BMA Scotland response: National Health and Social Care Workforce Planning Discussion Document

1. General comments
BMA Scotland is the trade union and professional association for doctors. In Scotland we represent around 16,000 members.

We commend the Scottish Government (SG) for its commitment to improving health and social care workforce planning, and for its recognition that this can only be done collaboratively. Medical workforce planning in particular is notoriously difficult to get right. Depending on the specialty, it takes 10-15 years to educate and train a doctor, which means that planning and decision-making around future medical workforce needs have to adopt a very long-term perspective. This involves making important strategic assumptions about future patient need, the model of health service delivery and the size and shape of the workforce that will be required to meet that need, along with frequent review to ensure that those assumptions are still correct and that plans to have the right number of and type of doctor in the right place remain on track.

While the discussion document is a useful summary of the areas where improvement in workforce planning is required, the absence of any detail on long-term future workforce numbers suggests that such work is still at an early stage. As such, the SG’s target of publishing a workforce plan by the end of May this year seems rather ambitious. Given the very short timescale, we would assume that realistically this first workforce plan will by necessity focus less on specific long-term decisions than on the decision-making process by which the SG intends to bridge the gap between the overall strategic direction being set by the SG and the decision-making on what that means for the future size and shape of the workforce. This seems a reasonable approach, but we would be keen for the resulting work to be progressed quickly, with more explicit, detailed long term plans for the future workforce set out in the workforce plans published in 2018 and beyond.

At the same time, urgent action is required to address the medical workforce issues facing the NHS right now and over the next few years, not least the significant workforce gaps in both primary and secondary care due to ongoing severe recruitment and retention problems. It is essential that this year’s workforce plan acknowledges these difficulties and sets out clearly the actions that the SG intends to take to address them.

2. Strategic workforce planning
The strategic direction for health and social care services in Scotland, both long and short term, is set nationally by the SG, based on its understanding of the future needs of the population of Scotland, the expected model for the delivery of health services and the resources it plans to make available to provide those services. That strategic direction has been provided by the SG’s plans to move towards health and social care integration and recently by the National Clinical Strategy.
Understanding the implications of such high-level strategy for the workforce, and translating it into firstly a blueprint for the future workforce and then into a more concrete workforce plan is by no means a straightforward process. It requires extensive consultation with a wide range of stakeholders to determine whether what is being proposed is achievable within the financial and human resources available and the timescale proposed, the potential and limitations for new approaches to skill-mix, extended roles etc and crucially whether what is being planned will actually deliver the SG’s vision. In medical workforce planning this must include ongoing engagement at national, regional and local level with those doctors actively involved in delivering services to patients on a day to day basis, and who have the best insight into both the challenges facing the NHS and the potential barriers to change.

The long timescale for medical workforce planning also means that it must be seen as an iterative process, with plans being regularly revisited to monitor progress, reflect any changes in government policy priorities or new estimates of future funding allocations and as new information becomes available on changing patient demand, the projected supply of doctors and other staff and service capacity. It also needs to be as much ‘bottom-up’ as ‘top-down’, with a constant feedback loop as government ambition for public services is tempered by an appreciation of what can actually be delivered within the resources available.

BMA Scotland is ideally placed to play a key part in these discussions, as has already been demonstrated by the development of the shared vision for the future set out in the joint SG and BMA Scotland publication General Practice: Contract and Context – Principles of the Scottish Approach. Critical to this vision is a substantially expanded primary care workforce, including pharmacists, physiotherapists, mental health professionals and senior level practice nurses. This will require a significant proportion of the additional funding for primary care announced in 2016 (£500m additionally annually by 2021), and should be recognised in the national workforce plan.

Medical academics are a small but key group within the medical workforce, contributing to innovation and research and the coordination of delivery of undergraduate teaching for next generation, often alongside a significant clinical role. Generally employed by universities rather than directly by the NHS, it is nevertheless essential that the current and projected medical academic workforce is factored into both short and long term planning.

3. Improving workforce data

Good quality workforce data is essential to effective workforce planning, and the current lack of reliable data is a major barrier to improving decision-making around both current and future needs. We therefore welcome the SG’s explicit acknowledgement in the discussion document (page 17) that both data quality and availability must improve.

We were somewhat surprised to read (page 19) that the SG believe “there is scope to reduce the level of detail NHS Boards are required to provide in workforce plans and projections”, although we have been somewhat reassured in subsequent discussions with SG officials that this does not mean collecting less information, but ensuring that what data is collected is meaningful and helpful to workforce planning.

One key problem area in secondary care is vacancy data, an issue on which we have lobbied the SG for a number of years. The only vacancy information collected for junior doctors is the fill rate from the annual recruitment rounds, with no subsequent central monitoring of ongoing vacancies and subsequent rotas gaps. For SAS doctors, who form a sizeable part of the secondary care workforce, no vacancy data at all is collected. And even for consultants, where quarterly national statistics are
published, the way the data are collected and the lack of clarity around the definition of a vacancy means that the official figures are likely to significantly underestimate the true picture.

