BMA

The state of pre and post-graduate medical recruitment in England, September 2017

British Medical Association
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Summary of findings

- Although still highly competitive, fewer people are applying to medical school
- Foundation Programme posts and applications are decreasing
- Applications to specialty training are decreasing
- More trainees are choosing to take time off after F2 before entering specialty training
- Nearly three quarters of all medical specialties faced under-recruitment in 2016
- There continue to be some specialties that face recruitment shortfalls year on year (to varying degrees)
- There are geographical variations in recruitment trends with the northern regions bearing the brunt of the recruitment crisis
- Recruitment shortfalls lead to junior doctor rota gaps and could signal problems staffing services down the line
- After Brexit, the NHS will continue to rely on EU and overseas recruitment to fill workforce gaps
- Ultimately, long-term fixes to service pressures and greater investment in the health service are needed, but steps can be taken now to help improve recruitment and retention to medicine in the short-medium term

1. About this briefing

This briefing examines the current state of recruitment into pre and post graduate medical education and training. It also identifies some of the key concerns and questions that need to be addressed in order to maintain high standards of patient care. The analyses are based on publicly available data, some of which were obtained via a Freedom of Information request, and were current at the time of publication. We examined data from 2013 onwards to identify any on-going issues and trends in medical recruitment. The briefing focuses on recruitment in England only, however, figures for the UK Foundation Programme are UK-wide.

2. Introduction

The NHS has been ranked the best healthcare system in the world for the second year in a row[1], yet it has faced years of underinvestment in the face of rising demand which has led to pressures at all levels of the system with staff working under impossible conditions. The NHS is at breaking point, plagued by workforce shortages and exacerbated by funding cuts disguised as efficiency savings. Increasing workload, low morale, stress and burnout are unfortunately characteristic of life for too many doctors working in the NHS today. For many junior doctors, the imposition of the new contract has had a demoralising effect which compounds the pressures already faced at work.

In real terms, doctors' pay has sharply declined in the past five years, with junior doctors seeing their income drop by 17 per cent. Over the same period consultants have seen their pay drop by 14 per cent and GPs by 13 per cent.[2]

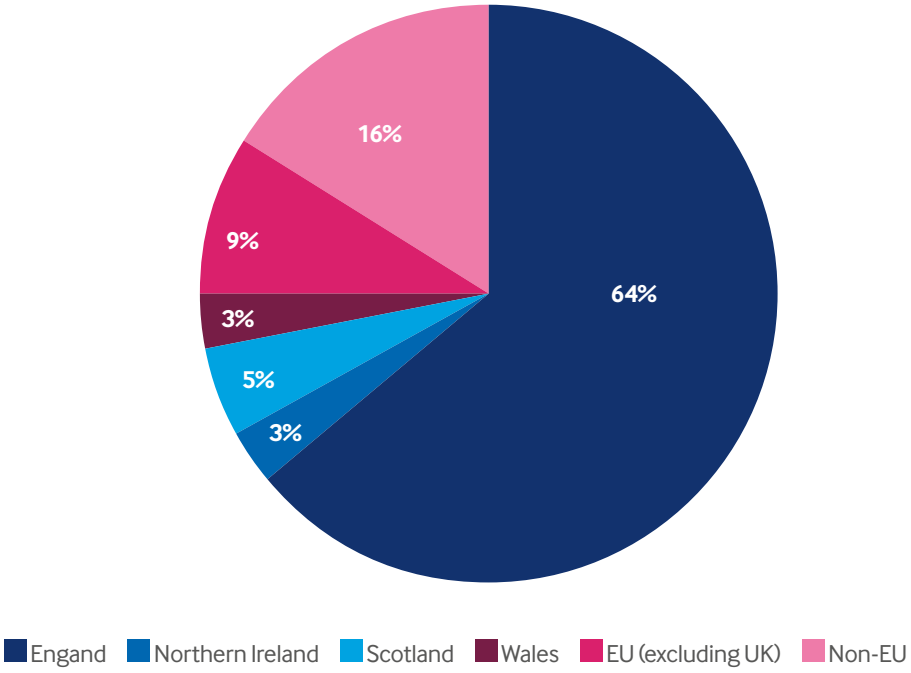
Against this backdrop, fewer people are choosing medicine as a career with many more choosing to leave the health service at a time when they are needed most. In the sections that follow, this paper explores some of the key issues surrounding recruitment to medicine at various stages, and how the system might begin to make improvements that could positively impact recruitment and retention in the short-medium term. Ultimately, however, long term fixes to relieve service pressures and increased investment are required to safeguard the ability of the NHS to continue to deliver safe services, and the perception of medicine as a preferred career choice now and in the future. To be successful, Government, staff side unions, ALBs (arm's length bodies), regulators and royal colleges must all work together to develop innovative and practical solutions for addressing the workforce crisis and most importantly, support a properly resourced NHS.

1 http://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-international-comparisons-2017
2 https://www.bma.org.uk/collective-voice/influence/key-negotiations/doctors-pay/pay-negotiations

3. Although still highly competitive, fewer people are applying to medical school

Just under 20,000 prospective medical students submitted applications to UK medical schools in the 2017 cycle. The majority of applicants were from England while the second largest group came from non-EU countries. EU nationals represented the third largest group of applicants.

