Health and Social Care Select Committee

'Workforce: recruitment, training and retention in health and social care' inquiry | 18 January 2022

Summary

The Royal College of Physicians (RCP) is the membership body for hospital doctors. Our role is to support physicians to deliver the best healthcare possible for patients and improve standards of care. We represent doctors 41,000 members and fellows in the UK and internationally from over 30 medical specialties from cardiology and gastroenterology to infectious disease and respiratory medicine.

The RCP welcomes the committee's inquiry into the recruitment, training and retention of the health and social care workforce. We are pleased to share evidence on shortages in the medical workforce, challenges in retaining existing staff and offer solutions for how we can put the NHS workforce back on a sustainable footing.

Workforce capacity is the key limiting factor in tackling backlogs and keeping pace with patient demand in the long-term. Nearly half (48%) of advertised consultant physician posts went unfilled in 2020, largely due to a lack of any applicants at all. Too few staff will hamper the ability of the health service to bring down waiting lists and deliver care in the long-term. The necessary pausing of non-urgent care again in December 2021 to facilitate the booster roll-out is a reminder that the ability of the NHS to deal with crises rests on the number of health and care staff we have. Staff absences over Christmas and into January 2022 have only reinforced that. We urgently need to take steps to expand the medical workforce, including through doubling medical school places, and ensure there is a collective national understanding of how many health and care staff the country needs now and in future through the publication of regular, independent projections of workforce numbers.

Recommendations

- Without significant investment in training more people in the UK, overseas recruitment will have to remain a central part of the solution to the UK's staffing issues. **The health and care worker visa should be open to all social care staff and indefinite leave to remain should be given to all NHS and social care staff who have worked during the pandemic, and their spouses and dependants.**

- The NHS must be open and welcoming to international colleagues, but we should not become overly reliant on recruiting already qualified doctors from other countries as the solution to the UK's workforce issues**. Government must take steps to expand the medical workforce, including through expanding medical school places to 15,000 and increasing the number of training places.**

- There is no system in place for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need that can be scrutinised by Parliament or the public. **The Health and Care Bill should be amended to include provisions for independently verified assessments of future health and care workforce requirements to be published.**

- **Government should consider fast-tracking the regulation of Physician Associates (PAs) so they can prescribe and order ionising radiation.**

- **The Certificate of Eligibility for Specialist Registration (CESR) needs to be reformed so it is simpler and faster for eligible SAS doctors to become consultants.**

- Many consultants are retiring early because of ongoing issues with pensions. The temporary measures put in place for the 2020/21 tax year to enable additional work for the pandemic were an acceptable solution. **We recommend that this temporary measure is extended over the next 2 to 3 years until more formal changes to legislation are achieved.**

- The NHS must embrace flexibility in training and in work. To retain existing staff, we need to get the basics right, including ensuring time off for significant life events and access to hot food and drinks.

1. **What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?**
    - **What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?**

1.1 While the RCP firmly believes the NHS must be open and welcoming to international colleagues, we should not become overly reliant on recruiting already qualified doctors from other countries as the solution to the UK's workforce issues. We should be aiming to train more staff in the UK. Until that happens, though, overseas recruitment will continue to be a part of the solution in the short to medium term.

1.2 The Certificate of Eligibility for Specialist Registration (CESR) needs to be reformed so it is simpler and faster for eligible SAS doctors to become consultants. This will be possible following the required legislative changes and we look forward to working with the General Medical Council (GMC).

1.3 Health and care must be seen and treated as equal partners for the system to work in an effective, integrated way. The RCP supports the recommendation made by the Migration Advisory Committee (MAC) in December 2021 to add Care Workers and Home Carers immediately eligible for the Health and Care Worker Visa and place the occupation on the Shortage Occupation List (SOL). This step by the MAC is a clear indication of the situation in which we find ourselves after years of underinvestment in the health and social care workforce. When the health and care visa was launched the RCP was concerned that the vast majority of social care roles were excluded. Adding these roles to that list will be a step in the right direction – but the minimum salary of £20,480 may be too high given care workers on average are paid around £17,000 a year.

