Royal College of Physicians

Response to *Facing the facts, shaping the future: A draft health and care workforce strategy for England to 2027*

1. The RCP welcomes this consultation and the commitment to take a long term strategic approach to service, financial and workforce planning. We look forward to coproduction of the strategy and operational plans following this consultation process.

2. We agree with the broad direction of travel and the common sense principles outlined. However, the document lacks detail so it will be important to consult with stakeholders on the first draft of a full strategy. If it does not, the government and its partners risk missing an excellent opportunity for consensus and coproduction.

3. Our main recommendations are

    a. the number of medical school places should be doubled to 15,000 per year, with the aim of a small surplus of supply
    b. we need to encourage doctors in training to take up posts in specialties and location with the largest gaps, by providing them with incentives such as protected time for leadership, education, training, research and quality improvement
    c. the UK should be more accessible to doctors and other professionals from other countries, with an immediate increase in the size of the Medical Training Initiative to 2,000 places
    d. we need to introduce more flexibility in terms of working patterns, regulation, moving between training programmes, moving between specialties, and meeting the aspirations of current and future professionals
    e. while we can and will act now, we need a single, robust source of data that brings together the various sets that tell us about how many people are in the system, how they move within it, and when and why they leave, to enable us to plan well for the long term
    f. there must be more investment in public health initiatives, including the public health workforce, that reduce demand.

4. The strategy will need to make clear how organisations will be incentivised and resourced to meet its aims. The RCP is encouraged by the fact this consultation has been jointly developed by the Department for Health and Social Care, HEE, PHE, NHS England, NHS Improvement, CQC and NICE. But it will need to be clear how progress against the strategy is collectively overseen.

5. When the draft strategy is published, the RCP expects to see a concrete plan for stakeholder engagement on both the strategy and subsequent operational planning.

6. Throughout this document we cite examples of the work we are doing to enhance education and training, improve morale and wellbeing, and help doctors relieve the pressure they are under. We look forward to working with the government and others, particularly in the areas of

    a. understanding demand and supply
    b. understanding the motivations and needs of doctors
    c. encouraging doctors in training to take up posts in specialties and locations with the biggest gaps
    d. portfolio careers
    e. credentialing
    f. Physician Associates
    g. multidisciplinary teams
    h. support for SAS grade doctors.

Do you support the six principles proposed to support better workforce planning; and in particular, aligning financial, policy, best practice and service planning in the future?

7. The RCP broadly supports the principles, subject to comments below. But achieving the vision they express will be difficult in a service that is under significant pressure. NHS Improvement data shows that 1 in 11 NHS posts are unfilled, including 12% of nursing vacancies and 8% of doctor vacancies.

8. In our annual census 2016-17

    a. 24% of consultants reported that trainee rota gaps occur ‘frequently’ or ‘often’, with gaps most frequently in geriatric medicine, respiratory medicine and acute internal medicine
    b. 1,542 consultant jobs were advertised, but only 853 certificates of completion of training were awarded
    c. 45% of consultant posts were not appointed to, 65% due to no applicants and 19% due to no suitable applicants
    d. the lowest rates of appointment success were in geriatric medicine and acute internal medicine.

9. Particularly problematic is the strategy's focus on reducing reliance on staff from other countries. The simple fact is, we do not have enough UK trained doctors. Until we do, we must make sure we can recruit staff from other countries to reduce the pressure on the system.

10. If that pressure is not relieved, the NHS will be unable to become the inclusive modern model employer envisioned in the consultation document. When you're fighting to keep your head above water, it's not possible to improve your swimming technique.

Securing the supply of staff

11. The RCP believes we should invest more in developing the home grown workforce. But we question the assertion that the NHS draws "staff from other countries in large numbers just because we have failed to plan and invest." The NHS benefits from people who have different training and life experiences, just as other countries benefit from their citizens training and working in the NHS.

12. The UK operates in a global marketplace, and if we are to promote UK plc after we leave the EU we need to make sure the UK is accessible. Key to that is recognising the mutual benefits of immigration.

13. We need to urgently

    - include more medical specialties on the shortage occupation list, particularly geriatric medicine, respiratory medicine and acute internal medicine
    - exclude roles that are on the shortage occupation list from the Tier 2 visa Certificate of Sponsorship (CoS) allocation process
    - increase the number of CoS available to the Medical Training Initiative to 2,000 and keep it under annual review
    - establish a scheme similar to the MTI for people from countries, such as Australia, that are not on the DfID priority list nor classed as low or lower middle-income
    - streamline the process for registering doctors who trained in other countries.

Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff

14. The RCP believes we should introduce accreditation of prior learning, to allow doctors in training to move between specialties where desirable. There should be more dual training in generalism and specialty, without a reduction in the length of training.

