

BMA Member Briefing: **Health and Social Care Select Committee report**

*Workforce: recruitment, training and
retention in health and social care*



Introduction

This briefing provides an overview of the House of Commons Health and Social Care Select Committee's [newly published workforce report](#), as well as the BMA's analysis of the Committee's recommendations to Government. This report forms part of the Health and Social Care Select Committee's [wider inquiry](#) into the health and social care workforce, to which the BMA [submitted written evidence](#) and [supplementary written evidence](#) in April 2022.

The report outlines the 'greatest workforce crisis in history'

Published in July 2022, the report examines the state of recruitment, training, and retention in the English NHS. In so doing, it describes 'the greatest workforce crisis in history' and emphasises the failure of the UK Government to take appropriate action.

On recruitment, the report concludes that almost every healthcare profession is facing shortages, with the situation regrettably worse in social care. On retention, the report highlights the need to revamp flexible working and emphasises the need for reform of the 'national scandal' of punitive pension taxation that forces senior doctors to cut their hours. In addition, it suggests the development of a national NHS 'retire and return' policy to replace ad hoc local schemes.

The report also notes the rising cases of racism, bullying, harassment, and abuse faced by NHS workers, which it acknowledges is affecting retention.

Much of the report aligns with the BMA's own calls

The Committee's report echoes many of the BMA's own positions on the key areas it addresses, and we see it as an important contribution to the ever-growing evidence supporting a radical change in UK Government policy on the NHS workforce.

A number of recommendations set out in the report align with our own calls, including a call for the publication of a comprehensive workforce strategy with short and long-term workforce projections, immediate reform of pension taxation, improving international recruitment, and removing unnecessary administrative barriers for IMGs (international medical graduates). The report also reflects several of the BMA's recommendations for [delivering racial equality in medicine](#).

Report recommendations and BMA analysis

The report establishes a wide range of recommendations to the UK Government and NHS regarding the health and social care workforce, addressing:

- workforce planning
- recruitment
- retention
- training
- working culture – including the experience of ethnic minority staff

This summary only covers those recommendations directly impacting the medical workforce. Additional recommendations covering the social care workforce can be found in the [report](#).

Workforce planning

Recommendations from the Health and Social Care Select Committee report

The Health Secretary must publish objective, transparent and independently audited reports on workforce projections for health, public health, and social care. These should; cover the next 5, 10, and 20 years; state current staffing levels, future projections, and assess whether enough are being trained in each profession and specialty; model demand on demographic change among patients and staff; and consider changes in technology, treatments, and costs.

The Government must authorise arm's length bodies to publish data on workforce gaps and publish the full report of the NHS workforce strategy with gap analysis and workforce projections for the next 5, 10, and 15 years for each profession by the end of 2022.

BMA analysis: The BMA welcomes the recommendations on workforce planning, particularly the need for transparency when publishing the data used to calculate workforce shortages and projections. The BMA is a founding member of a coalition of more than 100 organisations calling for independent, long term workforce projection data to be routinely published. The BMA lobbied for this during the passage of the Health and Care Act and continues to call for this to be included in the NHS Long Term Workforce Plan. Published assessments are vital as without transparency on these numbers, the calculations used for workforce planning cannot be scrutinised by expert organisations – and without this scrutiny, there can be little confidence that progress is underway to address the workforce crisis.

Recruitment

Recommendations from the Health and Social Care Select Committee report

Formal re-entry programmes should be developed by the NHS, HEE, and the GMC for secondary care doctors who wish to return to work after a long break.

The UK Government must consult with relevant bodies to explore further opportunities to mobilise the volunteers used during the pandemic and consider whether further changes to the law are necessary in order to allow more volunteers to work temporarily on specific tasks in the NHS.

The GMC should introduce a 'green list' of countries whose doctors are given an automatic right to practise in the UK following the minimum necessary checks and review CESR (Certificate of Eligibility for Specialist Registration) processes to ensure demands on IMGs are fair and proportionate.

