COMMENTS

CENTRE FOR WORKFORCE INTELLIGENCE (CFWI)

SHAPE OF THE MEDICAL WORKFORCE : STARTING THE DEBATE ON THE FUTURE CONSULTANT WORKFORCE

The Royal College of Physicians of Edinburgh (RCPE) is pleased to respond to the Centre for Workforce Intelligence on its consultation on the *Shape of the Medical Workforce: Starting the Debate on the Future Consultant Workforce*. Our comments are as follows:

1. The Royal College of Physicians of Edinburgh is engaged actively in workforce planning developments across the UK both as an individual College and in partnership with sister Colleges through the Federation of Royal Colleges of Physicians in the UK and the Academy of Royal Colleges and Faculties in the UK. The Federation supports an annual census of consultant physicians and specialist trainees which provides trend data on many metrics of direct relevance to workforce planning and the Academy co-ordinates policy advice from all Colleges and its trainee doctors committee.

2. The RCPE's active Trainee and Members Committee has submitted a separate response which calls for patient safety and quality of care to be improved and maintained, for medicine to remain an attractive career option with a reasonable expectation of job security and career progression, and for support of the consultant grade which has patient confidence and is recognised as the best model for delivering safe and effective care. The College believes it is important for those with workforce planning responsibilities to understand the perspective and strength of feeling of trainees and commends their response.

3. The College welcomes the opportunity to contribute to improved understanding of workforce data and of trends in medical practice as part of a multi-disciplinary approach to workforce planning – such work cannot be determined by any organisation in isolation. Indeed it is vital that workforce planning should continue as a UK wide activity reflecting the easy mobility of doctors around the UK. We have considered the scenarios in the discussion paper and the challenges they present and have the following key comments and observations:

   - **Excellence in patient care should drive workforce planning.**
   - **Better evidence is required before services move into the community.**
   - **Consultants deliver high quality patient care.**
   - **Attrition rates and multiplier assumptions may be underestimated and require review.**

- **A sub consultant grade will make the UK a less attractive place to train and work.**
- **Inaccurate base line data makes for poor modelling.**
- **Workforce modelling must be speciality specific and sensitive to local circumstances.**
- **Medical school places should reflect the needs of both the NHS and academic medicine.**

4. Excellence in patient care should drive workforce planning

The College believes that a long term perspective is essential if workforce planning is to be successful in delivering an effective and flexible medical workforce for the future. The College accepts that the status quo is not sustainable if the net result increases the medical pay bill by 60%, but the shape of the medical workforce must be guided primarily by the needs of patients and advances in clinical care.

5. Better evidence is required before services move into the community

The College is concerned about the un-evidenced assumptions in many secondary care planning models that services can be delivered effectively and efficiently in the community. The King's Fund stated in 2010[1] that, despite a longstanding ambition within the NHS to 'manage demand' and reduce unplanned hospital admissions, this has yet to be realised. For example, a recent Audit Scotland report found that attempts to provide enhanced care services in the community through Community Health Partnerships (CHPs) had made little impact, as emergency admissions for older people increased in three-quarters of CHP areas between 2004/05 and 2009/10[2]. When examining the shift of care from the acute sector to the community in 2011, the Health Foundation published a report that stated *"the research literature did not reveal any examples where establishing community-based services had led to a reduction in, or decommissioning of, the corresponding acute inpatient service"*[3]. Large scale, widespread pilots are needed to examine the potential of all strategies to move acute care services into the community: this is especially important in remote and rural parts of the UK.

6. Consultants deliver high quality patient care

The College supports the move towards a consultant-present/delivered service (including 24/7 for emergency/acute areas of hospital) as evidence accumulates to demonstrate improved quality of care and outcomes for patients.

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[1] P.3, The King's Fund: *Avoiding hospital admissions- what does the research evidence say?* (Dec 2010)

[2] Paragraph 42, p.7, Audit Scotland- *Review of Community Health Partnerships* (June 2011) http://www.audit-scotland.gov.uk/docs/health/2011/nr_110602_chp_km.pdfv

[3] P.9, The Health Foundation, *Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community*(summary) (June 2011)

7. Attrition rates and multiplier assumptions may be underestimated and require review

The College urges the CfWI to review assumptions on attrition rates, including the multipliers applied to adjust for demographic change in the workforce. Recent surveys by the Joint Royal Colleges of Physicians Training Board (JRCPTB) and by NES in Scotland have identified low unemployment rates among recently completed trainees and significant moves away from medicine and/or UK for jobs e.g. attrition rates in CMT are reducing the competition ratios for specialty training. Attrition rates and multipliers should be speciality specific; standardisation will distort results. For example, in the medical specialties cardiology remains a largely male dominated specialty with palliative medicine populated almost entirely by female trainees.

8. A sub consultant grade will make the UK a less attractive place to train and work

Both the calibre of candidates entering medical school and the attrition rates for trainees will be influenced by the shape of, and prospects in, medical careers in the UK. Medical students will graduate with significant debt and facing rising service pressures in the NHS; it is vital that medicine remains an attractive career option.

Trainees are understandably sensitive to the notion of "sub consultant" and "trained doctor" grades with no or limited progression into consultant roles. Terminology and definitions are critical; trainees are being prepared for independent professional practice as consultants and, although the shape of job plans may change over time, they seek consultant posts rather than the more restricted "trained doctor" options. The UK must remain competitive within a global marketplace for skilled medical professionals and already we are seeing attrition from training programmes as doctors leave for "better" opportunities overseas. The expected bulge in trainee numbers is failing to materialise and in some parts of the UK it remains difficult to recruit and retain consultant physicians and specialty (particularly CMT) trainees.

9. Inaccurate base line data makes for poor modelling

The College has good reason to challenge much of the base data used for modelling, particularly at sub-speciality level for physicians. The College is particularly concerned about the lack of accuracy in data on acute medicine which confuses the acute components of other disciplines with the specific specialty of acute internal medicine. Accurate data is vital for workforce planning in both acute internal medicine and those medical specialties carrying shared responsibility for acute medical admissions.

10. Workforce modelling must be speciality specific and sensitive to local circumstances

A "one size fits all" approach to workforce modelling in medical specialities is unacceptable and national training numbers must reflect the needs of different sized

hospitals and locations across the UK. Workforce planning should not be undertaken in isolation by any part of the UK despite the devolved responsibility for healthcare.

11. Medical school places should be reflect the needs of the NHS and academic medicine

There is a strong case for balancing undergraduate places for UK students with the indicative workforce requirements of the UK. However, workforce models which focus on the service needs of the NHS should also reflect the needs of academic medicine to preserve the research base in the UK and the quality of our medical teaching.

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