Bobacka</td>
<td>Service Manager in H @ N</td>
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<tr>
<td>Lesley Brander</td>
<td>Medical Education Quality Manager</td>
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<tr>
<td>Graham Brechin</td>
<td>Workforce Information Analyst</td>
<td>Attended</td>
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<tr>
<td>Dr Paul Broadhurst</td>
<td>Consultant Cardiologist</td>
<td>Attended</td>
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<tr>
<td>Andrew Bayliss</td>
<td>Consultant</td>
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<tr>
<td>Louise-Anne Budge</td>
<td>Support Manager</td>
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<tr>
<td>Dr Lesley Carson</td>
<td>Consultant Pathologist</td>
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<tr>
<td>Dr Richard Coleman</td>
<td>Director of Postgraduate Medical Education</td>
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<tr>
<td>Susan Coull</td>
<td>Head of HR</td>
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<tr>
<td>Ashley Catto</td>
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<tr>
<td>Amanda Croft</td>
<td>General Manager</td>
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<tr>
<td>Dr Phil Crockett</td>
<td>Consultant Psychiatrist</td>
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<tr>
<td>Dr Rebecca Docea</td>
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<td>Dr Callum Duncan</td>
<td>Consultant Neurologist</td>
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<td>Prof James Ferguson</td>
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<td>Dr Mahalakshmi Gurumurthy</td>
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<td>Dr Ann Hodges</td>
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<tr>
<td>Alison Hardy</td>
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<tr>
<td>Dr Annie Ingram</td>
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<td>Dr Peter Johnston</td>
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<tr>
<td>Mr David Lawrie</td>
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<tr>
<td>Gerry Lawrie</td>
<td>Interim Deputy Director of Workforce</td>
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<tr>
<td>Jane Lawson</td>
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<tr>
<td>Billie Lewis</td>
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<td>Joyce Leys</td>
<td>Healthcare Science Board Lead</td>
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<tr>
<td>Dr Alan</td>
<td>Consultant Rheumatology</td>
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<td>Fiona Mckay</td>
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<tr>
<td>Dr Margaret Mclean</td>
<td>Lead Consultant Psychologist</td>
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<td>Alistair McLennan</td>
<td>Consultant Gastroenterologist</td>
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<td>Anne Millar</td>
<td>NMAHP Workforce Manager</td>
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<tr>
<td>Dr Emma Metcalfe</td>
<td>Specialty Doctor GI</td>
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<tr>
<td>Dr Said Mishriki</td>
<td>Consultant Urological Surgeon</td>
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<tr>
<td>Dr Ashis Mukhopadhya</td>
<td>Consultant Gastroenterologist &amp; Honorary Senior Lecturer</td>
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<tr>
<td>Mr Euan Munro</td>
<td>Consultant Vascular Surgeon</td>
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<td>Julie Murray</td>
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<td>Prof Gillian Needham</td>
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<td>Fazeena Nawuwar</td>
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<td>Workforce/Information Manager</td>
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<td>Fiona Robertson</td>
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<td>Karen Shearer</td>
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<tr>
<td>Anna Simpson</td>
<td>Education Development Advisor</td>
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<tr>
<td>Dr Diane Skatun</td>
<td>University of Aberdeen</td>
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<tr>
<td>Kim Walker</td>
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<tr>
<td>Dr Steven Wilkinson</td>
<td>Consultant Group Clinical Director</td>
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<td>Dr Reddi Yadavali</td>
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<tr>
<td>Ruth Stephenson</td>
<td>Consultant Anaesthetics</td>
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