Academy of Medical Royal Colleges

Workforce: recruitment, training and retention in health and social care Inquiry

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This is a response to the UK Parliament Health and Social Care Committee Inquiry into Workforce: recruitment, training and retention in health and social care.

Introduction

The Academy of Medical Royal Colleges is the representative body for medical royal colleges and faculties in the UK. We speak on standards of care and medical education across the UK. By bringing together the expertise of the medical royal colleges and faculties we seek to drive improvement in health and patient care through education, training and quality standards.

Given the Academy's remit, our submission focuses on the medical workforce, but it also considers broader issues relating to recruitment, training and retention of staff across health and social care.

Summary of evidence

Workforce pressures are the greatest challenge facing health and social care today. Attracting and retaining high-calibre and appropriately trained professionals is crucial to ensuring a sustainable health and care system across the four nations. In the short term, this requires immediate action to tackle staff shortages and attrition. In the longer term, it requires a transparent approach to workforce planning which considers workforce supply, patient demand, and new ways of delivering care.

Steps to recruiting extra staff

The widespread and persistent staff shortages across health and social care require a strategic approach focused on both tackling immediate vacancies and longer-term arrangements for workforce planning.

The recent increase in medical school places has been welcome but we firmly believe there is need for further expansion. The Academy recently supported a call from the Medical Schools Council (MSC) for a significant expansion and individual colleges have made assessments of the numbers of additional places required.

There is a significant 'lag time' between entry into medical school and the completion of specialty training. The increase in student places must be matched by expansions to the number of Foundation Programme and specialty training places, to ensure there is a smooth flow through the training pipeline. This is crucial if we are to stem attrition and make sure that additional medical students result in an expanded medical workforce.

As well as increasing the number of doctors, there needs to be more imaginative and effective use of all clinical staff. Healthcare professionals should be enabled to work at the top of their scope of practice and expertise. This allows clinicians to focus their time on what they alone are trained to do, while tasks that other practitioners are skilled and trained to do can be undertaken by them. Effective workforce optimisation releases time for care. With more health and care tasks being delivered by other groups – such as Medical Associate Professionals (MAPs) and Advanced Clinical Practitioners (ACPs) – it is likely that doctors' remit will increasingly shift towards leadership, support on complex clinical matters, and care to patients with the most complex needs.

The staff groups needed and the skill-mix required will change over time. As well as recruiting for and training new roles, it is important to focus on the continuing development of current staff so they can adapt to changing practices, work to the top of their competence, and find work meaningful and rewarding. Full restoration of the CPD budget within HEE is critical to enabling this.

Across health and social care, there is widespread support among stakeholders for the Health and Care Bill to be amended to strengthen workforce planning arrangements in the longer term. The proposed amendment would require the Health and Social Care Secretary to publish independent assessments of current and future workforce numbers every two years. This would increase transparency and accountability on whether we are training enough staff to meet future demand.

Workforce planning must not focus solely on current vacancies and staff numbers but should consider a range of factors, such as: changing patient needs (with health inequalities and an ageing population); new models of care and ways of working (including increased use of technology and multi-professional teams) and increasing demand for flexible working.

Balance between domestic and international recruitment

The UK is not self-sufficient in producing health and care staff to meet patient demand. Overseas-trained doctors and other staff form a significant part of our workforce, and will remain crucial to the delivery of care in the future. Even with greater investment in UK education and training and incentivisation of domestic recruitment, there is a substantial 'lag time' needed to train healthcare professionals. Further, staff from countries beyond the UK bring a wealth of skills, experiences and attributes that enrich professional life and clinical practice and which enable the workforce to better serve the needs of diverse patient communities.

The Medical Training Initiative (MTI) is an important component of ethical international recruitment. This scheme allows doctors from across the world, particularly DfiD priority countries, to work and train in the UK for up to two years before they return to their countries. The doctors benefit from training in the NHS, while their home countries can benefit from the skills and experience they have obtained in the UK. An expanded MTI scheme would bring even greater benefits to both the UK and overseas health services. MTI doctors coming in on Tier 5 visas have to pay the NHS surcharge and then seek to reclaim unlike all other healthcare staff from overseas and this inequity should be rectified.

There must be greater support for staff from overseas once they are in post. There is important work underway by the GMC to improve induction processes for internationally-recruited staff, and efforts by various stakeholders to tackle bullying and harassment, which disproportionately impact those from minority ethnic backgrounds and overseas-trained staff. We would also welcome work to streamline the CESR process to ensure it is straightforward for International Medical Graduates (IMGs) with the requisite competencies to join the Specialist Register, if they choose to do so and meet the relevant criteria.

