Written evidence submitted by the Royal College of Physicians and Surgeons of Glasgow (EPW0015)

The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow has a membership of 15,000 and represents Fellows and Members throughout the UK. Over half of its membership in the UK is based in England

The College was founded by Royal Charter in 1599 to improve the practice of Medicine and Surgery. Through a forward looking, progressive approach to training, assessment, career support and professional development, we continue to inspire and nurture our 15,000 members throughout all parts the UK and abroad to deliver the highest possible standards of care for their patients.

Planning for the workforce - Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.

The current shortage of staff in NHS England is the consequence of years of an inadequate increase in the workforce and the associated training. There is not currently an adequate system in place for determining current and future workforce needs to meet patient demand in health and social care. Each country of the UK considers the workforce question independently and does not consider workforce movement across borders. There is need for a consolidated and agreed plan. Ensuring that we have a sustainable workforce that is able to meet current and future patient demand is fundamental to protect our NHS, our staff, and our patients.

As part of a coalition of more than 100 health and care organisations, we have urged the Government to support an amendment to the Health and Care Bill which would mandate the regular publication of independent assessments of current and future workforce numbers. Successful and accurate planning for an adequate workforce to meet the health and care needs of the population is dependent on having a mechanism that can provide clarity on the number of staff that will be required. Regrettably, this amendment failed to be carried.

We have, independently and as part of the Academy of Medical Royal Colleges, called for a paradigm shift in workforce planning. We are calling for the establishing of a single planning group to advise on and oversee workforce planning and a commitment by the UK Government to resource this workforce. Domestically the fundamental obstacle to recruitment of skilled healthcare professionals is a lack of supply. In the UK there are not enough trained healthcare professionals to meet patient demand, and significant investment is therefore needed for education and training. However, there is always a time lag between when individuals start training and when they finish and they are able to enter the fully trained workforce. Therefore, the investment required must be sustained in the long term.

The needs of the workforce are changing. Modelling for workforce planning must be improved to take into account.

- Many trainees work less than full time and unpublished data suggests that many trainees will not wish to work full time. This is similar for both primary and secondary care. Current manpower assumptions are that virtually all trainees and consultants will work full time.
- Many trusts and boards do not appoint at interview, do not advertise agreed vacancies or do not even declare vacancies (“hidden vacancies”).

- Sufficient time needs to be made for training purposes, supervision by educators and non-clinical work. The pandemic has shown that trainees are not achieving their milestones to achieve their CCT. Established Consultants are having difficulty maintaining certain specialist skills.
- Many trainees are taking time out of training to do other things eg travel or study other than medicine. They therefore do not progress to speciality training.
- Retention of staff at the end of their working life is an important issue which many employers have failed to grasp (see below).

The UK has always relied on medical staff from other countries to maintain workforce numbers. Before the UK left the EU there were significant free flow of Medical, Nursing and allied health staff to support it. This has reduced. It has yet to be replaced form other countries. However, in trying to attract staff form other countries there is the moral argument that the host country denies expertise in the country of origin. The Medical Training Initiative (MTI) provides education and training so that doctors can return to their home country with new skills. However, entry to the UK has become difficult because of Home Office Visa regulations.

The pandemic has shown the reliance of the health and social care network. There is a shortage of care staff across the system which has been exacerbated by the UK exit from the EU and Visa requirements.

Building a skilled workforce - Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead

To ensure a sustainable medical workforce it is necessary to increase the number of medical school places at universities across the UK. The expansion of medical school places must be matched by a commitment to provide consultants with sufficient time for the additional teaching pressures that this change will entail. Employers (NHS Trusts ad Heath Boards) and government must recognise the importance of ensuring that medical students and trainees are properly supported throughout their training. It is the norm for staff to be blocked from teaching, examining, selecting (interview) and assessing candidates by employers yet this is a vital part of maintaining and improving the workforce. It is common for staff to be asked to take annual leave to participate in these essential workforce related tasks. It is not acceptable for senior clinicians to be asked to use their annual leave to select, train and assess the future medical workforce.