Figure 1. Applicant country of origin 2017



Although medicine remains highly competitive, with only 6,000 places available in England, figures from UCAS (Universities and Colleges Admissions Service) show that the number of people applying to UK medical schools from England has decreased for the third year in a row and by more than 15% since 2013. This year, the number of EU applicants dropped to its lowest since 2013 as did applicants from non-EU countries. The 16% decrease in EU applicants from last year is notable and could reflect the uncertainties surrounding Brexit.

Table 1. Applicants for medicine courses with 15 October deadline (2017 cycle).[3]

Domicile of applicant	2013	2014	2015	2016	2017	% change from prior year (2016-2017)	% change over five years
England	14,520	14,670	12,930	12,620	12,320	-2.4	-15.2
Northern Ireland	660	590	570	580	540	-6.9	-18.2
Scotland	1,160	1,170	1,060	1,050	1,030	-1.9	-11.2
Wales	670	710	660	570	570	0	-14.9
UK	17,000	17,140	15,220	14,820	14,450	-2.5	-15.0
EU (excluding UK)	1,990	2,110	1,940	2,050	1,720	-16.0	-13.6
Non-EU	3,130	3,490	3,230	3,240	3,040	-6.2	-2.9
All	22,130	22,740	20,390	20,100	19,210	-4.4	-13.2

3 https://www.ucas.com/file/79436/download?token=xK6EjMvM

3.1 The rising cost of medical education and training may be a prohibitive factor for many would-be doctors

For many prospective medical students, rising tuition fees and higher student debt could be a major factor in deciding whether to attend medical school. Tuition fees were previously increased from £3,000 to £9,000 in 2012, substantially increasing the amount of debt students carry following graduation. For many, student debt can exceed £80,000 (including maintenance) and medical graduates on an average salary are unlikely to repay their SLC (Student Loans Company) debt in full.[4] With student loan interest rates set to rise to a staggering 6.1%,[5] students in England and Wales are likely to experience even more difficulty with debt in the future.

To make matters worse, tuition fees are again set to increase in line with inflation prior to 2020 following passage of the Higher Education and Research Act[6] earlier this year. As proposed, the increase in fees could then be linked to the TEF (Teaching Excellence Framework) after 2020, which could, in the long-term, lead to noticeable differences in tuition fees across providers. In responding to the proposal for TEF in 2016, the BMA argued that TEF would effectively need to be tailored to each course. Hence, the whole approach could risk misleading prospective medical students and further disrupt the successful recruitment of medical students needed to meet the country's workforce requirements and their distribution across the UK.

3.2 More needs to be done to ensure that medicine remains an attractive career choice for people from all backgrounds

While entry to medicine remains highly competitive, the decrease in the number of applications to medical courses rings alarm bells. Doctors work in highly pressurised environments and experience high levels of stress and burnout. The realities of this are not lost on those just starting out in their medical careers. More than three-quarters of medical students said that they were now less likely to recommend studying medicine to friends and family, according to a recent BMA survey.[7] More needs to be done to help doctors stay healthy while dealing with the stress of working in today's NHS if medical schools are to continue to attract the best candidates (see section 5.5 on health and wellbeing). Potential students should not be put off studying medicine by the negative experiences of existing students and doctors.

The BMA has long argued that the medical profession should be more representative of the people that it serves. However, in the past, half of all schools in the UK did not produce a single applicant to medicine and, in 2011, only four per cent of medical students came from low income backgrounds.[8] It is encouraging that the Government has made a commitment[9] to widen participation and incentivise social mobility in the medical profession, but efforts to increase diversity appear to be slowing. For example, the GMC reports that fewer women are studying and training in medicine and fewer BME trainees are working in the NHS today.[10] Widening participation by under-represented groups is key to a diverse workforce and would positively impact recruitment to the profession. The BMA's 'Right Mix' report explores the issue of widening participation in medicine in more detail.

4 http://bmjopen.bmj.com/content/5/4/e007335
5 https://www.theguardian.com/money/2017/apr/11/student-loan-interest-rate-rise-uk-inflation-brexit
6 http://services.parliament.uk/bills/2016-17/highereducationandresearch.html
7 https://www.bma.org.uk/news/2016/april/study-shows-student-dismay-over-contract
8 https://www.bma.org.uk/features/therightmix/
9 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/636527/Expansion_undergraduate_medical_education_consulation-response__2_.pdf
10 http://www.gmc-uk.org/SoMEP_2016_Chapter_two.pdf_68136455.pdf

3.3 Medical school places in England will increase next year

The UK Government recently announced plans to increase the number of places at medical schools in England by 1,500 beginning in 2018/19.[11] This expansion is an effort to increase the UK's supply of home grown doctors so that the NHS can continue to deliver safe and effective care. However, the BMA has cautioned that the new places must also be matched with additional foundation and subsequent specialty training posts to mitigate the risk of unemployment within the medical profession. While the expansion might be considered a positive step toward addressing workforce shortages, Medical Schools Council data shows that there are fewer medical academics than there were in 2013[12], meaning there are fewer people to educate the increased numbers of medical students. These numbers could shrink even further if EU academics find it more difficult to live and work in the UK following Brexit. Additionally, it takes more than 10 years after selection for medical school for the prospective medical student to reach a level of training appropriate for independent practice, thus increasing medical school places is going to have little immediate impact on current pressures and workforce gaps.

