ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

The Royal College of Physicians and Surgeons of Glasgow was founded in 1599 to improve quality and practice of Medicine.

Although based in Glasgow we have 14,000 Fellows and Members who work as senior clinicians throughout the United Kingdom and across the world. Unlike our sister Royal Colleges, we have a multidisciplinary membership, which we believe gives us a more complete viewpoint of the health environment and the needs of patients and medical professionals.

Do you support the six principles proposed to support better workforce planning; and in particular will the principles lead to better alignment of financial, policy, and service planning and represent best practice for the future?

The six principles are:

1. Securing the supply of staff that the health and care system needs to deliver high quality care in the future. Since the NHS began patients have been well served by staff from around the world. However, maximising the self-supply of our workforce is critical. It cannot be right for the NHS to draw staff from other countries in large numbers just because we have failed to plan and invest.

The principle to reduce the use of an international workforce which superficially is attractive has the potential for unintended consequences. Irrespective of careful planning, workforce needs have been previously very difficult to predict. Additional challenges such as the demographic of the workforce, the lack of progression of junior trainees into higher careers, the ageing population, the impact of new treatment modalities e.g. biologic drugs, genomics or robotics and the rise in obesity could all significantly and adversely impact on the success of future planning. Limiting the connection of the international community to the UK workforce could have long lasting deleterious consequences.

Moreover, the vital research connections outlined in principle 6 of the 'global healthcare workforce' have to date been significantly enhanced by the affiliation created during the undergraduate study of international students who have then returned to their parent country and maintained strong research collaboration with the UK.

Such international students, currently studying in the UK have chosen to do so, on an understanding that they would leave the UK with a registrable qualification. Denying them access to Foundation posts removes this and will significantly reduce future international student applications to the UK, especially those best able to afford to do so without harm to overseas healthcare delivery. In turn this will have the potential to harm UK undergraduate programme delivery as income from international students helps to offset University deficits currently incurred by serial reductions in SIFT.

The suggested move of the point of registration to remove the need for international students to undertake a post graduation year is ill conceived. The assessment of doctor performance in real practice, under the challenging conditions of responsibility for patient care, is completely different to that of assessment while a student. Patient safety in the UK demands the level of scrutiny afforded by such real-work assessment prior to full registration and UK undergraduate programmes are not currently equipped to provide this. The proposed Medical Licensing Assessment GMC (which could apply to all graduates) will not replace this important assessment in real practice.

Programmes such as the Medical Training Initiative will also train doctors for Health services which may be poorly developed in other countries and is part of a global health strategy.

Whilst increasing the number of available staff is admirable, this may not be technically possible, it is has proven impossible to match supply with demand and using staff from other countries allows an increase in more junior grades without increasing higher grades (such as Consultants in the case of Medical staff).

2. Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff. Individual NHS professions have distinct roles but there is scope for more blending of clinical responsibilities between professions. This flexibility is rewarding for staff and can provide the NHS with more choice in how we organise our services.

The potential to enable a flexible and adaptable workforce will be shaped by the extent to which the definition of the needs of patients will be patient or service planner derived.

Patients may continue to have expectations of local access to highly specialised skills. New models of cross-country MDTs, as part of managed patient networks, may be needed to provide local access to a reduced proportion of specialists.

Patients may have a different perspective on the definition of a specialist and the acceptability of a multi-professional workforce in that context.

Liability for specialist care delivery in network and multi-professional care set-ups will need to be clearly defined and transparent to all who use and provide such care.

It is vital that this group of professionals work within Consultant lead teams (akin to the old firm system) but involving a number of different adaptable professionals

3. Providing broad pathways for careers in the NHS, and the opportunity for staff to contribute more, and earn more, by developing their skills and experience. Structured career opportunities which enable staff to progress both within and between professions will enhance retention and make the health and care system more resilient and attractive in the face of changing demands from staff.

It is unlikely that structured interchangeable career opportunities will impact on retention and resilience.

There will always be a tension between the investment needed to cover the time to train in specialist skills, especially practical skills and the capacity to provide flexible career pathways, especially in highly skilled careers. Flexible training pathways cannot be addressed by ever more generic initial training pathways, without significant cost in either time to train, or loss of specialist skill at the end of training.