1.4 Physician Associates (PA) are very much a part of the workforce solution, as is the new role of Doctor's Assistant. The RCP has hosted the Faculty of Physician Associates (FPA) as the membership body for PAs since 2015 and the FPA holds the Physician Associate Managed Voluntary Register. PAs are a growing part of the health and care workforce and bring new additional capacity to a team. The latest FPA census showed that the majority of PAs (65%) were based in secondary care but that 31% were employed by either general practice or a primary care network. There are growing numbers in acute medicine (11%) and emergency medicine (9%) and 2021 saw the first PA in Interventional Radiology. Many teams where PAs are embedded think the model is very successful. Their impact will continue to be limited, though, until they are able to prescribe medicine or order ionising radiation such as chest X-Rays. The legislation to give prescribing rights was expected in Autumn 2021, but this has been pushed back - regulation by the GMC will now begin no earlier than the summer of 2023. Fast tracking the regulation of PAs would be a huge help to the workforce in the short to medium term.

1.5 In the long-term, expanding the number of doctors in the system by increasing medical school and training places is the only way to ensure we have enough medical professionals to meet demand. The RCP has long

called for this. It takes time to train a doctor – to feel the benefit in 7 or so years' time, we need to expand places now. The RCP welcomed the expansion of medical school places in 2020 and 2021 in response to a larger proportion than usual meeting their grade requirements. We recognise that government did not have to take this decision. But given the scale of the challenges we know are coming, with an ageing population and a growing proportion of doctors working part-time, we need to go further and embark on a funded multi-year programme of gradual expansion of medical school and training places for new doctors.

1.6 The RCP is calling on government to expand medical school places in England over the next decade to 15,000. The RCP's blueprint *Double or quits* estimates that doubling the number of medical school places will cost £1.85bn annually[1] – less than a third of the £6.2bn hospitals spend on agency and bank staff in 2019/20. This is significant considering the RCP 2020 census found that 48% of consultants report having locums staffing vacancies. Although locums play an important short-term role, reliance on them is not a long-term solution. Investing in expanding the medical workforce would represent a long-term saving in locum costs and prepare for the increased patient demand we know is coming.

1.7 Public, robust and independent workforce projection data - based on modelled future population demand - would be the best foundation for strategic long-term decisions on the health and care workforce. The Health and Care Bill must be amended to secure assessments of current and future workforce numbers so that we can better understand the skill mix and numbers of healthcare staff that will be needed to deliver the care patients expect. These assessments should support smart investment in the workforce and in time provide savings by reducing locum use and enabling strategic expansion of, for example, certain professions that will be needed for the patient demand of the future.

2. What is the correct balance between domestic and international recruitment of health and social care workers in the short, medium and long term?

- **What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?**

2.1 Without significant investment in training more people in the UK overseas recruitment will have to remain a central part of the solution to the UK's staffing issues. The health and care worker visa should be open to all social care staff and indefinite leave to remain should be given to all NHS and social care staff who have worked during the pandemic, and their spouses and dependants.

3. What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors? In particular:

- **To what extent is there an adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need?**
- **Do the curriculums for training doctors, nurses, and allied health professionals need updating to ensure that staff have the right mix of skills?**
- **Could the training period for doctors be reduced?**
- **Should the cap on the number of medical places offered to international and domestic students be removed?**

[1] RCP (January 2021) https://www.rcplondon.ac.uk/news/rcp-publishes-blueprint-reducing-pressure-nhs-workforce

3.1 Workforce is one of the biggest limiting factors for the government's ambitions on health and care and sustainably delivering NHS care in the long-term. The RCP welcomed the committee's recommendation for the publication of regular workforce projections across health and social care in its *Department's white paper on health and social care* and *Workforce resilience and burnout in the NHS and social care* reports last year. **Throughout the passage of the Health and Care Bill so far, the RCP has been one of many health and care sector organisations arguing that the bill should be strengthened to improve transparency and accountability on workforce planning.**

3.2 There is no system in place for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need that can be scrutinised by Parliament or the public. The duty on the Secretary of State to publish a report describing the system in place for assessing and meeting workforce needs in Clause 35 does not go any where near far enough. While it may bring clarity to the system and process of workforce planning, it will not shed any light on the numbers of health and care staff that will be required to meet demand now and in future.

3.3 The RCP recognises that there are more staff working in the NHS and record numbers in training, but we also have a population that is larger, older and experiencing more ill health then ever before. For medicine, the larger than usual number of students will in part be down to the government expanding the number of medical school places in 2020 and 2021 in response to a larger proportion than usual meeting their grade requirements. But this is a drop in the ocean given the scale of the problem. Before COVID-19, 43% of advertised consultant posts in England and Wales were unfilled due to a lack of suitable applicants and the RCP's most recent census shows that in 2020, 48% of consultant posts across the UK were unfilled. More staff in training is always welcome – but we do not know if this record number is enough to meet either current or future demand. We will only know that by modelling future health need and projecting the staff numbers that would be required to meet it. At the same time, we are emerging from the pandemic with more than a quarter of senior consultant physicians expecting to retire within 3 years, and the majority of trainees entering the NHS (56%) reporting that they are interested in working part-time. The growing desire to work less than full time means we need a higher headcount in the future. The lack of flex in the system due to too few people means those who want to work part time are often unable to, which has a negative impact on morale and wellbeing. **There are challenges coming that we can prepare for if we act now.** All successful organisations rely on long-term workforce planning to ensure they can meet demand and the NHS and social care system are no exception.