International medical students

The Government has also announced plans to lift the current cap on the number of international students that can be recruited by UK universities.[13] Although this could ensure a reliable flow of students, removing the cap could create a perverse financial incentive for universities to attract more international medical students resulting either in an imbalance in the makeup of the future medical workforce or a failure to meet the workforce objectives of the expansion of medical student numbers. The BMA has advocated[14] that safeguards be put in place to protect against such an imbalance. Furthermore, more international graduates will have very little impact on the workforce if they are not permitted to remain in the UK.

4. Fewer people are applying to the UK Foundation Programme

4.1 Foundation year 1

2016 had the lowest number of applicants and the fewest appointments to F1 posts via the national allocation process since 2013. The reasons behind the fall in numbers are not entirely clear.

Most foundation doctors are allocated via a national allocation process. However, not included in that process are those transferring from another foundation school, academic foundation posts, LTFT (less than full time) trainees who were recruited the previous year, those trainees who are repeating their F1 year, and those recruited by other methods including one-year posts, returners from maternity leave and supernumerary[15] flexible trainees [16]. These posts are all included in the final recruitment figure for the year (Table 2).

11 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/600835/Medical_expansion_rev_A.pdf
12 https://www.medschools.ac.uk/media/2026/medical-clinical-academic-staffing-levels-2017.pdf
13 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/600835/Medical_expansion_rev_A.pdf
14 https://www.bma.org.uk/news/2014/august/bma-urges-caution-following-call-to-relax-cap-on-overseas-students
15 Supernumerary posts are additional to a normal complement of trainees and so are often the ideal posts for LTFT trainees. As these posts are not dependent on finding someone else to take the other half or make up the other hours, they allow more independence of choice. Increasingly however they are only offered for those who require LTFT at short notice and many employers no longer offer supernumerary posts as a standard form of training, but this does not preclude a trainee from requesting a supernumerary post (source: BMA Less Than Full Time Guidance).
16 UKFPO Annual Report 2016. http://www.foundationprogramme.nhs.uk/pages/resource-bank/general

The number of newly qualified doctors recruited to the AFP (Academic Foundation Programme) has fallen slightly over the past three years. The number of LTFT foundation doctors recruited was less than half of what it was in 2013. The number of foundation doctors repeating their F1 year has remained steady over the past few years. Meanwhile, recruitment by other methods has increased three-fold since 2013, although numbers remain small.

The figures reported at the end of the national recruitment process don't always match the number of foundation doctors who start in post. This, according to UKFPO (UK Foundation Programme Office), is due to the fact that some withdraw from the programme before training commences at the start of August. Any posts remaining vacant are then advertised as one-year locum appointments.

Table 2. Foundation year 1 recruitment statistics 2013-2017

	2013[1]	2014[2]	2015[3]	2016[4]	% change from prior year (2015-2016)	% change over four years
Vacancies advertised (excluding AFP)	7,242	7,114	7,086	7,112	+0.4	-1.8
Applications at the time of allocation	7,537	7,349	7,438	7,157	-3.1	-2.8
Appointed through national allocation process	7,123	7,006	7,148	6,923	-3.3	-3.2
Posts not included in the national allocation process:						
Transfer from another foundation school	25	40	13	16	+23.0	-36.0
Academic recruitment	480	462	476	465	-2.3	-3.1
LTFT (recruited previous year)	51	86	55	21	-61.8	-58.8
Repeating F1	80	63	65	64	-1.5	-20.0
Recruited via other method	12	0	4	34	+750	+183.3
Total recruitment (including national allocation)	7,771	7,657	7,761	7,523	-3.1	-3.2

4.2 Foundation year 2

In 2016, the number of foundation doctors beginning the second year of their two-year foundation training was higher than in the previous year and higher than in 2013. However, total recruitment to F2 has fallen by almost three per cent since 2013. In 2016, those recruited to the second year of AFP also fell from previous years and those appointed to one-year F2 posts decreased from the previous year.

The number of foundation doctors repeating their F2 year, however, was significantly lower in 2016 than in the previous three years.

Table 3. Foundation year 2 recruitment statistics 2013-2016

	2013[5]	2014[6]	2015[7]	2016[8]	% change from prior year (2015-2016)	% change over four years
Beginning second year of two-year programme	6,688	6,961	6,334	6,781	+7.1	+1.4
Repeating F2 year	88	183	162	64	-60.5	-27.3
Appointed to one-year F2 posts (locally recruited)	323	224	313	263	-16.0	-18.6
2nd year of AFP	407	476	445	261	-41.3	-35.9
Recruited via other method	89	9	17	7	-58.8	-92.1
Total recruitment	7,595	7,853	7,271	7,376	+1.4	-2.9

Foundation trainees make up a vital part of the medical workforce and a reduction in numbers will lead to an increase in rota gaps, impacting doctors at all levels. It will also have a knock-on effect on specialty recruitment and ultimately impact the NHS' ability to provide safe services.

It is also imperative that the number of Foundation Programme and specialty training posts match the increase in medical school places to ensure that all newly qualified doctors are able to secure work in the NHS without any interruption to their training.

5. Fewer people are applying to specialty training

5.1 Fewer F2s are moving directly into specialty training

Applications to specialty training are decreasing and yet the number of training posts continues to increase year on year.