The GP workforce information that is currently available is also inadequate. Using headcount data as the official indicator to describe the GP resource in Scotland is not acceptable when GPs are increasingly looking to work less than 8 or 9 sessions a week. This must be explicitly accepted by the Scottish Government to allow increasing investment into collecting information that more accurately reflects the workforce. Considerable attention must be given to collecting data on locum GPs where it has been long understood that there is an absence of useful workforce data. In particular, the current data appears unable to delineate GPs that work solely as locums from those that also work as contractors and/or in out-of-hours.

Retention is every bit as important as recruitment, and is an area where there is potential for real improvement in our understanding of the medical workforce to assist both short and long-term planning. We know that only just over half of those doctors who start foundation training in Scotland are still training in Scotland 30 months after the end of the foundation programme, and that less than half of those who graduated from a Scottish medical school are still training in Scotland 30 months after the end of the foundation programme. This clearly demands the SG’s attention, but in order to tackle the problem we need much more detail on why this is happening, which trainees are leaving Scotland, their reasons for doing so, and whether their departure is temporary or permanent.

We also need better data on why those doctors who are further on in their career choose to leave the NHS in Scotland, to move elsewhere in the UK or overseas, or to leave medicine altogether. Good quality quantitative information on chosen destination, supported by qualitative work around their reasons for leaving, eg from exit interviews could provide valuable information, and we would be keen to help with this. Retention is particularly key towards the end of a doctor’s career. We need a clear sense of the age profile of our medical workforce, an awareness of any changing patterns of work among older doctors including projected average retirement age, and an understanding of the barriers to retaining them in the workforce. In particular we should not assume, without evidence to support it, that an increase in the NHS pension scheme retirement age will lead, in itself, to doctors working longer.

The SG should examine the extent to which the requirements of appraisal and revalidation are making it unduly difficult for both those doctors who wish to continue to contribute to the NHS after retirement, and for those doctors who have been undertaking voluntary work overseas to return to the NHS.

We also need to recognise that the demographics of the medical workforce have changed, and that more doctors will want to take time out to have children and to work less than full-time for significant parts of their career. And this is unlikely to just be an issue for female doctors, as more male doctors take on caring responsibilities, and as studies show an increasing desire for a better work-life balance across younger doctors more generally. Like the rest of society, many doctors will find themselves part of the ‘sandwich generation’, caring for both their children and elderly parents at the same time. All this means that careful attention must be paid to projected participation rates, ie the gap between headcount and whole-time equivalent numbers when making assumptions about the future size of the medical workforce. A small miscalculation in this area can have significant effects.

4. Addressing immediate workforce pressures

As we have highlighted, there is an urgent need for this year’s workforce plan to focus on not just the strategic direction over the medium and longer term, but also to demonstrate how the SG intends to
address current workforce pressures. Within the medical workforce this primarily means the ongoing recruitment and retention difficulties across a range of specialties. Prolonged workforce gaps left unaddressed can lead to unsustainable levels of workload intensity for those still in-post, low morale, and the potential for burnout. It also makes it increasingly harder to attract doctors to work in such environments, creating a vicious circle.

Within primary care, while the shared vision for general practice will require an expanding GP workforce, the current picture is one in which a career as a GP can be unattractive to trainees and a growing number of GP practices are vulnerable to collapse due to their inability to replace GPs. The difficulty in appointing new GPs is compounded by the inability of practices to secure GP locums and the expected levels of GP retirement in the next five years.

In terms of the secondary care workforce, the SG has always been keen to highlight the upward trend in consultant numbers, although even this has not been sufficient to keep pace with changes in patient demographics and ever-increasing clinical need. Moreover, what is often not properly acknowledged is that the Scotland-wide figures mask major recruitment and retention difficulties across a range of specialties and locations, with almost half of all consultant vacancies remaining unfilled for over 6 months, often despite repeated advertising. While the SG do not collect vacancy statistics for SAS doctors, feedback from our members suggests the recruitment and retention picture is very similar.

The picture regarding junior doctor recruitment is also a concern, with 27% of GP and 19% of core psychiatry trainee vacancies left unfilled in this year’s recruitment round, a worsening of the position since 2015. In higher specialty training, 29% of vacant posts were left unfilled.

The SG needs to understand that it is working in a very competitive market when trying to attract and retain its medical workforce, and that the competition comes not just from NHS employers elsewhere in the UK but also internationally. Doctors are a highly-skilled, highly motivated and highly mobile section of the healthcare workforce. While an attractive remuneration package is important to them, they are equally motivated by a desire to work in an environment where they feel genuinely valued, adequately resourced to provide a high quality level of care, and are able to enjoy a good work/life balance.