The UK Government should invest in the AoMRC's (Academy of Medical Royal Colleges) Medical Training Initiative, which recruits international medical graduates to work in the NHS for a fixed-term period with a specific remit of improving the quality of healthcare in developing countries.

The UK Government must commit to revising the level of proof required for doctors to bring their adult dependants in the UK via visa routes to ensure it is not deterring recruitment and retention.

Scrap rules requiring medical staff entering the UK on Tier 5 visas to pay the NHS surcharge.

IMG GP trainees should be offered Leave to Remain on successful completion of speciality training.

A default six-month visa extension should be granted after an IMG's expected GP training completion date, to give them time to find an appropriate employer.

Immigration and visa authorities should work with the NHS to support GP practices to sponsor IMGs.

It should be made easier for IMGs to bring immediate family members to the UK.

BMA analysis: Overall, the BMA is supportive of the Committee's recommendations on recruitment, particularly the call to introduce a formal re-entry programme for secondary care staff who wish to return to work after a long break – while there is a formal re-entry programme for primary care doctors, no similar programme exists for secondary care doctors.

In relation to the recommendation on granting a six-month visa extension to IMGs after completing GP training, the BMA is calling on the UK Government to go further by introducing a permanent solution to allow newly qualified GPs to transition into full time employment without the anxiety of having to find a GP practice with a sponsorship licence.

The impact of failing to secure full time employment before a visa expires can be dire, putting a doctor's immigration status at risk. Efforts to support GP practices to navigate the sponsorship process have not prevented many newly qualified GPs from finding themselves in an uncertain situation. This is a tremendous loss and economically wasteful as GP training is funded by the UK taxpayer and impacts on future GP numbers, which in turn impacts patient care. This is particularly concerning given the existing workforce shortages in general practice – BMA analysis has shown that as of August 2022 (latest data) we now have the equivalent of 1,850 fewer fully qualified full-time GPs in England compared to September 2015 (when the current collection method began, despite the 2019 Conservative Party manifesto pledge to recruit an additional 6,000 more GPs). A permanent solution – which could include an accelerated route to indefinite leave to remain after three years, or an umbrella sponsorship, with an overarching organisation acting as a sponsor for two years post-CCT – is therefore paramount to avoid future trainee GPs facing the same uncertainty and to helping address the shrinking medical workforce in general practice.

On the recommendation for the revision of proof required for doctors to bring adult dependants, the BMA is calling on the UK Government to remove the restrictive adult dependency rules for healthcare workers. The BMA has consistently raised concern about the potential impact on patient care and the wider NHS if doctors choose to relocate due to the restrictive rules and given the cost it takes to train a doctor – it makes little economic sense to risk losing them from the health service altogether. At a time when doctors and the healthcare system have been under enormous stress due to the Covid-19 pandemic and dealing with the backlog of care, it is vital that this cruel policy which is negatively impacting their wellbeing and causing them to leave the NHS, is scrapped.

The BMA supports ethical recruitment. We believe that unnecessary and expensive bureaucratic barriers faced by IMGs should be removed to ensure that the NHS is attractive and welcoming, and strongly believe that IMGs must have high-quality inductions, mentorship programmes and safeguards against exploitative contracts.

The BMA has also called on the Government to grant all international doctors currently in the UK and on route to settlement automatic indefinite leave to remain – to clearly signal that our international workforce is an integral part of our healthcare system. This would be an appropriate move in recognition of their commitment and sacrifices during the pandemic and, with the UK facing a huge healthcare backlog, it would allow them to continue their invaluable contributions to the healthcare system without having to worry about their immigration status.

Retention

Recommendations from the Health and Social Care Select Committee report:

The NHS should conduct a welfare provision assessment to consider how to provide all staff with 24/7 access to hot food and drinks, free parking, and places to rest, store their belongings, shower and change, and take breaks with colleagues.

The UK Government should review the provision of affordable and flexible childcare for people working in health and social care and assess if it can be improved.