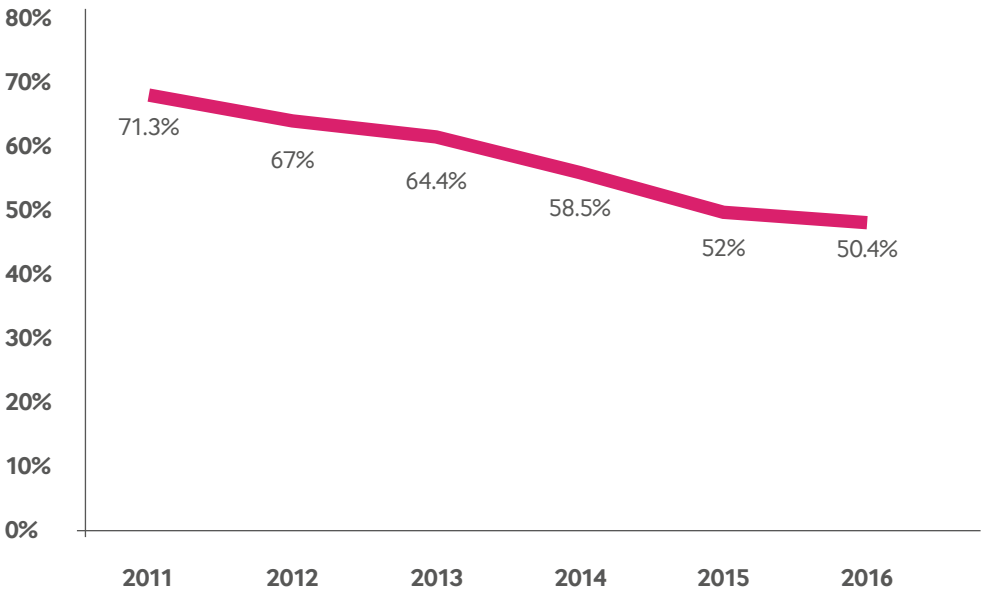
Table 4. Round 1 (CT1/ST1) overall competition ratios 2013-2016

Year of entry	2013[9]	2014[10]	2015[11]	2016[12]	% change from prior year	% change over four years
Posts*	8,061	8,192	8,545	8,766	+2.59	+8.75
Applications	16,771	16,634	16,308	15,855	-2.78	-5.46
Competition ratio	1.6:1	2:1	1.9:1	1.8:1	N/A	N/A

* The number of advertised posts may change throughout the recruitment round but was current at the time these figures were reported by Health Education England.

In 2016, just 50.4% of F2 doctors reported that they would progress directly into specialty training following completion of their Foundation Programme training.[17] This number has been steadily declining since 2011.

Figure 2 Progression into specialty training following F2 year



Because the end of the F2 year represents a natural break in training, many doctors choose to take a career break at this point.[18] The "F3" year[19], as it is commonly known, is becoming increasingly popular and future workforce planning must account for this.

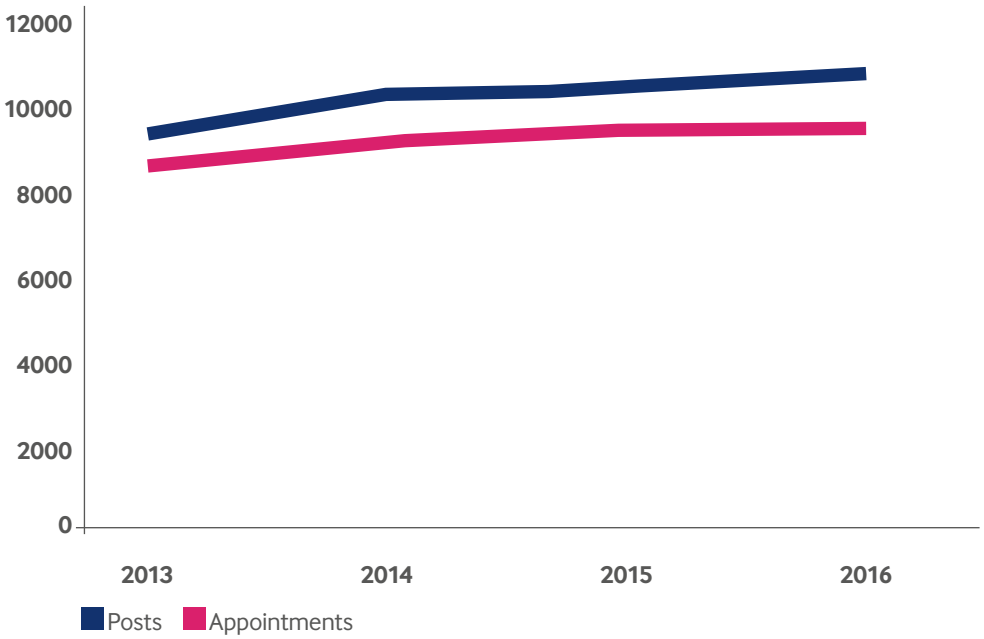
The decision to take a break at this point could be motivated by a variety of factors, such as the need for more flexibility for caring or family responsibilities, a desire to undertake further study, the chance to travel and work abroad before making the commitment to specialty training, or the need for time out due to the pressures of the service. Some doctors choose to take up locum or trust grade posts prior to choosing a specialty. It could also reflect the desire of doctors to have a better work-life balance resulting in changing attitudes toward established patterns of training and working. Future BMA research will seek to shed more light on this growing trend and the implications it has for training programmes, the nature of doctors' jobs and workload.

