Migration Advisory Committee
Call for Evidence: Review of Tier 2

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 154,000, which continues to grow every year.

Much of the rhetoric about immigration has focused on the pressures that increased immigration has placed on public services including the health service, housing and schools. The debate frequently fails to acknowledge the significant impact that highly skilled migrants, including doctors, have played, and continue to play, in delivering and sustaining public services including the NHS and our universities. The rationale for justifying restrictions on skilled migration ignores the potential negative repercussions of this on public service delivery with employers facing increasing barriers to retaining and recruiting the staff they need. The consequences of health providers being unable to recruit the staff they need to maintain service standards and deliver appropriate patient care are extremely serious.

- The BMA does not support unfettered immigration of overseas doctors but believes that employers must have the capacity to recruit and retain overseas doctors where other solutions to staffing have been unsuccessful and where a clear workforce need exists. The immigration system must remain flexible enough to recruit doctors from outside the UK/EEA should the resident workforce be unable to produce suitable applicants to fill specialist or generalist vacant roles or if an individual has particular skills and knowledge not readily available in the UK.

- Level of earnings cannot be used an indicator to determine the labour market for medical practitioners. Salary levels are set nationally by central government and should not be used as a proxy for skill.

- Medical training is closely linked to the future workforce needs of the NHS. It is essential that a link is maintained between Tier 4 and Tier 2; this route is essential for overseas graduates of UK medical schools to progress from the Foundation Programme into Specialty Training.

- The current design of Tier 2 (General) protects the local workforce whilst ensuring that employers also have the flexibility to employ doctors on Tier 2 (General) when and where the need arises.

1. Background

Tier 2 (General) is used by overseas graduates of UK universities and by international medical graduates who have qualified overseas and are successfully appointed to jobs in the UK where the RLMT (Resident Labour Market Test) has been met, or are appointed to jobs on the shortage occupation list.

1.1 Overseas Graduates of UK Medical Schools

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The numbers of each medical school cohort across the UK are closely matched with the projected number of doctors that the UK requires and the number of training places available. It is for this reason that the number of overseas graduates is capped at 7.5%. Overseas graduates of UK medical schools are treated as ‘home-grown’ doctors and have a legitimate expectation that they will be able to progress through the Foundation Programme and specialty training grades. The following diagram highlights the visa pathway UK graduates currently follow:

Graduates switch from Tier 4 into Tier 2 (General) after completion of the Foundation Programme and they are exempt from the RLMT when making this transition. The training pathway of doctors in the UK necessitates rotations to different employing organisations and competition between core training and higher specialty training.
The recruitment process for specialty training is centralised across the UK with a system of ranking preferences and offers being made during an 'offers' window. Applications are made according to a national timetable through Oriel, the online specialty training application system. The removal of the Tier 1 (post study work) category and the requirement for the RLMT to be run if a specialty training doctor changed to a new Tier 2 (General) sponsor (usually at the point of rotation) caused disruption for both trainees and employers. In order to mitigate the issues being faced, a single Tier 2 (General) sponsor has been established for trainees in Scotland and England. In Scotland sponsorship is provided by NHS Education Scotland and, in England, the single sponsor is Health Education England. This means that overseas graduates of UK medical schools in training programmes in England and Scotland are able to compete for training programmes on an equal footing to their UK and EEA-national peers, without the need for the RLMT to be run each time they rotate to a new employer. These doctors are not seeking preferential treatment: they have attended UK medical schools and have been incorporated into UK workforce planning.

1.2 International Medical Graduates

Tier 2 (General) is also used by IMGs (International Medical Graduates) who have qualified overseas and are appointed to posts within the NHS to a job on the SOL (Shortage Occupation List) or to a position where the RLMT has been met.

2. Wider Tier 2 Review: reducing migration through greater Tier 2 controls

The Government has commissioned the wider Tier 2 review to address concerns regarding the rising number of migrants in that route and the reliance on them to fill workforce shortages. The BMA supports the long-term aim of self-sufficiency in NHS medical staffing but recognises that workforce gaps remain in certain regions of the UK and within particular medical specialties. These gaps mean that employers must remain able to recruit doctors from outside of the EEA (European Economic Area) if the resident workforce cannot produce suitable candidates for specific vacancies.

In UK medicine, effective workforce planning is essential; this must be a key consideration of the MAC when considering changes to Tier 2. The MAC must give particular consideration to the impact any changes to Tier 2 would have on the medical profession, the wider NHS, and the subsequent impact on the delivery of services and patient care. The BMA is concerned that further restrictions to Tier 2 could compromise the ability to employ non-EEA migrants where there is a workforce need that cannot be met by the UK workforce.

Historically, doctors from outside the UK have been an essential part of the NHS medical workforce. Enforcing a drastic reduction in Tier 2 visa levels may well lead to problems in filling vacant posts. Although we do have some vacancy data, eg. for consultants in Scotland, and UK-wide fill-rates for trainees, we do not currently have comprehensive UK-level vacancy data for the NHS so it is unclear how many vacancies there currently are which might need to be filled through Tier 2.