The NHS must review flexible working arrangements in all Trusts, to ensure that within 12 months all staff have similar flexibilities in their working arrangements to those enjoyed by locum or agency staff – reduced or flexible hours must be made available to everyone, but especially those with caring responsibilities or those nearing retirement, and investment should be made in technologies which allow for homeworking or remote consultations.

The UK Government must act swiftly to reform the NHS pension scheme to prevent senior staff from reducing their hours and retiring early from the NHS.

The Temporary suspension of regulations governing the administration of NHS pensions, made under the Coronavirus Act 2020, helped to ameliorate the pension issue during the pandemic. The UK Government should consider ways to achieve the same outcome now.

NHS England should develop a national 'retire and return' policy, replacing ad hoc local schemes.

The UK Government should instruct NHS England to require NHS Trusts to follow existing pension recycling guidance to help deal with the short-term impact of the pension problem.

BMA analysis: The BMA agrees with the majority of the report's recommendations on retention. The focus on improving staff facilities in NHS hospitals is critical and reflects the BMA's ongoing work in this area.

Pensions

The Health and Social Care Select Committee's support for urgent pension taxation reform is encouraging and reflects a key focus of the BMA's main asks of Government in addressing retention within the NHS. We would fully agree with the assertion of the Committee that it is indeed a "national scandal" that doctors are forced to reduce hours or leave because of NHS pension taxation, as well as crucially recognising that the problem persists *despite* changing the taper rate of the annual allowance. We would highlight that this echoes the calls made by the DDRB, which sought to "urge the governments to consider swift action to address these [pension taxation] issues," who also "would expect national NHS leadership to take charge of this situation."

We are therefore pleased with the support for an immediate solution to the pension taxation issues faced by doctors across the UK and would agree with the Committee's recommendation of introducing ways which would achieve similar results made under the Coronavirus Act 2020, in supporting retired members who are willing to work for the NHS. We also welcome the opportunity the UK Government has to instruct NHS England to require trusts to provide a short-term fix to some of the issues doctors are experiencing through utilising pension recycling within their trust.

We note and welcome the Committee's recognition that abatement indeed is a wider issue than purely for 'the highest earners in the NHS' and would agree with the position that this needs to be permanently extended.

Furthermore, the BMA would emphasise that, whilst the Committee have highlighted some important solutions, the Government needs to go much further in delivering solutions that do not force or heighten the need for doctors to retire early in the first place, which we would encourage the Committee to consider and raise with the Government in their future work. The report falls short of lending support to these necessary alternative options provided by the BMA, as described below.

Long Term solutions:

Tax Unregistered Scheme

We are clear that in the long term, the solution to this problem is a tax unregistered scheme for those impacted by pension taxation in the NHS. When faced with similar recruitment and retention problems with the judiciary because of these taxes, the UK Government introduced a tax unregistered scheme. This immediately addressed the issue and resulted in more judges being appointed. This is a fundamentally fair system: it ensures that the correct amount of tax is paid on pension growth, and as no tax relief is provided on employee pension contributions there is no requirement to subject scheme members to either the AA or LTA.

Immediate solutions:

1. Amend the Finance Act

We would note that the report does not take into account the fundamental issues around the impact of CPI on the pension scheme. This is an incredibly complex area that requires fixes that go beyond simply amending the pension scheme and instead make changes within the Finance Act. We have highlighted in our [public messaging](#) that, in order to fix this, only growth above inflation should be tested against the AA. However, in this rapidly moving inflation environment, the Finance Act (Section 235) does not do this as two different values are used. Simply, amending Section 235 to ensure that the opening value is aligned with this year's CPI (not last year's), so the inflationary uplift of benefits is tested in the same year. This will ensure that only "growth" above inflation would be subject to testing against the AA as was clearly originally intended.