3.4 It is disappointing, therefore, that MPs voted to reject an amendment at Report Stage of the Health and Care Bill in the Commons that would have mandated the publication of assessments of current and future workforce numbers every 2 years in England based on projected health and care demand of the population.

3.5 Government has dismissed amendments on workforce projections on the basis that the 'Long-Term Strategic Framework for Health and Social Care Workforce Planning' – or 'Framework 15' - commissioned by the Department of Health and Social Care (DHSC), will look at the drivers of workforce supply and demand and *'help to ensure'* we have the right numbers of staff. **But while Framework 15 was first published in 2014, and last updated in 2017, there is no agreed, publicly available assessment of workforce numbers now nor into the future.** The findings of this work could be fed into the assessments the amendment asks for so they take account of changing drivers – **but we do the Framework alone will not solve the ongoing data gap on health and care staffing numbers to inform strategic workforce planning decisions at all levels.**

3.6 Regular, independent public workforce projection data will not solve the workforce crisis. But having a collective national picture of the health and care staff numbers needed now and in future to meet demand will provide the strongest foundations to take strategic long-term decisions about funding, regional and specialty requirements and skill mix.

3.7 The Prime Minister said in his session with the liaison committee in 2021 that he would 'look at' the amendment, and the Secretary of State for Health and Social Care told the health and social care select committee in November 2021 that 'we need a much longer-term approach' to workforce planning. We hope that this issue will be picked up by Peers in the House of Lords and that progress will be made on having regular workforce projections given the strong cross-party and sector support. There are a record 6 million people now on waiting lists for treatment – and the recent Health and Care Levy will only go so far in tackling the backlog because we have too few staff to undertake additional checks, scans and appointments.

3.8 The cap on medical school places should be lifted and a planned, ongoing expansion should be implemented by government. The RCP's blueprint *Double or quits* estimates that doubling the number of medical school places from 7,500 to 15,000 will cost £1.85bn annually[2] – less than a third of the £6.2bn hospitals spend on agency and bank staff in 2019/20. The Office for National Statistics (ONS) predicts that by 2040 there will be over 17 million UK residents aged 65 years and over, meaning that the cohort of people potentially requiring geriatric care will make up 24% of the total population. If we do not increase the number of people in the system now, we will struggle to meet patient demand in future.

3.9 There should be an increase in foundation places alongside medical school places. The combination of a reduction in trainees completing training and the increased number of trainees coming back from out-of-programme or continuing in training without taking time out means that many more training posts will be needed following the government lifting its cap on medical school places in 2020 and 2021. This will require additional funding over a number of years so that any increase in places is supported through to completion of training. The colleges and specialties are absolutely committed to providing support for any additional training places and supporting all trainees as we manage the 'training recovery' that is needed as badly as the 'service recovery'.

3.10 More generally with regard to training, the RCP would like to see:

- a greater focus on ensuring that new graduates feel prepared and ready to undertake FY1, and that an apprenticeship style year in the final year of medical school can help FY1 doctors feel prepared for practice. The apprenticeship year should expose them to a range of clinical settings including primary, secondary and community care.
- a greater focus on generalist skill sets but also ensuring that med students and those in foundation programme are exposed to a range of clinical settings. The range of settings they are exposed to in FY2 should be more focused than in medical school, balancing the needs and interests of trainees with the needs of the service.

3.11 Final year medical students 'acting up' as part of the FiY scheme during the pandemic was highly successful. Increased exposure of medical students to such scenarios would be very beneficial. The importance of community placements focussing on health inequalities and public health must also be recognised and deployed in parts of the country where it is most needed due to disease burden.

[2] RCP (January 2021) https://www.rcplondon.ac.uk/news/rcp-publishes-blueprint-reducing-pressure-nhs-workforce

3.12 In February 2020, the government announced that it intended to create shorter, more flexible routes for healthcare professionals to become doctors and nurses after the UK left the EU. This was followed in March of this year by Health Education England beginning work with Skills for Health to develop an apprenticeship standard for doctors. The proposed duration of this apprenticeship is five years and will include the Medical Licensing Assessment. Apprentices would then be eligible to apply to the GMC and a foundation training place.