An increase in students studying medicine must also be matched by additional funding for corresponding increases in Foundation Programme places and subsequently in Specialty Training posts. The GMC may have to relax its requirements to allow smooth progress through the system. A Medical Licensing Assessment may for instance be unnecessary given that the GMC already controls all courses and assessments at undergraduate and post graduate level.

Training takes time and newly trained specialists will not appear overnight. There will be a lag in time between training entry and completion which will take several years.

For many trainees, the pandemic has meant missed training opportunities and cancellation of study leave which has had an impact on progression. There has been difficulty achieving training milestones including experience, assessment and examination.

There is opportunity to develop the roles of and training capacity for Physician Assistant, Surgical Care Practitioners, Anaesthetic Associates, Optometrists, Pharmacists, Nurses, Physiotherapists

Podiatrists and other enhanced roles to maximise the workforce. However. this can only be achieved if educators are released to train.

The new contracts for SAS doctors (speciality doctors and specialists) have yet to have an impact. While these doctors support the NHS, there is no indication as yet of expansion to increase and develop their skill set. The new contract has not been introduced in Scotland.

Extra funding for the care sector is important. Without it the health sector cannot function efficiently. We have already pointed to manpower issues in the provision of care above. The care sector needs to be more closely aligned to health. While information technology may assist this, it should be remembered for many in the community, there is no access to technology. These individuals often belong to groups who have considerable health inequalities (eg older people, homeless people and those who have socio-economic disadvantage).

While we support improving communication in the community, this depends on the infrastructure of digital devices. The UK network is poor with many areas reliant on outdated inadequate systems. Hybrid systems will need to work. Care nearer the home is a worthwhile aim but is not always the answer for good outcomes and any change will need to proven by pilot and audit before implementation. Systems currently in practice can often block or delay access to care.

Wellbeing at work - Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services. Reduce bullying rates in the NHS which are far too high.

The pandemic has brought conversations about the wellbeing of health and care staff into the spotlight in political and public debates. These problems are primarily the consequence of chronic excessive workloads, which has been magnified by the Covid pandemic.

We have called on the UK Government to ensure all healthcare workers have access to:

- Mentoring, peer support, psychological support and specialist mental health services.
- Basic facilities in the workplace, including hot food throughout the 24 hours somewhere to rest and adequate sleeping facilities.

We welcome the initiatives that have been set up during the past two years to offer support to the profession during the pandemic. Attention must now turn to wellbeing initiatives that are sustainable over the long term. In addition to the points above, this should focus on ensuring all staff have realistic workloads. All staff need to be seen as valued members of the service.

NHS Employees should be considered no different to the general public with good access to dedicated Health and mental health services.

Improved flexibility in working and training, including improved accessibility of less than full time (LTFT) training, will allow many doctors to make choices to improve their work life balance and wellbeing.

We are supportive of implementing a culture of compassionate leadership within health and social care with zero tolerance for bullying and poor professional behaviour. We have previously stated our

view that non-medical managers are unregulated and employers need to demonstrate that they are responsible.

It is now recognised that the NHS needs to consider the workforce issues at the end of a career lifetime. This may involve altering roles and responsibilities. It will also require a philosophy of seeking to retain staff. This may require relaxation of appraisal and revalidation rules by parliament and the GMC. There continues to be an issue with pension contribution taxation both for exceeding Life Time Allowance and exceeding annual contributions which penalise individuals for continuing to work or performing additional duties. The pension scheme for judges has exempted them from this punitive taxation issue on similar grounds. It is now urgent for the healthcare professions to be similarly exempted.

It is clear given the number of NHS inquiries that managements systems within the health service need rethinking. There have been issues in Mid-Staffordshire, Shrewsbury and Telford, Highland, East Kent, Gosport and Morecombe Bay (maternity and bullying). A change in work culture is required as these events do not seem to be lessening. Bullying in particular needs addressing throughout the service.

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