2. Addressing the Issue around Negative Pension Input Amounts

We would also highlight that whilst workers in the NHS will only receive one NHS pension, following the Public Sector Pension Reforms, many NHS staff are in both the 1995/2008 and 2015 pension schemes. Under the Finance Act, including section 234 and related regulations, these schemes are considered separately. Therefore, even though one scheme may have negative growth, this negative growth is not offset against positive growth in the other schemes. For example, if a member had £20,000 negative growth in the 1995/2008 scheme and £60,000 positive growth in the 2015 scheme, even though their combined Pension growth was £40,000 and within the standard annual allowance, the 1995/2008 is considered to be zero and instead the member is taxed on the £20,000 excess in the 2015 scheme. In addition, the negative growth in the 1995/2008 cannot be carried forward or backward to offset previous positive growth in those years.

3. Repeat of the 2019/20 Annual Allowance compensation scheme

Given the urgent nature, and the significant impact on the impact of CPI on senior doctors and senior NHS staff, a repeat of this compensation scheme would stabilise the workforce and reduce the need for this group to consider retiring or reducing work over the next 12 months as it would prevent the penalty associated by being taxed on non-existent pension “pseudogrowth” that arises due to the anomalies within the Finance Act. It has been implemented rapidly in the past and is a fully operational solution that could be introduced immediately. However, it is essential that if this is utilised it covers all four nations across the UK.

We would also emphasise to the Committee for the need to pick up on the failure of the Government’s current chosen method of ‘flexibilities’ to address these issues. The option to “flexibly” contribute towards an NHS pension does not work for several reasons. Firstly, it adds another layer of incredible complexity to an already extremely complicated pension scheme and pension tax system. Secondly, scheme members will not know their own pension growth position during a given tax year and once a tax year has ended, there is no ability to retrospectively adjust your pension inputs, so any flexible options are not available.

The complexity is such that you cannot predict your pension growth in advance, even with specialist advice and if trying to “guess” the level of accrual, it is very likely that the majority will over or under contribute. The penalties for guessing wrong are so severe and the complexity so high that most members simply will not be able to use this option. Furthermore, without recycling being available, flexibility (i.e., reducing how much you contribute towards your pension) is simply an overall pay cut.

Pay

While the report broadly recognises the importance of pay in relation to retention, its recommendations are concentrated on lower paid parts of the NHS workforce and the Committee fails to include any specific pay recommendations for doctors. The BMA’s position is extremely clear regarding stagnating pay and its impact on the recruitment, retention and motivation of doctors. Continuing this pattern of pay freeze or pay restraint for health professionals will only compound the workforce crisis.

Wider retention issues

As stated in the BMA’s [‘Weathering the Storm’](#) report, measures to help retain staff should include enhanced childcare support for parents, more generous parental leave, and support for staff going through the menopause. Similarly, the lack of flexible contractual arrangements and working arrangements available for all staff is causing staff to retire early or change careers, so the report’s clear focus on these issues is welcome. The BMA also supports developing a national “retire and return” policy, and we have highlighted some options around [retiring and returning to the NHS](#) on specific contracts to accommodate this, which can be used by employers as a means of retaining experienced clinicians. The BMA naturally urges NHS employers to make the best possible use of these potential contractual models as an essential retention tool to mitigate the existing workforce crisis.

Training

Recommendations from the Health and Social Care Select Committee report:

Medical school places in the UK should be increased by 5,000 from c.9,500 per year to 14,500.

The cap on the number of medical school places offered to international students should be lifted, by allowing full registration at the end of the Primary Medical Qualification and asking international students to fund the cost of their foundation year placements.

If medical school places are increased, the UK Government must consider increasing the size and resourcing of medical schools – including their facilities and faculty, increased numbers of clinical placements throughout the country, and more speciality training positions for the graduates produced.

The UK Government must commit to expanding the number of medical student places available at the 2018 cohort of medical schools, starting in the academic year 2023-24.

The UK Government must ensure the 2018 cohort of medical schools, and all other medical schools, are appropriately funded to train UK students and are not financially dependent on international recruitment for funding.

The UK Government must commission an independent review of all postgraduate training to consider whether it is possible to; reduce the time it takes to obtain a postgraduate qualification; ensure those who train less-than-full time are not penalised for doing so; provide an independent assessment of the training places needed for each speciality. The UK Government must implement the findings of this review.