Equally, while earlier entry to defined medical career pathways has reduced the previous tribes of 'lost SHOs', this has been at the cost of reduced uptake of such career pathway posts. This may partly reflect an uncertainty of career choice at an early stage in a career which the Foundation programme's rotation through specialties has not alleviated. Taster weeks and 4-month specialty rotations have not worked. Further, planned generic rotations are unlikely to achieve the desired impact on commitment to careers.

The disconnect between the most junior and most senior layers of the profession has limited development of confidence in an ongoing professional career. The absence of a prolonged attachment of individual trainees to individual consultants or inclusive teams has limited the development of aspiration to a particular career.

Career resilience and attractiveness at mid and later career points are also unlikely to be significantly affected by opportunities to move between disciplines. Rather, to address the opportunity to participate in portfolio careers, or flexible working patterns within acute disciplines other issued must be addressed, such as the requirement to manage patients as an individual over 5 days, rather than as a team over 7 days.

Moreover, retention and resilience amongst middle grade and senior medical staff, and the junior staff who observe them, are not well served by the current working culture. In a time when pressures of work mean it is rare to see medical staff taking time together for coffee or lunch, the impact of day to day professional isolation contrasts poorly with the social expectations of the current generation.

In terms of other professions, there is little recognition within the system for other professionals (such as Nurses) who become specialist. There training and CPD needs are not recognized by Trusts and when they wish to move there is no formal acceptance of their specialist expertise.

4. Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare.
This enshrines the public duty to provide equal opportunity for all and will ensure the NHS workforce of the future more closely reflects the populations it serves. If delivered successfully it will increase the pool of people available to be recruited into the NHS.

When widening participation of access to NHS jobs, it is important to take account of the public finance and personal commitment invested in training and to provide transparent and

realistic career pathways, rather than to encourage individuals to train for careers which will ultimately be significantly limited in the settings within which such careers are practiced.

Since the shortening of training for Doctors, we now have a group who when they have finished specialist training find it difficult to assume the full role of a consultant, becoming reliant on others and tending to use more resources.

5. Ensuring the NHS and other employers in the system are inclusive modern model employers with flexible working patterns, career structures and rewards. These need to support staff and reflect the way people live now and the changing expectations of all the generations who work in the NHS. To retain dedicated staff now and in the future requires employment models that sustain the values which drive health professionals every day whilst protecting against burnout, disillusionment or impossible choices between work and home life.
As above.

Trusts do not see their staff as a resource which needs to be nurtured. They are often poor employers looking only to maintaining service provision, avoiding the important teaching component and maintenance of professional development.

6. Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested. This will help ensure the NHS gets the best for patients from all its resources. Aligning service and workforce planning fosters realism alongside creativity in considering what the workforce in all the relevant groups can best contribute to a new or changing service. This will also increase the resilience of workforce planning and ensure the NHS workforce is rightly seen as an enabler of improved services, not as a constraint.

Policy changes with thought through and tested implications would be ideal. Education and continuing professional development must be a mainstay.

What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?
It is important to recognise the changing healthcare dynamic and the need for doctors of the future to be able to undertake new tasks e.g. to take a 'technological history' from patients, of the apps and internet guidance they have used; to be able to readily source up to date clinical advice as part of routine practice; to routinely advise patients on the impact of their lifestyle; to appreciate shifts in the practice of their career discipline due to advancing technology.

However, it is also important to note that the significant changes to training models and postgraduate and undergraduate curricula creates a culture of uncertainty. In the context of a system under strain and professional layers increasingly disconnected from one another, this may drive people to dis-engage and may increase those who step out of clinical

medicine to retire or pursue other activity, may reduce UK retention of training grades and may limit applications to study medicine.

How can we ensure the system more effectively trains, educates and invests in the new and current workforce?

Serial changes in funding and training models make this difficult. The concept of regular tendering for medical school places would completely destabilise the staffing structures and placement agreements needed for effective undergraduate medical programme delivery and paralyse revisions to curricula that might temporarily reduce student satisfaction ratings.