17 UKFPO Career Destination Report 2016
18 UKFPO Career Destination Report 2016
19 http://student.bmj.com/student/view-article.html?id=sbmj.i1125

5.2 The number of doctors applying to specialty training posts is not keeping pace with demand

The overall number of available training posts has increased in every region in England since 2013. However, there is a widening gap between the number of posts and the number of appointments, suggesting that recruitment is not keeping pace with demand.

Figure 3. Number of posts and appointments to specialty training (England)



The ratio of appointments to available training posts (fill rate) generally fluctuates year to year but overall was nearly 6% lower for all medical specialties in England in 2016 than it was in 2013. Nearly three quarters of all medical specialties faced under-recruitment in 2016.[20] Many of these specialties have experienced year on year shortfalls leading to junior doctor rota gaps and signalling difficulties staffing services down the line.

The workforce shortages in general practice, emergency medicine, paediatrics and the psychiatric specialties are widely acknowledged, and there are ongoing initiatives at the local and national levels to begin to tackle them. However, many other smaller specialties are finding it increasingly difficult to recruit trainees too, calling into question the NHS' ability to continue providing these services in the same way they are currently provided. For example, Allergy (ST3), Clinical Pharmacology and Therapeutics (ST3), Endocrinology and Diabetes Mellitus (ST3), Genito-urinary Medicine (ST3), Haematology (ST3), Metabolic Medicine (ST3) and Rehabilitative Medicine (ST3) have been unable to fill all available posts for several years.[21]

5.3 Fill rates don't tell the whole story

It is important to note that healthy fill rates do not necessarily indicate adequate overall workforce numbers in any given specialty (see below on recruitment to general practice training). While they are just one indicator and can provide a good starting point for projecting future supply of senior doctors, workforce shortages are also driven by overall failure to retain doctors in particular specialties and in particular geographical areas, high turnover and difficulties filling current vacancies at all grades. Unfortunately, there is a paucity of data on turnover of doctors at the various stages of their career which would be helpful in more fully understanding the nature of workforce shortages in the NHS. To address wider workforce challenges, both recruitment and retention strategies must be implemented at all levels of the system.

20 Specialty fill rates England 2013-2016, Health Education England. www.bma.org.uk/medicalrecruitment
21 Specialty fill rates England 2013-2016, Health Education England. www.bma.org.uk/medicalrecruitment

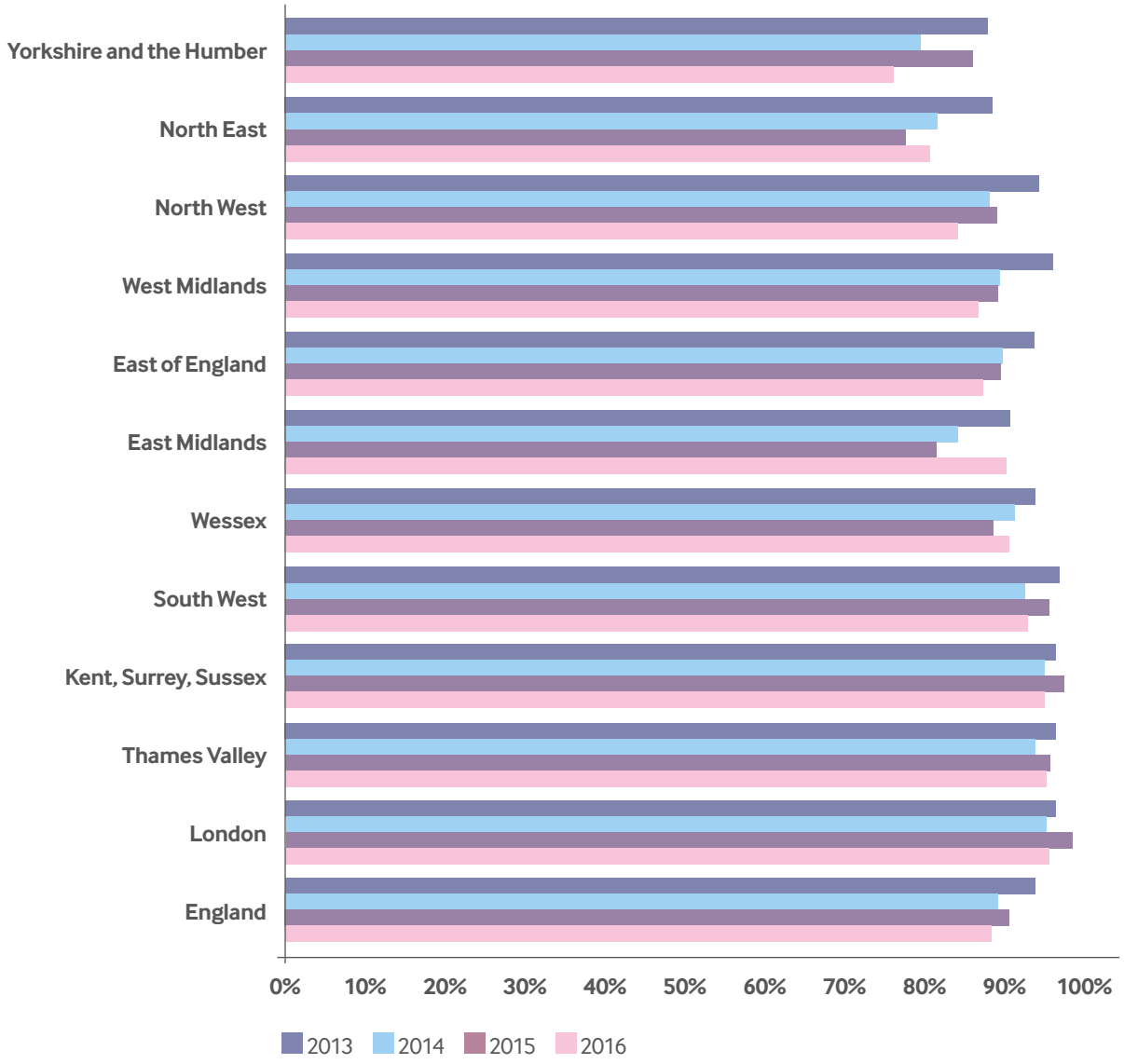
Recruitment to general practice training