It is clear that a number of pressure areas do exist, for example in general practice, and we will be providing further evidence of this within this submission. Changes within the NHS at present are contributing to the inherent difficulties of workforce planning. The Five Year Forward View of October 2014 set out several new care models which aim to 'dissolve traditional boundaries' between general practice, community providers, hospitals, health and social care and mental health services. The document proposed creating a number of major new care models, recognising that England is too diverse for a single model of care to work everywhere. A total of 29 sites have been chosen for vanguard status and represent a wide variety of projects. In 2013 the Shape of Training review was launched into whether changes are required in postgraduate medical training to ensure it continues to meet the needs of patients and health services in the future. This review is ongoing. The vanguard sites and the Shape of Training are examples of how it is essential that the immigration system provides the NHS with sufficient flexibility during a time of great change.

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In reducing economic migration, the MAC must take into account the number of individuals who work within public services in the UK on Tier 2 visas and the potential impact of any reduction on the ability of public service providers, such as the NHS, to recruit staff. The anticipated consequences of reducing skilled migration more stringently than has already been introduced cannot be oversimplified by emphasising reduced stress on public services and increased job opportunities and career prospects for resident workers. It must be subjected to more rigorous scrutiny and measures must be taken to ensure that the delivery of vital public services is not compromised as a result of reducing net migration through the Tier 2 (General) visa route.

3. Focusing on particular skills shortages

How well does the RLMT provide evidence that no domestic labour is available? How could the test be improved?

Does the points mechanism operating in respect of the limit on Tier 2 certificates of sponsorship prioritise those migrants of greatest benefit to the UK? How could its efficiency at doing this be improved?

What criteria should be used to select jobs and occupations that are genuine skills shortages and people that are highly specialist experts?

What use should be made of selection criteria such as salaries, points for particular attributes, economic need, number and length of vacancies and skills level? What other criteria should be considered?

The NHS employs its workforce on nationally agreed contracts and pay scales. Any move to amend Tier 2 needs to take place within the broader context of the NHS and the pressures it faces.

The NHS uses nationally agreed pay scales which determine the salary an individual is paid. It is normal practice for new entrants to job roles to be placed at the starting salary for the appropriate salary scale. The salary thresholds for the SOC (Standard Occupational Classification) codes are based on the first point of each pay scale. Amending the salary thresholds would not be appropriate for the NHS as individuals progress through each salary point annually.

Salary as a selection criterion disadvantages applications for Certificate of Sponsorship for the NHS. In June 2015, the Tier 2 cap was reached for the first time with the allocation panel only approving Certificates of Sponsorship for applications with a minimum of 50 points. This would have required the applicant to have a minimum salary of £50,000 which far surpasses the starting salary for nurses, doctors in training and specialty doctors. An increase in the minimum salary threshold beyond the entry point of each grade would restrict employers from recruiting professionals from overseas and appointing them in line with nationally-agreed pay arrangements.

The BMA is concerned that Certificates of Sponsorship have been rejected for essential NHS staff on the basis of pay. The impact of this has far-reaching consequences: current staff have to cover the shortages at short notice, an increasing reliance on locums and the high costs associated with this, and the closure of services due to a lack of available staff. Salary cannot be used as a proxy for skill within the NHS.

**Recommendation:** It is essential for the NHS that the starting salary on nationally-agreed pay scales remains the basis for determining the pay for highly-skilled NHS professionals.

4. Restricting Tier 2

4.1 Restricting Tier 2 (General) to genuine skills shortages

What will be the impact of restricting Tier 2 (General) to genuine skills shortages and highly specialist experts?

How could a restricted Tier 2 (General) route maintain flexibility to include high value roles and key public service workers?
In a survey undertaken by the HSJ in 2014 more than 54% of HR directors said they planned to recruit staff from overseas and this rose to 82% for acute trusts. Tier 2 (General) currently provides a balance between relieving workforce pressures through the employment of migrants whilst protecting the UK trained workforce. Problems have only recently arisen since the monthly cap has been reached and salary has been introduced as a determining factor in the approval of applications.

4.2 Regional differences in skills shortages

<table>
<thead>
<tr>
<th>What evidence is there of significant regional differences in skills shortages?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Particular concerns have been raised in regard to defining shortages by specialty as this does not adequately take account of national and regional variations. Given the number of vacancies in Wales, consideration needs to be given to establishing a separate Shortage Occupation List (SOL) for medicine in Wales, as is the case with Scotland. There may also be specific shortages in Northern Ireland, such as in radiology, which are not addressed through the UK list. There is a concern that, while the list remains UK wide, removing a specialty from it may be detrimental to the workforce in Wales and Northern Ireland due to the devolved nature of healthcare and associated workforce planning.</td>
</tr>
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</table>