3.13 The RCP recognises the advantages of more flexible conversion routes to study medicine that lead to candidates meeting GMC requirements, including for existing healthcare professionals. These routes could help tackle workforce shortages and improve the socioeconomic diversity of medicine. In May 2021, the RCP set out principles against which it will assess any proposals to create more flexible routes to studying medicine and becoming a doctor. Models that combine work and study warrant further exploration but the **RCP would have concerns if this meant a shorter period of study.** This would risk under-preparing students for an increasingly complex career caring for patients with multiple health conditions.

4. What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?

4.1 The medical workforce was already under pressure before the COVID-19 pandemic due to understaffing, and this has only become more acute over the course of the last 18 months. Staff are tired and burnout is common. During the pandemic, pressure on the health and social care workforce increased hugely. In response to a survey by the RCP in January 2021, almost a fifth (19%) of doctors reported that they had sought informal mental health support and 10% had received formal mental health support from either their employer, GP or external services. A third (33%) of trainees said that working in the pandemic had made them question medicine as a career. A large proportion of respondents (64%) felt tired or exhausted, and many felt worried (48%). **The RCP is concerned that the pressure of prolonged pandemic working is leading to many experienced doctors considering early retirement.**

4.2 In our most recent survey (January 2022), we asked respondents whether they had felt overwhelmed at work during the past three weeks and 69% said they had. 27.5% said they had felt overwhelmed once or twice during that period. A further 21.5% said they had felt overwhelmed once or twice a week, **and a fifth (20.5%) said they had felt overwhelmed almost every day.** We also asked respondents whether they had been asked to fill a rota gap at short notice in the past three weeks. 55% said they had. This had happened on one occasion for 34.5% of respondents, on 2 occasions for 29.5%, on 3 occasions for 16% and on 4 occasions for 5%. 15% of respondents had been asked to fill a rota gap at short notice on 5 or more occasions. Almost a quarter (24%) had been asked to do this at least once while on annual leave.

4.3 Even if doctors do not take early retirement as a result of COVID-19, the RCP 2020 census estimates that taking an average retirement age of 62.4 years, 41% of the UK consultant physician workforce will retire over the next decade. 38% of consultants responding to the census said they had excessive workloads and 11% estimate they work more than they're contracted to, mainly due to their clinical workload. The RCP as a membership body does not often talk about terms and conditions. But we know from surveys and member communications that consultants are reducing the amount of direct patient care – including the backlog – they are providing because of the problems associated with the annual allowance. Some consultants are retiring early because of this issue. The temporary measures put in place for the 2020/21 tax year to enable additional work for the pandemic were an acceptable solution. **We recommend that this temporary measure is extended over the next 2 to 3 years**

until more formal changes to legislation are achieved. The increase in activity needed to overcome the backlog will be impossible without such a step.

4.4 As we have been saying for many years, to increase job satisfaction and retention of current staff, all NHS organisations should get the basics right. This includes access to hot food and drink and rest facilities at all hours of the day, which are still woefully lacking in many places. Embracing flexibility and ensuring time off for significant life events would also make a big difference. Opportunity to talk to other colleagues both within the hospital – such as the mess or doctors' area – and across the system (joint primary and secondary care meetings) are a vital part of the Autonomy, Belonging and Competence needs which we know are crucial to job satisfaction and retention. Other things that the RCP recommends the system implements to retain existing staff include:

- make sure social care roles at all levels are attractive to increase that workforce so we can reduce hospital admissions and speed up discharges
- reduce the administrative burden on clinicians
- simplify mandatory training and appraisal/revalidation processes
- embrace remote working for suitable activity
- embrace flexibility – see the RCP's toolkit 'Working flexibly'.
- help employees access flexible, affordable childcare
- make sure every member of staff who needs it has the right equipment to join online meetings at work and to work remotely, and has received any training they might need
- ensure everyone is reviewing job plans to make sure they are making the most of the available people, including by being as flexible as possible, providing a variety of professional activities, and helping staff balance work and life
- provide targeted assistance to help doctors get back "up to speed" when they return to work after time out of practice

4.5 Many of our recently retired members frequently say they have been unable to retire and return, despite wanting to. Their trusts have either been unwilling to allow this or have stipulated unreasonable conditions in a new contract. However, many trusts do allow such working and it is a highly effective and valued process. Standardised 'retire and return' contracts would be a helpful part of the solution.