The number of general practice training posts has grown from 2,761 in 2013 to 3,250 in 2016 – an increase of nearly 500. In 2016, just over 90% of these posts were filled – an increase of more than 160 appointments from the previous year.[22] While such increases should be viewed positively, they must be considered within the context of decreasing numbers of GPs working full time. With overall GP numbers stagnating, and record numbers nearing retirement[23], it is difficult to see how the Government's pledge to increase the number of GPs by 5,000 by 2020 can be realistically achieved. It is therefore not surprising that the NHS is forced to recruit from overseas in order to meet its target.

5.4 Northern regions are experiencing the brunt of the recruitment crisis

The north of England (North East, North West, Yorkshire and the Humber) experienced the lowest fill rates in the country indicating serious problems with recruitment in those regions. East of England and West Midlands have seen a steady decrease in fill rates since 2013 signalling a worsening problem with recruitment. Fill rates increase significantly in London and the southern regions.

Figure 4. Total fill rate (%) by region



22 Specialty fill rates England 2013-2016, Health Education England. www.bma.org.uk/medicalrecruitment
23 https://www.bma.org.uk/news/2017/april/nearly-half-of-gps-plan-to-quit-finds-survey

5.5 There are steps that can be taken that may improve recruitment and retention in the short-medium term

Robust recruitment initiatives and clear plans to help doctors stay working or return to working, particularly in shortage specialties, are essential. These plans must also support doctors to work safely and mitigate fatigue, stress and burnout, for example, by supporting guardians of safe working hours[24] and encouraging exception reporting.[25] While long-term fixes to address service pressures and increased investment in the medical workforce are needed to attract and keep the doctors we need to deliver safe and effective care, below are some other ways the system can make improvements that could aid recruitment and retention in the short-medium term.

Increase opportunities for flexible careers

To make a real impact on recruitment and retention for trainees, as well as for more senior doctors, more must be done to enable flexile careers. Flexible working is becoming increasingly attractive to doctors wanting to diversify their work experience, including taking time out to study/ work overseas, as well as combining work and family life and opting for portfolio careers, including significant periods of locum work. For many younger doctors who will likely be working to 70 and beyond, flexible working offers practical, workforce retention benefits[26]. Flexible working includes not just part time working, but parental leave and carers leave, more flexibility around shift patterns, out of hours working and locum working.

Addressing these issues would make a practical difference to work life balance for doctors and could, importantly, increase the pool of doctors working in the NHS:

- **More affordable childcare that is flexible and available to cover out of hours work** – The Academy of Medical Royal Colleges[27] has found that almost 70% of doctors surveyed reported no family support, indicating most are paying expensive private providers. This cost increases for out-of-hours childcare. The imposed 2016 junior doctor contract has compounded this problem, by decreasing the number of hours that now qualify for higher "unsociable hours" pay. Providing on-site quality, flexible childcare facilities could be one way that employers could support LTFT (less than full time) doctors in work, and potentially enable them to work longer/more shifts.

- **Shared parental and carers leave** – While the right to shared parental leave exists in theory, in practice it still has very low take up. If the Government wants to change the culture to encourage more fathers to take parental leave, it must ensure that the occupational pay available for maternity leave is made available for shared parental leave in a way that will enable more fathers to utilize it in practice. Carers' leave would be an important recognition of people's caring responsibilities for older, frail and disabled relatives and allow many people to work longer.

- **More flexibility in part time medical roles** – Currently the proportion of part time working permitted depends on the LETB (local education and training board), trust, speciality and grade, as well as restrictions set by the GMC (General Medical Council). LTFTs are often also restricted on the amount of out-of-hours work they can do. Many doctors would like a wider range of opportunities for part time working and if there were more flexibility some would be able to work more hours than they are currently contracted to. A pilot in Emergency Medicine, whereby all higher trainees were offered the opportunity to train LTFT at 50%, 60% or 80%, was launched in England this year. These trainees were not required to give a reason for wanting to train LTFT, unlike the current situation, where a well-founded reason must be given for approval.