4.3 Recruiting highly specialist experts

<table>
<thead>
<tr>
<th>What evidence is there of the need to recruit highly specialist experts?</th>
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<tbody>
<tr>
<td>UK medical research depends upon the contribution of international doctors. It is important for UK companies, universities and research institutes to attract and retain top researchers from all over the world. The employment of world class researchers helps to ensure that UK universities and companies involved in medical research maintain an internationally competitive edge. The highly specialised nature of much medical research means that it can be difficult to sustain research projects employing solely UK nationals. Experts within a specific field may simply be so few in number that there are none available domestically. The loss of top medical research and academic talent would impact adversely upon UK medical research activity. If companies carrying out medical research find that in the UK they are unable to employ the best medical researchers from around the world, then they may move their operations abroad to countries where this is possible. Clinical Academic Medicine requires specific consideration in regards to its unique workforce needs.</td>
</tr>
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</table>

4.4 Restricting switching from the Tier 4 student route

<table>
<thead>
<tr>
<th>What would be the impact on business and the economy of restricting recruitment to genuine skills shortages and highly specialised experts for migrants switching from the Tier 4 student route?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ability to switch from the Tier 4 student route into Tier 2 (General) is essential for the medical workforce. Overseas graduates of UK medical schools receive Tier 4 sponsorship to undertake the two year Foundation Programme. There would be significant consequences if overseas graduates of UK medical schools were prevented from switching from the Tier 4 student route into Tier 2 (General). Health Education South London, on behalf of the UK Foundation Programme, currently sponsors 478 doctors in Foundation Year One and 536 doctors in Foundation Year Two. Removing the ability to switch from Tier 4 to Tier 2 would prevent these UK trained doctors from progressing into specialty training and in turn would restrict the number of UK trained doctors who were available to take up future specialty doctor, general practitioner and consultant roles. The BMA cannot support the implementation of visa rules that retrospectively impact on students and doctors who have already committed to studying and working in the UK for up to 8 years. Students who are currently at UK medical schools have a legitimate expectation that they will be able to progress from the Foundation Programme through an RLMT exemption when switching from Tier 4 to Tier 2. Medical workforce planning is predicated on this.</td>
</tr>
</tbody>
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1. [http://www.hsj.co.uk/news/overseas-recruitment-of-nurses-to-rise-amid-fears-over-shortages/5071536.article#Vb9Q8PvHbD](http://www.hsj.co.uk/news/overseas-recruitment-of-nurses-to-rise-amid-fears-over-shortages/5071536.article#Vb9Q8PvHbD)

2. Statistics received from Health Education South London, current as of 11 September 2015
**Recommendation:** The ability to switch from Tier 4 to Tier 2 must be retained for doctors on the Foundation Programme.

### 4.5 All other in-country applications

What would be the impact on business and the economy of restricting recruitment to genuine skills shortages and highly specialised experts for migrants switching from all other in-country applications?

There are a number of instances where doctors make in-country applications:

- Doctors in training complete a two or three year core training programme then apply for higher specialty training through national recruitment. Those successfully appointed to a higher specialty training post will make an in-country Tier 2 (General) application.
- Doctors who have completed their three year training in General Practice then make an in-country Tier 2 application when appointed to a position as a GP (General Practitioner).
- Doctors moving out of training and into the specialty doctor or consultant grades, having met the RLMT, will make an in-country Tier 2 (General) application.

If the ability to make an in-country application was removed or restricted, UK trained doctors, who are subject to the visa rules, would face significant difficulty when applying for jobs within the NHS. The total investment in a registrar level\(^4\) doctor trained in the UK is estimated at £441,219. Removing the ability to switch from Tier 4 to Tier 2 and in-country applications risks losing this investment from the NHS.

**Cost of training of doctors employed within the NHS (extracted from Unit Costs of Health and Social Care 2014, PSSRU, University of Kent)\(^5\)**

<table>
<thead>
<tr>
<th></th>
<th>Pre-registration</th>
<th>Post-graduate training</th>
<th>Totals</th>
<th>Expected annual cost at 3.5% (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tuition (£)</td>
<td>Living expenses/lost production costs (£)</td>
<td>Clinical placement (£)</td>
<td>Tuition and replacement costs (£)</td>
</tr>
<tr>
<td>Foundation Officer 1</td>
<td>42,634</td>
<td>59,797</td>
<td>132,698</td>
<td>NA</td>
</tr>
<tr>
<td>Foundation Officer 2</td>
<td>42,634</td>
<td>59,797</td>
<td>132,698</td>
<td>43,664</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>42,634</td>
<td>59,797</td>
<td>132,698</td>
<td>205,090</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>42,634</td>
<td>59,797</td>
<td>132,698</td>
<td>262,845</td>
</tr>
<tr>
<td>GP</td>
<td>42,634</td>
<td>59,797</td>
<td>132,698</td>
<td>249,261</td>
</tr>
</tbody>
</table>

\(^4\) The component grades of this group are specialist registrars (SpRs), senior registrars, registrars, specialty registrars (StRs) who are on run through specialist training (ST grades) and other staff working at equivalent grades that are not in an educationally approved post. Health and Social Care Information Centre. NHS Workforce: Summary of staff in the NHS: Results from September 2013 Census [http://www.hscic.gov.uk/catalogue/PUB13724/nhs-staf-2003-2013-over-rep.pdf](http://www.hscic.gov.uk/catalogue/PUB13724/nhs-staf-2003-2013-over-rep.pdf)

Over a third of doctors practising today qualified overseas and they enrich the NHS with their skills and diverse perspectives. Many doctors who qualified overseas have overcome a number of difficulties when integrating into the NHS. Restricting the ability of these doctors to make in-country applications when national and regional workforce shortages exist is counterproductive and would result in doctors who have developed knowledge and experience in the NHS having to leave the country, and new doctors having to enter the UK to fill the continuing national and regional shortages that exist.