It is neither ethical nor sustainable to over-rely on international recruitment and more work should be done to increase our domestic supply of suitably trained health and care staff. Further increases in the numbers of medical school places across the UK are required, and this should include broadening the pool of future doctors to include those from widening access backgrounds. The Academy is feeding into discussions about Medical Doctor (Degree) Apprenticeships, which will provide another opportunity to broaden access to medicine.

Initial and ongoing staff training

Long-term workforce projections

There is presently no effective system for determining how many doctors, nurses and allied health professionals (AHPs) should be trained to meet long-term patient need. As

outlined, there is a pressing requirement for current and future projections of workforce supply and population health demand. This work should be undertaken at a national level and draw on expertise and data sources from organisations such as the colleges and faculties, trade unions, and HEE.

Curricula and skill-mix

The curricula for doctors, nurses and AHPs are updated to reflect the changing needs of the healthcare system. Regular reviews of curricula are important to ensure staff have the right mix of skills to support patients. Formally revising and approving curricula can be time-consuming, however. It is therefore important that curricula remain agile so they can adapt to an evolving healthcare environment while continuing to ensure patient safety.

The Academy and colleges are closely involved in discussions with HEE and the GMC about 'generalism' in medical practice and training. There is broad consensus on the value of a generalist approach but still considerable work to be done to determine what this actually means in terms of specialist training. It is important to be clear that promoting generalism does not dispense with the need for doctors with highly specialised skills and expertise. These approaches are not mutually exclusive but complementary.

Additional material cannot keep being added to curricula. This request is often the response to many perceived failings, but it can be a simplistic and sometimes impractical approach.

Credentialling can also be an important way to offer training and/or upskilling where there is not currently a pathway in place.

Training period for doctors

The Academy supports the shift to outcome-based rather than time-based training. The move towards recognition of competences rather than time served is reflected in medical curricula, though progress has been variable. System-wide acceptance of this paradigm shift is needed so it becomes a reality.

Training time can remain very long for those less-than-full-time (LTFT). Professor Dame Jane Dacre's *Mend the Gap* report suggested this was a contributory factor to the gender pay gap in medicine. The Academy supports a more flexible and individually tailored approach to LTFT training which would help doctors and the wider healthcare system.

When considering any reduction in training time, the driver must be a clear assessment of what is actually required of CCT-level doctors rather than just a desire to reduce training costs. (Indeed costs will not be reduced if trainees move to consultant posts more quickly.) It is also important that trainees have sufficient time to gain confidence (as well as competence) to manage patient complexity and risk. This is particularly crucial in craft specialties where 'hands-on' experience is so vital.

Cap on medical student places

The Academy has called for a substantial expansion in medical school places to ensure a modest oversupply of doctors (as in our joint statement with the MSC). Staff involved in training the future workforce must be given sufficient time and support to manage the additional work created by this expansion. As emphasised, increases in medical student numbers must also lead to more resourcing to increase the number of Foundation Programme and specialty training posts. While some doctors choose to take breaks in their training or pursue SAS (Specialty Doctor, Associate Specialist and Specialist) careers long-term (and should be supported to do so), those keen to progress in their training but who are unable to risk becoming a 'lost tribe'. This can have a negative impact on staff retention, as trainees unable to progress may leave the NHS.

Alongside increases to medical school and training places, it is important to develop the training and utilisation of the wider multi-professional team. Nurses, AHPs, MAPs, and other roles are crucial to help ensure a diverse skill-mix that can provide appropriate support to patients with a range of different needs.

Factors driving staff attrition

The principal factor driving people to leave the NHS and social care is the challenging workload caused by increasing staff shortages, patient demand, and under-resourced services. These conditions were true before the pandemic and pressures have only intensified in the last two years with the COVID caseload and substantial backlog.

There are a number of measures that might be taken to tackle these pressures, as set out in our recent proposal for short-term workforce solutions. Employers have a critical role in improving the day-to-day experiences of staff to make sure they feel valued and respected in the workplace. The culture also comes from the top, however, and the Government and national organisations have important parts to play in creating a culture in which all staff feel their hard work is recognised and appreciated.

There is increasing recognition of the need for the NHS to address issues around equality, diversity and inclusion. Failure to do so has a corrosive effect on staff experience and ultimately the quality of care provided.

Further actions to improve the culture include:

- Greater flexibility in training and working. This is essential both for recruitment and retention.
- Enhancing support for trainee doctors who do not progress directly from foundation to specialty training (or through specialty training), but who wish to remain in medicine.
- Offering more innovation in training pathways and providing personalised training.

- Improving recognition and development opportunities for the SAS workforce, making this a viable career path.
- Improving facilities and resources for NHS staff, from access to rest spaces and refreshments to modern technology.
- Supporting staff approaching retirement who wish to remain in the NHS but work differently. E.g. Older doctors may want to shift their balance of clinical and non-clinical responsibilities.
- Allowing doctors time to conduct research and ensuring the availability of appropriate clinical training and job opportunities for those entering academic careers.