24 The guardian is responsible for overseeing compliance with the safeguards outlined in the 2016 terms and conditions of service for doctors and dentists in training. The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. Read more here.

25 Exception reporting allows trainees to quickly and easily flag up if their actual work has varied from their agreed work schedule. Read more here.

26 Review Body on Doctors and Dentists Remuneration 2017 report, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/602319/58665_DDRB_Book_Accessible.pdf

27 "Maternity/Paternity Survey Results." Academy of Medical Royal Colleges, 2016. http://www.aomrc.org.uk/publications/reports-guidance/maternity-paternity-survey-results/

- **Part time work should be a reality throughout medical careers** – The evidence shows that despite many wanting to work part time, the vast majority[28] of consultant posts are only advertised as full time roles. As trainees advance in their careers, fewer opt to train LTFT; the numbers plateau at ST3 and then fall at more senior grades[29]. Similarly adopting a more flexible approach may well encourage many doctors to delay retirement. Encouraging part time working throughout medical careers will reduce the stigma of and discrimination against this working pattern.

- **Further extend opportunities for less than full time training and working into academic careers**, including by encouraging funders to support innovative job-sharing schemes.

- **Deferral of training posts** – Currently, according to the Gold Guide[30], training can only be deferred for statutory reasons, or – recently for the first time – GP training in England. Giving trainees the option to defer their training posts would allow flexibility and could aid recruitment and retention.

- **Increased access to Out of Programme** – There are currently fairly stringent requirements that must be met in order to have approval for time out of a training programme, either for experience (OOPE), research (OOPR) or a career break (OOPC). Allowing trainees more capacity to take time out of programme, or to step on or step off, would allow trainees to explore outside interests, or to adapt their programme according to their personal needs. This would aid in the retention of doctors who might otherwise leave the training programme altogether.

- **Recognition of skills gained outside of training programmes** – Currently, only training completed in a recognised training programme can count towards a Certificate of Completion of Training (CCT), which means that doctors with experience in other countries or in non-training grade posts find that this experience is not included. Early assessment of a trainee's competencies, however, would mean that trainees' expertise can be recognised early, with potential for proceeding faster through training than they otherwise might have, in recognition of their pre-existing skills. This would also help to increase workforce numbers.

- **E-rostering** – Current arrangements for rostering shifts mean that LTFT trainees do not get advance notice of shifts and are not guaranteed the same shift patterns from week to week. They may therefore struggle to arrange shifts around fixed childcare and caring responsibilities, which e-rostering could potentially help to address. However, there are wider systemic issues that must also be considered to ensure trainees are able to access their rotas six weeks before starting a job as per the Code of Practice[31].

- **Shift patterns** – Although many trainees work beyond the end of their shift the implications of finishing late for LTFT trainees with caring responsibilities can be extremely serious. No trainee should have to work beyond their rostered hours, and the culture whereby this is acceptable (to the point where some trainees are denigrated for leaving work on time) must change to enable a healthy work-life balance.

To learn more about flexible working and less than full time training, read the BMA's guidance here.

28 Boney, Oliver. "Why male trainees should consider the flexible option." BMJ Careers, 20 Feb 2013. http://careers.bmj.com/careers/advice/view-article.html?id=20010962#ref7
29 GMC NTS survey results, 2013 quoted in BMA less than full time training guidance, appendix 2 https://www.bma.org.uk/advice/career/applying-for-training/flexible-training/what-is-ltft
30 The Gold Guide is the reference guide for specialty training in the UK.
31 The Code of Practice lays out the agreed set of information that recruiting organisations and employers should provide to doctors in training at each stage of the recruitment process, the first post and subsequent rotations.

Improve health and wellbeing services

Improving doctors' health and wellbeing must also be prioritised. One way to do this would be to provide a fully functional and resourced occupational health service for all staff working in the NHS, to help them when they are under pressure or struggling to cope with the demands of the service. Current provision is inadequate in many areas. Alongside this, the BMA itself is exploring how awareness can be raised within the medical profession about the range of health and wellbeing services (including mental health services) currently available to doctors such as BMA Counselling and the Doctor Advisor Service as well as trust or practice-based support services.

Tackle rota gaps

Alongside measures to tackle the workforce crisis, innovative thinking around alleviating the negative impacts of rota gaps is also needed. Anecdotal evidence from junior doctors suggests that many trusts are underestimating the effects of rota gaps and the impact they have on retention. According to a recent BMA survey, two thirds of respondents reported that there are currently rota gaps in the department in which they work.[32] Many trainees have reported being put under considerable pressure to accept extra shifts and cover additional wards as a result of rota gaps, leading to an increase in stress levels and contributing to feelings of burnout. The GMC found that "around one third of doctors in training, and a similar number of trainers, believe that rota gaps impact on training opportunities".[33] The BMA is currently working with junior doctors to investigate the impact of rota gaps on their working lives and identify possible ways to mitigate the worst pressures.

Address geographic variation in medical recruitment

As employers in shortage areas grapple with how to attract sufficient numbers of doctors to deliver a service, it is important to better understand how doctors choose their career paths, both in terms of specialty and location, in order to identify possible solutions. We are aware that many medical graduates tend to continue to train and work in the region of their medical school, particularly during their foundation years. However, certain parts of the country appear to be less attractive than others which could impair the NHS' ability to train doctors in these areas. To support recruitment efforts, investments need to be made to ensure that high-quality training placements are provided consistently across geographical areas.