**Recommendation:** It is essential that the ability to make in-country applications is retained for the medical profession for both those qualified in the UK and those qualified overseas.

5. **Shortage Occupation List**

The Shortage Occupation List is designed to capture occupations and job titles that are currently experiencing a labour shortage that would be sensibly filled using non-EEA labour. One potential way to restrict Tier 2 (General) to genuine skills shortages would be to have one route based on an expanded Shortage Occupation List which replaces the current Resident Labour Market Test route.

How could the methodology to set the SOL be expanded to develop a revised Tier 2 (General) which restricts the route to genuine skills shortages and highly specialised experts only?

What occupations would you expect to see on an expanded shortage occupation list? How does the occupation or job title you are suggesting satisfy each of the criteria in relation to “skilled”, “shortage” and “sensible”?

How far in advance can your organisation, sector or local area anticipate a potential shortage in skilled labour?

Alternatively is it sensible to leave the present Tier 2 (General) route intact and achieve any reduction in economic migration by raising the pay threshold only?

The proposal to replace Tier 2 (General) with an expanded SOL is concerning. It would be difficult for an expanded SOL to reflect the complex workforce needs of the medical profession and the wider NHS. Whilst the Resident Labour Market Test places a number of requirements on employers, it also provides them with the flexibility they require to meet workforce needs.

We have already outlined in this submission that the medical workforce is unique in its treatment of overseas graduates as ‘home-grown’ UK doctors. Stakeholders have worked hard to establish single sponsorship processes in Scotland and England that meet the needs of the medical training pathway. A significant amount of work has gone into this and the initial outcomes from the 2015 recruitment round to specialty training suggest that this unified system is fit for purpose.

As stated under section 3 it would not be appropriate for the NHS to achieve any reduction in economic migration simply by raising the pay threshold. The NHS uses nationally-agreed pay scales to prevent undercutting of the local job market and to ensure equality measures are met. Increasing pay thresholds would result in the NHS being unable to recruit internationally.

**Recommendation:** The BMA urges the MAC to recommend to the Government that the Tier 2 (General) route should be retained in its current format for the medical profession and the wider NHS. A specific Shortage Occupation List (SOL) should be retained as part of the Tier 2 (General) route to deal with specific shortages.

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* http://bma.org.uk/equalityresources
The balance of Tier 2 (General) with an associated SOL ensures that where acute shortages exist the NHS can recruit from overseas without meeting the RLMT but in all other instances the RLMT has to be met to ensure the availability of roles for UK/EEA applicants.

5.1 Shortage of GPs

The BMA recommends that general practice is added to the SOL; shortage of GPs impacts every other specialty. Access to GPs is key to dealing with pressure on the NHS but only if it is dealt with through long-term and sustainable solutions.

The Centre for Workforce Intelligence (CFWI) review of the GP workforce concluded that the current level of GPs being trained is inadequate and likely to lead to a major workforce demand-supply imbalance by 2020 unless action is taken. It recommended that Health Education England (HEE) consider a substantial increase in GP training numbers and proposed a number of measures to help boost workforce supply, particularly in the short term, given the significant lead in time in training new GPs.

The CFWI analysis shows that significant workforce undersupply is likely under both the baseline supply and all supply scenarios, posing a clear risk of major demand-supply imbalance. The main policy option to prevent this is to increase the intake of new GPs through additional postgraduate training posts. However, the analysis also shows that this may not, on its own, be sufficient to ensure that workforce supply balances expected demand unless it is accompanied by other measures to boost GP supply. Adding general practice to the SOL would be an interim measure to boost supply until the UK GP workforce has been trained up to meet the demand.  

5.1.1 Problems with recruitment of GPs

- The Department of Health had to defer the recruitment target of 3,250 GPs until 2016 and it seems very unlikely the DH target of half of all junior doctors going into GP training will be met
- The actual increase in GP trainee places in 2013 was just 95 compared with the previous year. The total number recruited – 2,725 – fell far short of the 3,250 needed for 2014 and beyond.
- In October 2014, only 124 additional medical graduates signed up for GP training posts as part of an unprecedented third recruitment round designed to ease the training crisis
- The figures from HEE revealed that the final intake for 2014 was 2,688 - which was 88% of the total places available, and represented a 2.7% decrease on the number of posts filled in 2013
- It also remained well below HEE’s target of 3,250 trainees per year entering general practice by 2016 - which, itself, was postponed from the original target date of August 2015.