15. There needs to be more training posts in hospital based specialties, especially general medicine, acute medicine, geriatrics and doctors dually accredited in general internal medicine.

16. More resources should be invested in training and educating Physician Associates. Demand for such training should be increased by promoting the role to both potential professionals and the organisations that could benefit from them.

Providing broad pathways for careers in the NHS

17. The RCP agrees NHS staff should have more opportunities to develop their skills and experience. In a recent survey of members, we found that

    - 56% of doctors undertaking research do not have protected time for it
    - 54% of doctors undertaking leadership do not have protected time for it
    - 45% of doctors undertaking education and training do not have protected time for it.

18. In our wellbeing snapshot survey, doctors told us they want more protected time for activities such as leadership, education, training, research and quality improvement. Trusts need to work with their teams to provide this time. With rotas under extreme pressure, we recognise the difficulties of doing that, but our chief registrar programme has shown it is possible. Our forthcoming portfolio career project seeks to do something similar, but with the addition of attracting people into specialties and locations that have the largest gaps.

Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare

19. The RCP believes the NHS, like every organisation, should be an accessible and inclusive employer. More should be done to encourage people from under-represented groups, particularly lower socioeconomic groups, to take up medicine. People in other healthcare professions could be encouraged to transfer to medicine, which would also help increase interprofessional understanding and learning.

Ensuring the NHS and other employers in the system are inclusive modern model employers

20. The RCP believes the NHS needs to better understand the motivations and experiences of all its staff, and introduce ways of retaining them. It can learn from the Royal Colleges and other professional associations. We have found from our research that the essence of the approach must be flexibility.

Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested

21. The RCP believes it is not possible to meaningfully consider service, financial and workforce planning separately. Planning must also consider national, regional and local needs and conditions, both in terms of the workforce and the population.

22. Central to the success of this strategy is robust data. While we can and will act now with what we know, we cannot model and plan for the future accurately if we do not understand the present and recent past. For example, we need a clear understanding of how many staff and from what disciplines will be required to make the service sustainable and viable over the next two decades.

23. That means a single source of data in which everyone can have confidence. The development of that data requires the collation and analysis of the various data sets held by all stakeholders.

24. We need to know how many posts exist, how many are filled and by whom, in both training and non-training grades. We need to know how and why people move within, and leave, the system. Only when we understand what is happening and why will we be able to solve problems of recruitment and retention.

Do you feel measures to secure the staff the system needs for the future can be added to, extended or improved, if so how?

25. The RCP agrees we need to train more UK doctors, but we should also recognise the essential role played by people from other countries. Doctors from around the world are valuable members of our workforce, bringing with them different experiences and perspectives. We should build on the value and benefits of knowledge and skills exchange in creating and delivering excellence.

26. Complete self-sufficiency is an unrealistic aim. Since the foundation of the NHS, doctors from overseas have been a crucial element of its workforce. The RCP therefore questions why the aim has been included in this document, without any analysis of whether or not it will have any benefits for patients, citizens in general, the workforce, the NHS or UK plc.

27. In terms of training UK doctors, the RCP believes we need to plan for a worst case scenario, as opposed to a best case scenario. Taking into account likely demand, attrition, changing demographics and working patterns, and retirement, the number of medical school places needs to be doubled to 15,000 per year.

28. At the same time, we need to be sure there are enough foundation doctor posts available. Particular attention should be given to creating these posts in areas and specialisms that have the largest gaps. Incentives should be created to encourage people to work in these areas, as we are piloting through our chief registrar programme and forthcoming portfolio careers project.

29. Credentialing and transferable qualifications need to be clearly defined and piloted before we know if they can help. There is likely to be significant scope in some medical specialties, but not all, and it is not a replacement for high-quality structured speciality training.

30. Employers need to be flexible enough to retain older doctors. They need to actively support portfolio careers after the age of 55 with the objective of keeping doctors working until they are 65. In April the RCP will publish guidance on supporting people to keep working later in their career. Anecdotally, changes to pension rules are reported as one of the drivers for early retirement. The government may wish to explore this.

31. Physician Associates and other medical associate professions are a key element of the solution as part of a multi-disciplinary team. By freeing up consultants and doctors in training they increase access to quality care for patients. They act in an enabling role, helping to reduce the healthcare team's workload, and bring new talent to the NHS, adding to the skill mix within the teams. Through the Faculty of Physician Associates the RCP is increasing understanding of what PAs are and can do. These efforts need to be scaled up so more organisations can benefit from their membership of the workforce.

Do you have comments on how we ensure the system is effectively training, educating and investing in the new and current workforce?

32. Until the pressure is reduced by the recruitment of more doctors we will not be able to ensure the workforce is being effectively educated and trained.

