Royal College of Physicians of Edinburgh

Scottish Government
National Health and Social Care Workforce Planning: Discussion Document

Question 1. Are these roles the right ones, or do you have an alternative model? What steps will be needed to ensure these proposals are fully effective?

The Royal College of Physicians of Edinburgh ("the College") has sought views from both Fellows across various medical specialties and from our Trainees and Members' Committee to inform our response to this call for views. The College is an independent clinical standard-setting body and professional membership organisation, which aims to improve and maintain the quality of patient care. Founded in 1681, we support and educate doctors in the hospital sector throughout Scotland and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties.

In general, colleagues were supportive of the proposals and roles described in the document, however concerns were raised about the the lack of resources available to implement these ideas; the measurability of the proposals and the level of detail provided. The College looks forward to the forthcoming publication of the Scottish Government's National Health and Social Care Workforce Plan in this regard.

The view was expressed that it would be helpful to include greater recognition of the age profile of the workforce; the increase in the uptake of less than full time (LTFT) working patterns; the impact of health and social care integration on the workforce and a stronger focus on recruitment and retention issues including addressing the loss of trainees to countries overseas. Trainees expressed the view that they generally do not feel included in workforce discussions and would welcome the opportunity to engage further on this.

Question 2. How can organisational and individual collaborative working be improved, and barriers removed, so that workforce planning can be effectively co-ordinated to ensure people get the care they need where and when they need it:
- Nationally?
- Regionally?
- Locally?

Increased engagement with the College, including the Trainees and Members Committee, and other

professional healthcare bodies as part of collaborative working to discuss workforce planning would be welcomed.

Fellows have indicated that a significant challenge to collaboration is the cultural gap between health and social care, which acts a barrier to genuine integrated working and workforce planning across the sectors and at all levels. Reference to the patient journey as described at question 4a would also be beneficial.

Question 3. How should workforce data be best collated and used to undertake workforce planning in an integrated context based on current approaches of a nationally-led NHS system and a locally-led care system?

The College highlights Focus on Physicians, the latest census of consultant physicians and higher specialty trainees in the UK (2015/16). Produced by the Royal College of Physicians, the Royal College of Physicians of Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow, the census emphasises the growing pressure in the NHS and the effect this is having on an ageing workforce.

The annual census measures the number of UK consultants and higher specialty trainees in all medical specialties, as well as capturing the views of those in the profession. In 2016, the Federation of the Royal Colleges of Physicians introduced a new format for the Census of Consultant Physicians and higher specialty trainees in the UK opting to conduct a shortened core survey of all consultants and trainees. The results are scheduled to be published in April 2017. Primarily the reasoning behind the change was to achieve a faster turnaround time of results and to avoid survey fatigue within the physician population.

In addition to the annual census, there will also be a number of smaller snapshot surveys undertaken in 2017 to sections of the physician workforce. The first of the snapshot follow up surveys took place in January of this year on the issue of rota gaps, with a third of UK consultant physicians surveyed. The College suggests that this continues to be an integral part of any workforce data considered at a national level in Scotland.

The Joint Royal Colleges of Physicians Training Board (JRCPTB) are also currently examining the workforce data that they hold for physicians across the nations of the UK and are undertaking assessment of it.

Question 4a). How might employers and other relevant interests in the Health and Social Care sector work, jointly and individually, to identify and tackle recruitment and retention issues, ensuring priority gaps are identified and addressed:
- Nationally?
- Regionally?
- Locally?

The medical workforce faces a number of challenges and the College recognises the need for safe and sustainable staffing levels throughout the NHS. We need to ensure that we continue to recruit and retain a world class workforce to deliver the best possible patient care. The College is committed to working with Government and other allied organisations to address issues around recruitment and retention such as consultant vacancies, rota gaps and trainee attrition rates, as a matter of priority.

Moving towards a patient centred approach to workforce planning would assist significantly. An increasing proportion of our population are ageing, and with multiple co-morbidities. If workforce planning could map out the true optimum patient journey and all the healthcare professionals they would need to see and frequency in which they would come in contact with them, on a 'worst case' or 'best case' scenario, then NHS Scotland may see a more accurate reflection of the number of workforce professionals required. At present the system tends to reinforce working in silos or seeing organs specific diseases rather than the multi-morbidity and multiple complex diseases which many patients now have.

The College would welcome additional recognition of the increasing movement to less than full time working; the ageing workforce and the current pressures placed upon those working at the frontline of both health and social care. Collaborative working will help to address this: we are committed to working with partner organisations to promote innovative ways of working in the NHS. The roles of Physician Associates, Advanced Nurse Practitioners and other examples of physician extenders should be further examined to create a workforce fit for the future.