The BMA consulted the GP workforce both in 2014 and 2015. Cohort doctors were asked to respond to a series of statements relating to the general practice workforce in their region. Most responses point to an increasing shortage of GPs. For example, 62% agreed with the statement that they know a number of partner GPs who have recently or plan to retire in the next year, 46% of cohort doctors said there is already a shortage of GPs in their area and 78% disagreed with the statement that GPs are unable to find work in their area. The findings from the BMA GP survey of 15,560 GPs undertaken in April 2015 supported the continuation of these trends and indicated that a third of GPs were considering retiring from GP practice in the next five years.

5.1.2 Specific shortage of GPs in Scotland

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7 http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce/@@publication-detail
8 http://www.pulsetoday.co.uk/20008297.article#VEodfvmF8aU
Information Services Division (ISD) figures of GP numbers (headcount) in Scotland from 2004 – 2013 show that numbers of GPs in Scotland have been decreasing since 2009.  

The Scottish Government’s 2013 GP Workforce Survey states that the estimated number of whole-time equivalent GPs is very similar to the 2009 number - 3735 compared to an estimated 3700 in 2009. However, while GP numbers have stayed approximately the same, the populations they are serving have grown, meaning more patients per practice and a rising workload. The average list size per practice has risen from 5,295 in 2007 to 5,622 in 2013 – a 6% increase.

Research done by BMA Scotland regarding GP recruitment shows that the number of GP training positions taken up each year is falling, from more than 95% of places filled in 2012, to less than 80% this year. There are also almost double the vacancies in Scotland this year as there were last year: 64 in 2015 compared to 33 in 2014.

### 5.1.3 Specific shortage of GPs in Wales

In 2004, the Welsh Government set an annual "Input to GP training in Wales" target of 136 individuals every year, which the BMA understood to mean the Welsh Government were aiming for a similar annual number of additional GPs 3 years or so after each intake.

We can compare the percentages of trainees recruited in each of the last few years to the target of 136. Significant attrition from training programmes greatly limits the predictive value of recruitment figures alone in assessing the adequacy of annual outputs from GP training in Wales each year. For several years the specified input target of 136 has not been achieved in Wales. The figures reflect this:

<table>
<thead>
<tr>
<th>OUTPUT figures</th>
<th>Number of GP trainees gaining a successful Certificate of Completion of Training (CCT)</th>
<th>Percentage of 136 (target number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>108</td>
<td>79%</td>
</tr>
<tr>
<td>2011</td>
<td>98</td>
<td>72%</td>
</tr>
<tr>
<td>2012</td>
<td>93</td>
<td>68%</td>
</tr>
<tr>
<td>2013</td>
<td>90</td>
<td>66%</td>
</tr>
<tr>
<td>2014</td>
<td>101</td>
<td>74%</td>
</tr>
</tbody>
</table>

Aside from the major recruitment and attrition issues outlined above, we would also make the point that the current input target of 136 new GPs in Wales per year may be too low. If we were to align GP recruitment in Wales to that in England on a Barnett or population basis, we should be recruiting between 190-200 trainees per year in Wales.

### 5.1.4 Additional costs of providing GP cover in Wales due to shortages in workforce

The BMA has been provided with figures from Primary Care Finance in NHS Wales to show the additional costs per annum for providing locum cover for GPs for five practices in North Wales (used as a sample) with list sizes ranging from 1,015 to 4,055, and vacancies varying in length from four months to three and a half years. These costs are calculated as additional to those which would have been paid through the contract to a permanent employee, and converted to an annual cost.

The average for each of the five practices is an additional £68,000 per annum, meaning an additional £29 per patient per annum. This means an average practice list of 6,746 could see an additional cost of £196,000 per annum to pay for

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11 [http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/Workforce/](http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/Workforce/) table 1
locum cover. NHS Wales state that, “The maximum we have seen (for additional costs to cover locums) is £133,000 per annum”.

**Recommendation:** The Shortage Occupation List should be retained in its current format for the medical profession with the addition of General Practice.

### 5.2 Shortages in Staff, Associate Specialists and Specialty Doctors

#### 5.2.1 Shortages of Staff, Associate Specialists and Speciality Doctors in England

The BMA defines staff, associate specialists and specialty doctors as doctors working in NHS trusts who are not general practitioners, nor in the training grades and whose posts do not require their names to be on the Specialist Register.

Currently, the SOL lists non-consultant, non-training, medical staff post in the following specialities:

- anaesthetics;
- general medicine specialities delivering acute care services (intensive care medicine, general internal medicine (acute);
- emergency medicine (including specialist doctors working in accident and emergency);
- rehabilitation medicine
- psychiatry.

#### 5.2.2 Difficulty in gathering evidence of vacancy rates

As has been stated before in this paper, it is difficult to quantify shortages when we no longer have access to vacancy statistics for SAS doctors.

In these circumstances, the BMA has therefore used Freedom of Information (FOI) Act requests to garner this information. In April 2014 the BMA sent an FOI Act request to 260 NHS organisations in England requesting the following information. A total of 149 responses were received. These responses showed that across the 149 responses there were 679 SAS vacancies, an average of 4.6 vacancies per organisation. 38 organisations reported that they did not have any vacancies. The highest number of vacancies in an individual organisation was 31, of which 7 were filled by locums.