33. As the RCP said when the UK Shape of Training steering group made its statement in 2015, we agree that we need more doctors with the general medical skills to care for the increasing numbers of patients coming to hospital with multiple medical conditions, particularly frail older patients. To train a good doctor who can provide generalist care together with specialist expertise requires adequate time.

34. We are against any shortening of training, as this would affect the quality of the care our doctors can provide. We were pleased that the announcement did not suggest a reduction in the number of years needed to train a doctor.

35. Medical associate professionals, such as Physician Associates, must be regulated. Regulation will ensure education and training, and therefore the professionals, meet the standards required by services.

What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

36. In recent years the RCP has been told time and again by its members that morale is low and dropping. The main reason is pressure of workload. It forces doctors to act down and doctors in training to take on more than they should. It means there is no time for activities other than direct clinical care, such as research and education. These are things that are valued by doctors and attract them to the career in the first place.

37. There needs to be a focus on improving morale and wellbeing that begins with reducing this pressure by recruiting more doctors. But it also needs to include

    - improving mutual understanding and working practices in multidisciplinary teams
    - improving understanding between clinical staff and management, through initiatives such as Schwarz rounds and interprofessional learning
    - providing adequate resources in workplaces, including 24 hour access to food and water, and rest facilities
    - designing shift patterns with rest and circadian patterns in mind, educating doctors about sleep hygiene and making sure they are able to take protected breaks and do.

38. There should be investment in initiatives that make careers more attractive. The RCP chief registrar scheme supports aspiring clinical leaders to develop the skills they need for consultant posts in the short to medium term. It also gives them the confidence and profile to pursue local and national senior leadership roles in the future, such as medical director and chief executive. Such a scheme could be rolled out in non-medical specialties and other areas, such as research, education and audit. These programmes should count towards training and extend beyond a single year.

39. The RCP is developing a flexible portfolio careers project. It will incentivise doctors in training to take up roles in specialties and locations that have the largest gaps. It will do that by providing with protected time to clinical informatics, education, leadership or research.

Do you have any comments on how to better ensure opportunities to, and meets the needs and aspirations of, all communities in England?

40. Medical schools, training providers and NHS organisations should focus more on local recruitment. This could begin with outreach to schools.

41. Education and training need to be more accessible. There should be part time medical school places and training should be delivered flexibly.

42. How medical schools recruit could be reviewed. The current focus is on people who perform well academically. A great focus could be given to identifying people who, while they may not be the strongest academically, possess other strengths, such as the psychological profile of a caring and patient-centred clinician.

What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?

43. A modern, model employer, first and foremost, is flexible. It understand the motivations and needs of its staff. It understands the needs and likely demand of people who use its services. It ensures it has enough people to deliver the service it aims to deliver. It makes sure everyone's workload is manageable, that they have development opportunities and the time to take them up, and that they feel valued.

44. If an employer does not have enough people, it cannot make these things a reality. If it cannot make these things a reality, it cannot protect the wellbeing of its staff, and morale will worsen.

45. This is why we need to maximise recruitment of doctors from outside the UK immediately. It will relieve short term pressure so we can focus on making the service sustainable in the long term.

Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?

46. We are not allowing NHS doctors, who have benefited from some of the best medical education in the world, to deliver the standard of care they were trained to deliver. Consultants regularly act down to fill rota gaps, and doctors in training are placed in situations that are unsafe for patients and themselves. This is both inefficient and ineffective.

47. Flexibility, effective deployment, and a greater focus on the health and wellbeing of patients will only be possible when we properly invest in health and social care. That funding must be enough to meet patient need, and there must be more investment in public health initiatives, including the public health workforce, that reduce that need.

48. There is growing evidence that the best performing hospitals are managed by doctors. There needs to be a greater emphasis on leadership and management training for doctors in training and consultants. That means protected time for non-clinical care work, access to more CPD, and schemes such as clinical fellows. The Faculty of Medical Leadership and Management, and similar organisations for other professions, should lead this work.

49. The lack of social care provision is adding to the pressure on hospitals. The government's green paper on proposals to reform care and support for older people is urgently needed. The RCP believes it must take a broad view, including residential homes and home care provision, but also wider community-based support that enables people to live well at home.

50. The RCP agrees more should be done to support and value the SAS workforce. The reality is that employers are experiencing difficulty in recruiting to SAS posts, particularly in Anaesthetics, Emergency Medicine, Paediatrics and Psychiatry. Employers are finding it hard to retain SAS doctors due to low morale. Unless issues of career development and progression, CESR process, recognition and status, pay and workload are addressed, it is unlikely that doctors will either want to join or remain in the SAS grade in significant numbers. The first step is to start a discussion with SAS doctors about what is needed, which we will be happy to facilitate.

51. If you have any questions or need more information, please contact Dan Sumners, senior policy adviser, via dan.sumners@rcplondon.ac.uk or 020 3075 1727.