For senior doctors there are specific and well-documented problems over NHS pension arrangements which are driving staff to leave. We acknowledge the steps that have been made by the Government but the problems are not solved. Pension arrangements that make it financially unviable for doctors to continue working make no sense at a time when we want to increase the workforce and retain doctors. This is a problem of the Government's making and the solutions are in their hands.

Issues with recruitment to specific roles and geographical locations

There are workforce shortages across the system, but the gap between supply and demand is particularly acute in some specialties, roles, and locations.

There are significant shortfalls in psychiatry, geriatric medicine, general practice, ophthalmology and social care – among other specialties – which are likely to intensify with the demand generated by an ageing population.

The pandemic has also revealed the significant undersupply of anaesthetists and trained intensive care medicine specialists. The Intensive Care National Audit and Research Centre reports have illustrated significant regional differences in critical care admissions with COVID-19. Addressing regional differences in critical care capacity requires increases in regional multidisciplinary staffing.

The acute issues in psychiatry have been recognised in recent years (as in the Five Year Forward View and Long Term Plan). However, medical workforce expansion has not kept pace with service expansion, partly due to the 'lag time' between recognition of shortages and the time needed to train doctors. The system must learn from these lessons before implementing reforms to the Mental Health Act and mental health access standards.

There are also shortages in many geographic regions of the greatest need and staff distribution is a crucial component of workforce planning. Health inequalities are most acutely felt in remote and rural, coastal and inner-city areas which experience the highest

levels of deprivation. Many of these struggle to attract and retain doctors. In recent years there have been welcome efforts to tackle these problems, from HEE's work on the geographic distribution of training posts to local initiatives to recruit and retain staff in remote and rural locations. More work is needed to incentivise living and working in under-resourced areas, however. These may be unattractive to staff due to reasons beyond health and care employment, but which are pertinent to family and personal life (e.g. housing, education, public transport, amenities).

The People Plan and recruitment, training and retention

The Academy has welcomed previous versions of the NHS People Plan (and similar initiatives in the devolved nations). It provides a helpful framework for tackling many workforce issues, and presents an admirable vision for treating and valuing healthcare staff. As indicated previously, however, we remain concerned about the lack of detail regarding workforce planning. Tackling workforce shortages is key to bringing about positive changes to workplace cultures and staff morale.

Since the publication of the last People Plan (July 2020) there have been some developments in discussions about workforce planning, including HEE's Long-Term Strategic Framework 15 review, and debates during the reading of the Health and Care Bill about the Health and Social Care Secretary's potential role in and responsibility for workforce projections. The merger of NHS England and HEE presents an opportunity to unify discussions about workforce, service and financial planning but there is a risk that HEE's ability to provide an independent voice on workforce issues may be lost.

For any future development of the People Plan to be meaningful, there must be a commitment to long-term workforce planning to ensure that ambitions for improving the experiences of working in health and care can become a reality. Tackling the issues identified here requires much greater clarity about how workforce planning will be taken forward and who will be responsible for it.

Contractual and employment models

While contractual models and employment conditions fall outside the Academy's remit, we recognise that workplace cultures and practices are important to attracting, training and retaining staff. As indicated, improved opportunities for flexible training and working are paramount. Workplans and contracts must also provide sufficient time to allow for education and training, supervision, research, CPD and other professional duties to enable doctors to have rewarding and varied workloads. We would reiterate the need to ensure that pension arrangements support medical staff retention.

Integrated Care Systems (ICSs)

The Academy and its member organisations strongly support the direction of travel towards greater integration across care systems, as emphasised in our submission to the DHSC inquiry into the health and social care white paper. We welcome the development of ICSs and greater integration both within the NHS and between the NHS and local government, which present vital opportunities to drive patient outcomes and improve health inequalities. Clinical engagement and leadership in ICSs is key to bringing about these changes. We want to see that engagement becoming a reality. Colleges will want to work with NHS England and ICSs locally to ensure this happens.

Integrated Care Boards (ICBs) will have a significant role to play in workforce planning and strategy at regional level. They can identify local population health needs and seek to address specialty shortages. However, ICBs will not have the levers necessary to make high-level policy changes. They cannot ensure national investment, expand and redistribute training places, or amend immigration policies, for instance. Neither can they bring about systemic changes that affect recruitment, training and retention across the four nations. While we welcome ICBs' role in driving local assessments of workforce supply and demand, there remains a pressing need for responsibility and accountability at national level when it comes to long-term projections and planning. Greater clarity is therefore needed on how the activities of ICSs and ICBs will form part of a national workforce strategy.

Conclusion

The Academy would be happy to expand on any of these issues in oral evidence.