Expand academic opportunities

Doctors in academia tend to have long careers and many continue to research and teach into their sixties. The Medical Schools Council 2017 staffing report shows that 34.4% of clinical academics are over 54 years of age compared to 18.2% of NHS consultants[34]. In addition, many clinical academics conduct research and teach beyond retirement in emeritus positions. This would suggest that widening academic practice could act as a means of retaining doctors.

There is also some evidence that we are not fulfilling the career intentions of doctors who wish to undertake academic work as part of their career. A survey of medical graduates in 2014 demonstrated that 13.5% of male doctors and 7.3% of female doctors indicated that they intended to apply for a clinical academic training post and 6% of men and 2.2% of women specified that they wished to pursue a clinical academic career[35]. However, these figures are below the proportion of available academic jobs.

Where inclusion of an academic component of work has been tried to improve recruitment it has been successful. For example, in Wales there has been poor recruitment to core training posts in medicine, but where these posts have been changed into academic posts the competition ratio has increased to 5 applicants per post. Similarly posts in primary care in a rural area of North Wales have been successfully filled once research has been included as a key component of the post.

32 https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/quarterly-survey/quarterly-survey-results/quarterly-survey-q2-2017
33 http://www.gmc-uk.org/2017_national_training_surveys_summary_report___initial_results_on_doctors__training_and_progression.pdf_71003116.pdf
34 https://www.medschools.ac.uk/media/2026/medical-clinical-academic-staffing-levels-2017.pdf
35 http://pmj.bmj.com/content/early/2014/08/18/postgradmedj-2014-132681

Maintain the NHS' ability to recruit from overseas

Of particular concern is whether citizens from the rest of the EU will continue to come to the UK to study, train and work in medicine in the years following the UK's exit from the European Union. More than 10,000 doctors are currently working in the NHS, representing nearly 7% of the UK medical workforce. Any drop in numbers will only further exacerbate recruitment challenges and it is clear that the NHS will continue to rely on overseas recruitment, whether from the EU or elsewhere.

The BMA has called for permanent residence for all EEA doctors (and their families) currently living and working in the UK. We are also urging the Government to allow sufficient stay for EEA medical students currently studying in the UK to allow them to complete their courses and continue to foundation and specialty training posts. Finally, we must ensure that any future immigration system and approach to mutual recognition of professional qualifications is flexible enough to allow for recruitment of overseas doctors where the NHS cannot fill posts with qualified UK nationals. This should include undertaking a review of the Shortage Occupation List, which does not currently include all high-risk medical specialties or creating bespoke arrangements for the healthcare sector.

Improve workforce planning

Substantive workforce planning at a national level, supported by high quality data, is essential to ensure that the future healthcare workforce is sufficiently staffed and has the flexibility to be able to deliver care in different locations as required, without leaving parts of the health service inappropriately or under-staffed. Despite this, workforce planning has been devolved to HEE's regional structures, LWABs (Local Workforce Action Boards), to support STPs (Sustainability and Transformation Partnerships) although many are only in the early stages of collecting data and developing workforce strategies. This risks making future workforce planning even more difficult as STPs may not consider the impact of their local strategy on their neighbouring areas.

Workforce planning and recruitment are complex processes with multidimensional challenges. The NHS has chronically under-recruited to some specialties and geographical areas and more needs to be done to understand and plan for current and future workforce needs as well as take into account new ways of working. This paper has identified a variety of things that can be done in the short to medium term to help plug gaps in the workforce and retain doctors currently working in the NHS, but a long term strategy for a flexible and sustainable workforce that is valued and treated fairly is urgently needed.

Footnotes for tables 1-4

1 UKFPO Annual Report 2013. http://www.foundationprogramme.nhs.uk/news/story/ukfpo-publishes-2013-fp-annual-report-and-f2-career-destination-report

2 UKFPO Annual Report 2014 http://www.foundationprogramme.nhs.uk/news/story/ukfpo-publishes-fp-annual-report-2014

3 UKFPO Annual Report 2015. http://www.foundationprogramme.nhs.uk/pages/resource-bank/general

4 UKFPO Annual Report 2016. http://www.foundationprogramme.nhs.uk/pages/resource-bank/general

5 UKFPO Annual Report 2013. http://www.foundationprogramme.nhs.uk/news/story/ukfpo-publishes-2013-fp-annual-report-and-f2-career-destination-report

6 UKFPO Annual Report 2014. http://www.foundationprogramme.nhs.uk/news/story/ukfpo-publishes-fp-annual-report-2014

7 UKFPO Annual Report 2015. http://www.foundationprogramme.nhs.uk/pages/resource-bank/general

8 UKFPO Annual Report 2016. http://www.foundationprogramme.nhs.uk/pages/resource-bank/general

9 http://careers.bmj.com/careers/advice/Applying_to_specialty_training%3A_considering_the_competition

10 http://careers.bmj.com/careers/advice/Specialty_training_applications_for_2015%3A_competition_ratios_and_changes_to_the_process

11 http://careers.bmj.com/careers/advice/Specialty_training_applications_for_entry_in_2016%3A_competition_ratios_and_the_application_process

12 https://specialtytraining.hee.nhs.uk/Portals/1/Competition%20Ratios%202016%20ST1_1.pdf

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