NHS England must ensure that temporary, bank, and agency staff are given full access to NHS training to allow them to improve their skills, ensuring that they can sign up for additional shifts.

BMA analysis: The UK has too few doctors and to address this an increase in medical school places is required. There not only needs to be a renewed effort to recruit and retain UK's domestic workforce, but also an effective long-term plan to increase the number of medical undergraduates each year. Whilst it is appropriate for medical school places to be controlled through a government cap, the Royal College of Physicians (2018 and 2021), the Royal College of Psychiatrists (2019), and the BMA (2020) have [previously called](#) for medical school places to be doubled to 15,000 per year within this decade. However, the medical workforce deficit is now worse than previously thought. Therefore, the BMA believes that the Government should take advantage of record numbers of people applying (28,690) – a 21% increase on the previous year – and initially expand medical school places to 14,500 as rapidly as possible, as recommended by the Select Committee's report, with a commitment to further increases being introduced to bring the UK up to the EU OECD average of doctors/population ([BMA analysis](#) has shown that there are currently 3 doctors per 1,000 people in the UK, while the average in comparable OECD EU countries is 3.7).

We do not agree with the recommendation that international students graduating in the UK should fund their own Foundation Programme. We support the view of the Medical Schools Council that this represents a misunderstanding of the transition from student to employment as a doctor. We also do not agree with proposals to provide full GMC registration at the point of graduation from UK medical schools. Unless there was an associated move to lengthen medical school programmes, an attempt to incorporate the clinical experience currently provided in the first year of the foundation programme into undergraduate curricula would lead to a reduction in the level of competence required for full registration.

The BMA has been clear that expanding medical school places will also require a long-term strategy and adequate investment to ensure that there is enough teaching space and infrastructure, medical educators, clinical placements, and support and accommodation for students. Sufficient resources are also needed to ensure that these medical graduates have places on the two-year national Foundation scheme, and on specialty training.

The BMA acknowledges that the geographical distribution of training places affects the future supply of doctors, which is also currently not proportionate to the population in each NHS region. Postgraduate medical training posts have been distributed across England based on historical arrangements, which therefore means that training posts are not fully aligned with local population health needs. In addition, specialist care services are often centralised in large cities while providing care to a far greater region, requiring a greater number of doctors as a result – so we see a larger doctor to population ratio in regions that contain major cities, like London and Manchester. The BMA has emphasised that the redistribution of specialty training places is unavoidable, but investment must also be made in increasing the number of available training places overall to ensure that this program can level up capacity, rather than simply redistribute it.

While the BMA supports competency-based training in place of time-based progression, it does not currently believe there is a safe substitute for the existing five-year undergraduate or four-year graduate entry medical curriculum for students. The BMA believes that any proposals for change – whether set out through an independent commission or any other format – should involve in depth discussions with the medical profession.

Working Culture

Recommendations from the Health and Social Care Select Committee report:

Senior and middle NHS management should be accountable for reducing racist discrimination amongst staff, with explicit equality, diversity, and inclusion duties in senior leadership job descriptions – against which senior leader performance is reviewed and to which their pay and promotion is linked.

The UK Government must commission a 'What Works Centre' to research issues of discrimination in public sector workforces, collate an evidence-base around existing initiatives, and co-ordinate learning.

NHS England must roll-out nationally an NHS pilot scheme from the East of England which sets independent panels to review anonymised case information before cases are formally referred to the GMC, which has shown this results in parity of referral between white and ethnic minority doctors.

NHS England should develop a strategy to attract and retain more women into surgery.

The UK Government should report progress made against recommendations on closing the gender pay gap made in '[Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England](#)'.

NHS England should implement a national menopause strategy focused on retaining senior staff who may be reducing their hours, leaving management or supervisory roles, or retiring earlier.

The NHS should improve complaints procedures to support doctors throughout investigations or inquiries, and ensure they are protected from spurious, vexatious, or discriminatory complaints.