The highest rates of vacancies in England across the 149 responses were:

<table>
<thead>
<tr>
<th>Branch of medicine</th>
<th>Number of vacancies in 149 NHS organisations</th>
<th>As percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medicine</td>
<td>70</td>
<td>47%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>41</td>
<td>28%</td>
</tr>
<tr>
<td>Accident and Emergency</td>
<td>36</td>
<td>24%</td>
</tr>
<tr>
<td>General surgery</td>
<td>34</td>
<td>23%</td>
</tr>
<tr>
<td>General psychiatry</td>
<td>32</td>
<td>22%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>32</td>
<td>22%</td>
</tr>
<tr>
<td>General medicine</td>
<td>19</td>
<td>13%</td>
</tr>
<tr>
<td>Old age psychiatry</td>
<td>17</td>
<td>12%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>16</td>
<td>11%</td>
</tr>
<tr>
<td>Adult mental care</td>
<td>15</td>
<td>10%</td>
</tr>
<tr>
<td>Older adult mental care</td>
<td>14</td>
<td>9%</td>
</tr>
</tbody>
</table>

A total of 2244 vacancies across the 149 organisations were advertised in the 24 months covered by the FOI
Act requests, averaging 15.2 vacancies per organisation. The highest number was 122 at one individual organisation.

**Recommendation:** In the light of the evidence above, we would urge the MAC to continue to include all of the current specialties on the SOL, as these specialties represent those with the highest vacancy rates, and where it would be sensible to recruit doctors from outside the EU/UK

### 5.3 Shortages in Consultant posts

Currently, the following consultant posts are on the UK SOL list:

- emergency medicine
- haematology
- old age psychiatry.

#### 5.3.1 Consultants in emergency medicine

Emergency Medicine continues to have difficulties with both recruitment and retention. The Commons Public Accounts Committee report Emergency Admissions to Hospital recommended that the Department of Health and NHS England develop and implement an immediate plan to address the ‘chronic shortage’ of emergency medicine consultants. It also suggested struggling hospitals should be allowed to offer higher pay to emergency medicine doctors.

Consultants working in emergency medicine face increasingly challenging, high-pressured and stressful work environments, often with limited resources and gruelling workloads. The report says in 2012, there were 5.3 million emergency admissions to hospitals in England — an increase of 47 per cent over the past 15 years.

In the same year, nearly one in five consultant posts in emergency departments was either vacant or filled by locums and just 18.5 per cent of specialty trainee four posts for emergency medicine doctors were filled.

We appreciate efforts to deal with the recruitment crisis through the current Emergency Medicine Workforce initiative, whereby overseas doctors are recruited short-term to fill gaps in the workforce. However, this is intended only as a stop-gap and does not deal with the ongoing problems with recruitment and retention of doctors in emergency medicine. The introduction of run-through emergency medicine is also encouraging; however, simply filling vacancies with the use of the Shortage Occupation List, or through the Emergency Medicine Workforce, does not remedy the issues of job satisfaction and long working hours, which see emergency medicine doctors leaving the UK for better conditions and working hours elsewhere, and consequent loss to the taxpayer and patients of these highly trained professionals.

#### 5.3.2 Consultants in haematology

Doctors report to us that haematology continues to experience shortages. It is difficult to quantify shortages when we no longer have access to vacancy statistics, other than some in Scotland.

Members report that there is a general shortage of suitable candidates for radiology consultant posts whether interventional or reporting. Posts in District General Hospitals have been vacant for many months and advertisements have attracted no suitable candidates. In a wider context, it has long been a challenge to fill vacancies across the whole of the Pathology specialty, especially histopathology and specialised posts in paediatric settings.

#### 5.3.3 Consultants in psychiatry

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Psychiatry in general continues to experience shortages. It is difficult to quantify shortages when we no longer have access to vacancy statistics, other than some in Scotland. According to the NHS Scotland figures, general adult psychiatry has an 8.9% vacancy rate and Old age psychiatry has a 15.8% vacancy rate.

However, we have received evidence from BMA members stating that they are aware of a number of long-term vacancies in General Psychiatry and that posts for Specialist Doctors in Psychiatry are not even advertised as there is no-one to fill them.

5.3.4 Consultant and other medical practitioner posts in Scotland

NHS Scotland workforce statistics reveal vacancies in consultant and other medical practitioner posts as a percentage of the workforce and list which vacancies have been open for six months or more. It should be noted that the way in which these vacancy numbers are calculated results in a large under-counting of actual vacancy rates, as the figures do not include jobs which are vacant where the health board has decided not to fill the post. Neither do they include jobs which are currently being performed by locum staff.

For example, for emergency medicine consultants, the NHS Scotland figures show a workforce numbering 184, with 163 staff in post and a vacancy rate of 11%. This is very high, and when one considers that many of the staff in post will be locums and that some posts will not be counted as vacancies because it has been decided not to fill them, the true vacancy rate is even higher.