Fellows have commented that there needs to be recognition that health and social care in its current form is not sustainable. This should be debated widely and consideration should be given to which, if any, activities and practices should be reviewed and how integration could help to address these, reiterating the vital need for culture change within health and social care.

Question 4b). Are there any process or structural changes that would support collaborative working on recruitment?

As mentioned above, however the College also suggests partnership working with specialist societies, such as the British Geriatric Society, which are also examining workforce data and future requirements according to patient need.

Question 5. Based on what is said above, would it be helpful at national level to have an overarching process (or principles, or framework) for workforce planning across the Health and Social Care sectors?

The integration of the policy for health and social care workforce implies that there will be flexibility of role across these services. Once health and social care is genuinely integrated this is likely to be an obsolete view, and as such, it may be preferable to have a role based strategy (eg. for allied health professionals (AHPs); for doctors; for paid carers).

Recruitment and workforce planning should start early and ways need to be found to make working in healthcare - particularly nursing - and in many aspects of social care more attractive to young people. This could include promotion of clear career structures; flexibility of work life balance and competitive remuneration.

Fellows commented that a national workforce planning strategy seems to infer that individuals will move freely from locality to locality or region to region to work - or be prepared to do so. History does not tell us that that is likely to be the case. Regional differences in employment patterns must be taken into account if patient needs are best met - even if that leads to a doctor/AHP/social worker in Region A being paid more or having different terms and conditions of service than their colleague in Region B.

There also needs to be a regional focus on recruitment allowing flexibility for doctors in training. A national recruitment process is already in process for doctors in training so this question may not be relevant; however regional areas also need to have the opportunity to recruit at different points outside of this national recruitment process particularly to Locum Appointments for Training (LATs).

Question 6a). How can a more coordinated and collaborative approach be taken to assessing student intake requirements across all relevant professions, and what other issues should be addressed to remove barriers to successful workforce planning?

Workforce planning has always focused on the minimum number required. However, NHS staff have their own work-life and health to balance and what might be possible for an individual to do in the early stages of their career may not be possible after some years due to, for example, caring commitments.

Less than full time working is increasing and needs to be given adequate recognition to ensure there are the necessary number of medical students in training. As medical professions can take a number of years to train, programmes which allow valued doctors from across the world access to work in Scotland – such as the Medical Training Initiative (MTI)- will be ever more important. Doctors from EU countries also seek reassurance about their position post-Brexit. Brexit could have significant implications on the workforce in Scotland and having a positive approach from the Scottish

Government ensuring the rights of EU doctors working, and EU medical students training, in Scotland would be welcomed.

Question 6b). What other issues should be addressed to remove barriers to successful workforce planning in both health and social care?

Workforce planning could be improved for doctors in training in Scotland: there is still not enough recognition of the number of doctors in training who wish to work less than full time due to balancing work-life commitments (both male and female doctors). If this could be promoted, it would help make a working environment that is more nurturing and prevent physician burn out.

The migration of medical trainees away from Scotland has happened for many years. Their decision to leave may not simply be based on the attractiveness or availability of posts in Scotland but on other factors, for example, the College is aware of trainees who leave due to inflexibility in the system – such as partners having jobs in other locations and the doctor in training being refused a transfer within Scotland. Recruiting and retaining trainees, or matching patient need to supply of doctors, is about more than mathematical precision in recruitment, but offering attractive, flexible, well paid jobs to highly qualified individuals - wherever in the world they trained.

There is a plan to make a single employer across NHS Scotland for doctors in training. However, many trainees are concerned about this being rushed in for August 2017 and also protection for trainees not being forced to move to a different location (and the potential upheaval this would entail for them and their families) to cover areas short of doctors in training.

Workforce planning in the social care workforce is much more affected by economic considerations, often regional, and primarily relating to remuneration. If these are not taken into account then there may be considerable difficulty in recruiting sufficient individuals into many roles. The implications of Brexit must also be taken into account in this regard.

The document comments on rising standards and expectations about quality of care from the public and the Government –however there is no specific mention of “realistic medicine” in the consultation, despite the CMO’s commitment to this. The document would be strengthened by reference to realistic medicine and its implications for the health and social care workforce.

Issues such as remote and rural healthcare; GP recruitment and recruitment and retention are underrepresented in the document and require further specific focus. In general, this active approach, both at broad strategic level but also with commitment to drill down into specific issues, is commendable and coherently highlights a number of difficulties and issues that warrant recognition and further work.