The UK Government should consider if the Medical Act 1983 can be reformed to ensure that GMC regulatory processes can be simplified, to reassure the public and clinicians.

The NHS must commit to creating positive working cultures and inclusive environments, creating and enforcing zero tolerance policies for harassment, discrimination, and bullying towards staff, with targeted policies for any particularly vulnerable to these behaviours, and online behaviours.

The UK Government should promote positive mental health and allow all frontline workers headspace – by reducing bureaucracy and administrative tasks for frontline staff, possibly achieved via reinstating administrative support staff and by investing in adequate ICT infrastructure.

BMA analysis: The BMA welcomes the above recommendations, which align with many of our own existing policies and public positions.

We believe that all organisations across healthcare must provide clear processes and policies for reporting discrimination, bullying, and harassment, or any other form of abuse and violence from patients and colleagues. The BMA's ['Bullying and harassment: how to address it and create a supportive and inclusive culture'](#) report stated that there should be clear action taken in the event of any abuse, including providing or enhancing security measures where appropriate. Our report also noted that disabled doctors face greater levels of bullying and harassment. This chimes with our ['Disability in the medical profession'](#) report.

The BMA has called for a long-term strategy for protecting and maintaining the physical, mental, and emotional wellbeing of the workforce. NHS England should ensure that any new wellbeing initiatives mirror the recommendations of the BMA's ['Mental Wellbeing Charter'](#). We believe that equality, diversity and inclusion (EDI) training should be mandatory for employers, managers and medical students and should include the topic of racial bias and how it manifests in medicine for patients of different ethnic groups and with colleagues in the workplace. Our key recommendation, as stated in our recent ['Delivering racial equality in medicine'](#) report is for regulators, employers, training providers and government bodies to publicly state how they are working towards the aim of having a just and inclusive learning culture, with evaluation of the effectiveness of the actions they have taken. Likewise, a zero-tolerance approach to bullying in the workplace must be taken by employers.

The recommendation that NHS England should develop a strategy to attract and retain more women in surgery, does align with the findings of our ['Sexism in Medicine'](#) survey report, which found that women respondents most frequently said they were discouraged to work in surgery or trauma and orthopaedics. However, the wider causes of this discouragement need to be addressed, with sexism, stereotyping and sexual harassment being addressed at all stages and in all specialties of medicine. In addition, the BMA calls for tackling poor behaviour, stereotypical attitudes and bullying cultures as well as for more work to be done to understand the differences in the gender pay gap at the intersection of different protected characteristics (e.g., race, disability). For instance, our [commentary on the gender pay gap](#) in medicine emphasises the need to look at the causes of the gap for doctors, such as unequal caring responsibilities and issues around working less than full time. We strongly support the recommendation for the UK Government to report progress made against recommendations on closing the gender pay gap, as there appears to be little accountability for progress since the review was published in 2020, as the BMA highlighted in an [article in the BMJ](#) in March 2022.

We support reform of the Medical Act and are deeply concerned by the government's current timetable for legislative reform, which will not see changes to the GMC's fitness to practise processes until 2025. Reform is urgently needed to significantly reduce the adversarial and combative nature of fitness to practise process that are stressful and damaging to the wellbeing of so many doctors.

The BMA's, ['Challenging the culture on menopause for working doctors'](#) report found that a significant number of women senior doctors have reduced their hours, left management roles or intend to leave medicine altogether, despite enjoying their careers, because of the difficulties they faced when going through menopause. We cannot afford to lose experienced doctors because of a lack of flexibility and support during a relatively short phase in life. We support the recommendation to create a National Menopause Strategy, any workforce strategy should also include adjustments to the workplace environment and support for mental health and wellbeing.

The workforce report highlights bullying and harassment, racism, the gender pay gap and the impact of the menopause. It is essential that any actions to create an inclusive, safe workplace culture recognise and take account of the intersection between characteristics such as ethnicity, gender, disability etc.

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