Consultant jobs in the following specialties show very high vacancy rates in the NHS Scotland figures:

- Child and Adolescent Mental Health Services (CAMHS) – 14.5% vacancy rate
- General adult psychiatry – 8.9% vacancy rate
- Old age psychiatry – 15.8% vacancy rate

The following medical practitioner jobs are also on the Scottish SOL:

- ST3, ST4, ST5 and ST6 trainees in paediatrics or anaesthetics
- SAS staff doctors in paediatrics or anaesthetics
- non-consultant, non-training doctors in the specialty obstetrics and gynaecology
- consultants in paediatrics or anaesthetics

Statistics for 2015 obtained from the Scottish Shape of Training Transition Group show particularly high vacancy rates in the following specialties, none of which are currently included on the Scottish SOL:

- Specialty and ST4-6 Forensic psychiatry – fill rate of 44% in 2015 compared to 100% in 2012
- Specialty and ST4-6 Old age psychiatry – fill rate of 42% in 2015 compared to 100% in 2011
- Specialty and ST4-6 Learning disability psychiatry – fill rate of 50% in 2015 compared to 100% in 2011
- Specialty and ST4-6 General adult psychiatry – fill rate of 37% in 2015 compared to 100% in 2011

Recommendation: In the light of the evidence above, we would urge the MAC to continue to include all of the current specialties on the Scottish SOL, and to add the following:

- Specialty and ST4-6 doctors in forensic psychiatry
- Specialty and ST4-6 doctors in general adult psychiatry
- Specialty and ST4-6 doctors in old age psychiatry
• Specialty and ST4-6 doctors in learning disability psychiatry
• Consultants in child and adolescent mental health services
• Consultants in general adult psychiatry
• Consultants in old age psychiatry

5.4 Occupational medicine

The GMC report on the State of Medical Education and Practice in the UK\textsuperscript{16} states that:

• Occupational medicine and public health had more doctors aged over 50 than other specialties.
• The number of OM specialists has fallen by 4.7% in 3 years.
• Doctors report high levels of stress. In one part of the UK, the proportion of GPs presenting to local occupational health services increased nearly five times from 2000 to 2012 and, in another part of the UK, 2013 was described as the busiest year for two decades for the number of GPs burning out from stress.

Recommendation: The BMA calls for consideration to be given to adding occupational medicine to the SOL.

6. Sunsetting

The MAC has been asked how to limit the length of time occupations can be classed as having shortages:

How long should any maximum duration be?

What, if any, exceptions should there be to this and why?

The Government has indicated that it wishes to remove all occupations from the Shortage Occupation List that have been on it for more than a given period. The BMA acknowledges that inclusion on the list is intended to provide temporary relief while measures are taken to mitigate shortages and recognises that the principle of reducing reliance on migrant workers and training and up-skilling UK resident workers to fill workforce gaps is entirely valid. There are inherent difficulties with being prescriptive with the length of time a specialty remains on the list as this will depend on a number of factors such as the point in the workforce where shortages exist along with regional variations. A UK medical student will typically spend five years as an undergraduate before undertaking the two-year Foundation Programme, followed by a specialty training programme which varies in length from three to eight years. Ensuring the necessary level of skilled doctors in each specialty takes time due to the length of training pathways. In relation to filling existing medical vacancies there remains a need to ensure that posts in less popular medical specialties and in less popular regions of the country are made as attractive as possible in respect of Continuing Professional Development and improvements made to national terms and conditions, to generate greater interest from the resident population; this is likely to take time and investment.

It would be inappropriate to proceed to automatic removal without first assessing the impact across all four nations. The BMA is committed to appropriate recruitment with the main aim of appointing people with the right qualifications, skills and language competence. This should be done in line with the needs of workforce planning in the UK and with an awareness of the restrictions that may be placed on international doctors as a result of the immigration rules.

\textsuperscript{16} http://www.gmc-uk.org/publications/25452.asp?WT.ac=WBPR141006
**Recommendation:** The primary consideration for the SOL for medicine is to align it to actual workforce needs. Sunsetting restrictions, were they to be put in place, ought to reflect the average length of training rather than being uniform across all occupations with particular consideration given to the long timeframe for medical specialty training. A consistent approach to country by country recording and reporting of vacancies could make evaluation of whether and how long to keep specialties on a shortage list more informed.

7. **Intra-company transfers**

The Tier 2 (Intra-Company Transfer) category is the most used route under Tier 2. The Government has asked that the MAC consider the scope for action to tighten the intra-company transfer provisions.

The BMA has previously raised concerns regarding the favourable treatment given to those on the ICT route compared to those entering the UK on Tier 2 (General) when the NHS has very limited capacity to use the Tier 2 (ICT) route. The introduction of the health surcharge exemplifies with those on Tier 4 and Tier 2 (General) being subject to the fee whilst those on the Tier 2 (ICT) route are exempt. A system where applications for Certificates of Sponsorship are being rejected due to the monthly allocations being exceeded for Tier 2 (General) but ICT applications remain unchecked has led to unbalanced visa allocations which particularly benefit IT outsourcing companies.

**Recommendation:** The favourable allocation of visas for the Tier 2 (ICT) route should be rebalanced in favour of Tier 2 (General).

8. **Skills levy**

The Government has asked that the MAC to consider applying a skills levy to businesses recruiting from outside the EEA, the proceeds from which would fund apprenticeships in the UK.