There are concerns that the current drive towards GP and psychiatry training is reactionary, unlikely to meet current needs and could simply shift the problem to another discipline, rather than achieving a balanced state.

Burnout is a serious problem that will be exacerbated by prolonged career duration and increasingly pressurised 'front door' specialty care. Measures to protect staff enthusiasm for their career and to support safe care delivery could include: sufficient staff to enable contracts for such doctors that routinely permit them to spend portions of their week away from the 'front door' e.g. in teaching roles; pairing of new junior and senior consultant posts, permitting a staged reduction in oncall activity for those over 55 linked to other roles such as managerial leadership roles and mentoring.

Flexible working in those specialties with continuous ward patient care can only be achieved when there are team-based models of such patient care delivery that do not depend on a named individual being available Mon-Fri 9-5. Moreover, it is very hard for individual specialists when they wish to change their working pattern. The numbers of specialists from any one specialty in any one Trust, who need to modify their work pattern at the same time e.g. through job-sharing, are limited. Centrally managed application schemes and regional matching schemes (e.g. of pre-retiring and child-caring requests) could be considered. Central funding could allow Trusts to retain a staff member who drops to part-time while appointing an additional whole-time post.

Clarity over what posts will be required to do is vital to ensuring training can match the delivery of this e.g. the physician associate and whether they will practice as part of a managed team in acute secondary care, or as more independent and generalist care deliverers in primary care. Skill as a generalist can be harder to acquire that that to provide a more refined specialist area of practice. There needs to be sufficient time in training programmes to permit any shift in training from more narrow specialist fields to a broader generalist application.

It is important to recognise that many Trusts at present do not recognise the resource of people coming to the end of their career. Many give the ultimatum of full time work or none. They fail to recognise a need to reduce intensity of activity. Retired staff who wish to continue in some clinical activity are underutilised or worse still rejected and not used at all.

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?

Multiple points of entry and paths may not create an attractive career if they result in an uncertain overall career or training pathway. Currently Trusts do not consider their staff as an important resource which needs to be nurtured.

How can we better ensure the health system meets the needs and aspirations of all communities in England?

Patient education and a steady trend towards patient empowerment and incentivised preventative medicine will be needed to provide the shift in cultural expectations required.

Health care workforce priorities can be helpful, but can also detract from the delivery of other care that impacts significantly on patient lives e.g. arthritis care

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

Credentialing or accreditation of services offers promise, but the UK must guard against this becoming a service -owned 'free for all' delivery model: training opportunities that underpin career development must be equitably available to all doctors, not limited to those whose larger trusts can afford to release them; to ensure standards of patient care continue to be delivered, training must be to set UK standards, such as nationally agreed curricula and delivered under reliable conditions of supervision; for the protection of patient safety and the best future deployment of NHS staff, attainment of competency must be assured through standardised, nationally agreed models recognised across the country.

It is false to assume that Trust grade doctors are predominantly those who do not achieve formal postgraduate training programme numbers. Several Trust grade doctors actively choose the flexibility afforded by such roles, in order to pursue parallel careers in other activities such as music or sport or indeed to allow their families to have support..

Doctors not in formal training can be developed by formal schemes that match service need to skill development. These need to be seen as completely different to 'CPD' and rather as targeted modular training, in keeping with that provided to trainees, for specific areas of service need. They require release from service, supervision and review of competency progression. Exemplar schemes, such as that operated by NES, have delivered success in this area.

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

NHS staff make up a high proportion of the UK workforce. If NHS staff themselves were to adopt the position of being personal champions for healthy living, that would have direct impact on the costs of healthcare, enabling greater availability of NHS funding for other purposes, and would also have indirect impact on the health of their families and communities.

Clinical research has been the bedrock of high value difference to patient care over the 21st century. Significant advances in how care is delivered and in the drugs and tools available to deliver it has been the direct result of the investment of NHS staff time in research activity. It is vital to protect and grow this activity despite challenging service models.

What policy options could most effectively address the current and future challenges for the adult social care workforce?

There must be a seamless border between health and social care. At present the difference in funding agencies (in England) means there are barriers to care and employing staff of the right quality. Combined funding and training of care staff is essential to maintain a quality service. The present system is unsustainable in the long term.