4.6 To encourage people near retirement to stay working, the NHS should:

- standardise retire and return procedures
- work with doctors in their early 50s to minimise burnout by reviewing their job plan and consider their out of hours commitment
- explain to its organisations that many doctors want to 'retire and return' on a substantive contract, but allow flexibility on contracts
- support its organisations to encourage and facilitate retire and return, including by using portfolio job plans that maximise the benefits of returners' professional experience
- support its organisations to provide a tailored and focused induction for doctors who want to retire and return, including reducing the burden of mandatory training on irrelevant topics
- make sure doctors who want to retire and return are able to work virtually where preferred and possible, providing them with the equipment and training they need
- Later careers: Stemming the drain of expertise and skills from the profession | RCP London.

5. Are there specific roles, and/or geographical locations, where recruitment and retention are a particular problem and what could be done to address this?

5.1 It is well known that the regional distribution of doctors does not match demand. Wealthier areas tend to be healthier but have more doctors. This is another reason we need a strategic approach to workforce planning, but it should also be an element of a cross-government strategy to reduce health inequalities. The RCP has been

leading the call for a cross-government strategy to reduce health inequalities as convenor of the 200 organisation strong Inequalities in Health Alliance.

5.2 The RCP 2020 census shows that there is significant regional variation in recruitment to consultant physician posts across several specialties. Across the UK, the census estimates that on average there is one full-time equivalent (FTE) physician consultant to every 4,616 people in the population. The region with the lowest ratio of physicians to population is Wessex, where there is one FTE physician consultant to every 6,450 people. In comparison, Central and North East London has one FTE physician consultant to every 2,608 people in its population.

5.3 Supply and demand need to be assessed across the medical specialties and the NHS as a whole. But some regions and specialties currently face bigger workforce shortages than others, and changing demographics are likely to result in these shortages being felt even more acutely in some areas over the coming years. As the population rapidly ages, bringing a rise in multiple long term health conditions, the demand for certain skills will increase at a similar rate. As people live longer, they also live longer with health conditions that in many cases impact on their quality of life. Coupled with the public health challenges of smoking, obesity and air pollution, demand will grow for geriatric, palliative and respiratory medicine. These are challenges that we know are coming and mean particular attention will need to be paid to some sections of the workforce. Yet the RCP census shows that 68% of geriatricians report locums staffing vacancies in their department. The census also shows that 30% report having a vacancy that is not staffed by a locum. For palliative medicine the proportion is more than half (52%). And while 70% of all consultants undertake either acute or GIM work, 97% of both geriatric and respiratory consultants do.

5.4 **It is vital that we model the 'type' of workforce we need, and we should not be afraid of placing trainees where those specialties are needed.** We know people are more likely to stay, live and work where they trained. But it all begins with having more doctors in the first place: the more doctors we have, the better we can shape the workforce to address specialty and regional shortages both now and in future. The only way to truly ensure that we are designing and moulding a workforce that can meet to the future needs of a population is through assessments of future workforce numbers based on projected patient need.

6. What should be in the next iteration of the NHS People Plan, and a people plan for the social care sector, to address the recruitment, training and retention of staff?

6.1. While there is much that the People Plan can achieve, without an expansion of the workforce the NHS will continue to struggle to recruit and retain staff. The experience of working under significant and ongoing pressure has a negative impact on people's experiences. For example, in our census of higher specialist trainees (HST), they consistently rate their experience of general internal medicine (GIM) training as significantly worse than specialty training. In 2018-19, 68% said their specialty training was 'excellent' or 'good', compared to 27% for GIM training. They consistently say that the things that would make the most difference to their experience of GIM training would be 'no rota gaps', a better balance between service and training, and more protected time for professional development. In short, the lack of workforce means that the need to provide direct clinical care overrides the need for training. As a result, around a third consistently report that if they could turn back time they would choose a non-medical job.

8. What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?

8.1 At Committee Stage of the Health and Care Bill, the Minister Edward Argar MP spoke about the role of Integrated Care Boards (ICBs) in workforce planning. ICBs will be given responsibility – already set out in draft guidance – to develop system wide plans to address current and future workforce supply locally and to undertake supply/demand planning based on population health needs.

8.2 ICBs do not have access to the levers that government does, such being able to increase training places or change immigration policies. This means that local assessments will not lead, for example, to national investment required to fill any staffing gaps that local ICB-led workforce assessments might reveal.

8.3 The RCP believes that locally driven assessments have a place but should come alongside a national picture and direction of travel. A local only approach would also not increase government accountability or transparency on workforce planning and would fail to ensure a collective understanding of current and future workforce numbers across health and care.