*What would be the impact of different levels of levy on your occupation or sector? Would a skills levy affect the way you recruit?*

*Should a skills levy apply to all businesses recruiting from outside the EEA? If not, to which businesses should a skills levy apply and why? Why should other businesses by exempt from the levy?*

*Should a skills levy be a one-off payment at the point of recruitment of a Tier 2 migrant or should it be on an annual basis for the duration of the migrant’s stay under their initial Tier 2 visa?*

*Would a skills levy have specific regional impacts?*

The BMA recognises that the principle of reducing reliance on migrant workers and training and up-skilling UK resident workers to fill workforce gaps is entirely valid. Training doctors is a lengthy process and requires an undergraduate medical degree. A UK medical student will typically spend five years as an undergraduate before undertaking the two-year Foundation Programme. It would not be possible to up-skill resident workers to become doctors without them going through this long and rigorous training process.

In relation to filling existing medical vacancies there remains a need to ensure that posts in less popular medical specialties and in less popular regions of the country are made as attractive as possible, including in respect of continuing professional development and terms and conditions, to generate greater interest from the resident population. This is likely to take time and investment but is not necessarily a process that requires any significant up-skilling of the resident medical workforce outside existing training structures.

The Staff, Associate Specialist and Specialty Doctor (SAS) grades provide a useful example. The proportion of SAS grades who qualified overseas has generally remained stable in recent years, moving from 49% in 2012 to 47% in 2014. This highlights the traditional reliance of these grades on the overseas workforce. The BMA has been undertaking work to make these grades a positive career choice but it is too early to tell what impact this

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will have on the UK workforce. The BMA urges employers to do more to make these grades more attractive through increasing opportunities for continuing professional development.

A single sponsor arrangement is in place for medical trainees in Scotland and England. These sponsors are already engaged in training doctors so enforcing an additional skills levy would be taking money out of an already overstretched NHS.

**Recommendation:** A skills levy is not an appropriate mechanism for the medical workforce; the NHS should be exempt from any skills levy.

### 9. Tier 2 Dependents

| **Dependants of** Tier 2 migrants, such as partners, spouses and adult minors, presently have the unrestricted right to work in the UK. The MAC has been asked to consider the impact of removing this automatic right. |
| **How would removing the automatic right of dependants to work affect main applicants’ decision of whether to come to work in the UK?** |
| **Would removing the automatic right of dependants to work have social impacts?** |

UK employers should be able to access the brightest and the best overseas doctors where there is a workforce need. Such doctors make an invaluable contribution to NHS service delivery and also to research. They should therefore be afforded the same rights and privileges as UK and EEA citizens. If they are to enjoy the right to a family life and to fully settle into the wider community, it is the view of the BMA that the immigration rules must include provisions enabling any overseas-based dependants to join them in the UK and for those dependants to work should they wish to do so. Overly restrictive policies on dependants will also discourage overseas students and doctors from coming to the UK as they will opt instead to migrate to those countries where they are able to live with their dependants.

The BMA is concerned about the impact the proposal will have on the ability of overseas doctors to integrate into UK life. This is supported by evidence from the Migrant Integration Policy index III which states that “families who are successfully reunited together have the socio-cultural stability to participate in society...a migrant who is kept apart from his family has few prospects to integrate in the community where he lives”\textsuperscript{18}. This is at odds with the concept of restricting the rights of Tier 2 dependants from working in the UK.

Doctors who make the decision to come to the UK to work face a number of challenges when settling into UK life. It is essential that those taking this step do so with the support of their family. The ability of a dependant to work may be fundamental to the stability of the family and essential for integrating into UK life. The BMA Immigration Advice Service frequently speaks to doctors employed in the NHS who are dependants of Tier 2 (General) visa holders. It is impossible to quantify how many doctors working in the NHS at any one time are Tier 2 dependants or work in another capacity within the NHS. It is unrealistic to expect migrants to come to the UK without dependants and, likewise, to expect those dependants to be prevented from contributing to UK society through meaningful employment.

**Recommendation:** No changes should be made to the Tier 2 dependant rules until a full assessment has been made of the impact of any change to the NHS and on the quality of life and integration of Tier 2 visa holders.

### 10. Overall Tier 2 design

As part of the review of Tier 2, the MAC would be interested to hear wider views about ways in which the design of Tier 2 can be changed to allow businesses to hire the skilled migrants they required in order to fill skills shortages.

\textsuperscript{18} Migrant Integration Policy Index III (British Council and Migration Policy Group, Brussels) 2\textsuperscript{nd} Edition February 2011 p14
To what extent do the existing Tier 2 mechanisms and framework work optimally to enable business to bring in skilled workers that they require?

What changes would you make to the design of the route that would address the issues identified and are not reflected in the changes discussed elsewhere in this call for evidence?

Throughout this response to the MAC call for evidence the emphasis has been on maintaining the current Tier 2 (General) visa route alongside the Shortage Occupation List. The focus on salary levels as a proxy for skill is detrimental to the NHS as a whole due to the nature of the pay scales in use.