In this year’s workforce plan, we are looking for the SG to set out the concrete steps it plans to take to address these pressing concerns. We have set out below a number of specific actions that we believe could make a real difference in improving recruitment and retention, and we would be keen to discuss these further. Some are major ongoing issues that we have raised previously, while others are of less significance in themselves but could send a strong message to doctors that the NHS in Scotland could be a good place to come and work.

**General practitioners**
- Scotland recognising general practice as a specialty
- address the unacceptably high workload and risk in the GP contract
- make sure there is consistency between the workforce plan and announced (and developing) Scottish Government programmes to increase the primary care workforce
- ensure that additional primary care workforce (such as pharmacists and LINK workers) are genuinely working to reduce practice workload
- ensure that GPs are not used to follow up secondary care work inappropriately
- review and improve arrangements for GP training practices, with a particular focus on training capacity
Consultants

- allow NHS boards to utilise the provisions for recruitment and retention premia set out in the agreed national consultant contract
- promote Scotland as a place where teaching, research, quality, reflection and innovation are honoured by allocating 25% of consultant time to these activities in line with the contract
- maximise the potential pool of candidates by routinely advertising consultant posts UK-wide
- make clear to potential applicants that named secretarial support will be provided to free them up to spend more time caring for their patients
- encourage proleptic appointments for highly specialised or remote/rural skill sets
- ensure that local medical advisory structures are listened to
- ensure that all consultants are able to access their full entitlement to study leave, and that all appropriate expenses are fully reimbursed and take account of geography
- promote retention of ‘later stage’ consultants by developing portfolio career options and through initiatives aimed at enabling those who wish to take only partial retirement to remain in the consultant workforce
- explore the future of distinction awards to ensure that Scotland remains competitive with the rest of the UK

SAS doctors

- show that Scotland can provide long term career progression for SAS doctors, by as a first step, endorsing NHS Grampian’s ‘proof of concept’ proposals to re-open the associate specialist grade
- ensure that all SAS doctors, including those working part-time, have sufficient allocation in their job plans for supporting professional activity
- promote improved access to CPD, study leave etc for SAS doctors, and their involvement in teaching, training and management
- promote retention by enabling retired associate specialists to return to work for the NHS without having to take a pay cut

Junior doctors

- demonstrate a clear commitment to valuing trainees by agreeing and publicising a concrete package of initiatives aimed at improving the working lives of junior doctors in Scotland, ie guaranteed minimum rest after a run of night shifts, access to rest facilities etc
- show that Scotland promotes good quality training by ensuring that all trainees are able to access their full entitlement to study leave, and that all appropriate expenses are fully reimbursed
- protect the continuous employment rights of trainees when they change employer, particularly trainees taking maternity leave

5. Future supply – medical student intakes
Focusing on the numbers of medical students entering the system is an important element of ensuring the workforce plan is sustainable. UK wide data shows that applications to medical schools have been reducing over the last few years while many specialties in medicine remain undersubscribed. However, proportionally increasing student numbers to provide a guaranteed increase in doctors is not realistic or sustainable as several other factors are at play. Below we have outlined the three main factors which need to be considered when exploring the relationship between the student intake and future supply of doctors.
The Foundation Programme
Once students graduate they apply to the UK Foundation Programme. Entry to and completion of this programme is necessary in order to register with the GMC and to continue the journey to becoming a doctor. A push to fill more places at medical school must be paired with an increase in the number of available places on the Foundation Programme. Increasing the number of medical students without also increasing the number of Foundation Programme places will not increase the number of doctors in the system, only the number of medical graduates.

Teaching capacity
An increase in student numbers will have an impact on the number of doctors needed to teach these students, both in universities and on placements. This pressure will increase into the Foundation Programme with more trainees needing support and guidance from qualified doctors. With the profession facing increasing workload and recruitment pressures it may be difficult to increase teaching capacity to match increasing student numbers.

Perceptions of job attractiveness
There is evidence that students and trainees won’t choose locations or specialties that they perceive to be unattractive, regardless of how many extra students are in the system. For example, the Scottish Government increased the number of available GP training places in 2016 and added an inducement of £20,000 for those trainees willing to take up places in traditionally hard to recruit locations. While a few more GP trainees were recruited than in previous years, most of these additional places remained unfilled.

A study by Cleland et al in 2014 found that students’ experience at medical school has a big impact on which specialty they choose. The four Scottish medical schools offering a complete medicine degree have different profiles of student specialty preference on graduation – tweaks to the medical school education and culture could change student perceptions of and choice of specialty. Some work has already been done on this by the Medical Schools Council. Their report, By Choice Not By Chance looks at how medical schools could make changes to prevent specialties such as general practice from being discounted by students.

BMA Scotland
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