Royal College of Physicians of Edinburgh Trainees and Members' Committee (RCPE T&MC) Response to the Centre for Workforce Intelligence Document 'Shape of the Medical Workforce'

The RCPE T&MC welcomes the cfWI document 'Shape of the Medical Workforce' for its recognition of the issues the medical profession faces over the coming decade and for initiating debate on how to tackle these and find realistic, workable solutions that benefit patients and doctors alike. There is no doubt that ignorance of these issues is not an option and that solutions need to be sought.

Our principal concerns are:

- that patient safety and quality of care are maintained
- ensuring that medicine remains an attractive career option with a reasonable expectation of job security and career progression
- avoiding the risk of undermining and devaluing the entire consultant grade which has strong public confidence and is widely recognised as the best model for safe, high quality patient care

In this document we consider the 7 scenarios proposed in the cfWI document and outline further generic concerns.

Scenario 1 (continuing with current system)

This is not sustainable given its financial implications. We continue to advocate that trainee numbers match projected consultant requirements as closely as possible. This scenario risks widespread medical unemployment and thus a substantial waste of money and resources. Moreover it risks poor morale in the medical profession following considerable personal and financial investment by medical students and trainees.

The RCPE T&MC does not support this scenario.

Scenario 2 (shift to GP)

This could potentially deliver cost savings but would have a significant impact on the number and range of specialty training jobs available to hospital trainees affecting individual doctors both intellectually and financially and potentially diminishing the quality of service provided to patients. It may also impact on the number of SAS posts either positively or negatively. Any such changes should be based on the projected needs of the population.

The RCPE T&MC does not feel that this scenario alone is sufficient to address the issues of increased numbers of hospital trainees attaining CCT but may work in conjunction with other measures.

Scenario 3 (change in retirement age- reduction to 60)

We have serious doubts as to whether this scenario would be legally competent if attempts were made to implement it. Following the removal of the default retirement age in 2011 employers cannot force employees to retire at set ages. Exemptions can be made for some groups of employees but this scenario would involve legally imposing a retirement age on consultants in order to solve a workforce issue. This could be viewed as discriminatory. Would it survive legal challenge? We do not believe that the cfWI would have a strong basis to feel legally confident about this. Furthermore we are surprised by its inclusion here given the current debate on pension reforms.

The RCPE T&MC does not feel this is a realistic or workable solution and as such does not support it.

Scenario 4 (Royal Colleges set level of demand)

The Colleges already inform discussions and recommendations on the projected workforce. To do this they must know what the service will look like and how it will function- eg consultant present/consultant delivered etc. If full responsibility lies with the Colleges there is the potential to apportion blame to them for any workforce planning crises. The level of demand should continue to be set centrally with significant input from the Colleges.

This scenario does not address the issues regarding the current projected increase in fully trained doctors nor does it offer a solution and as such is not supported by the RCPE T&MC.

Scenario 5 (consolidation period in training)

We cannot foresee that many trainees will view 'accepting the opportunity to work for a year at ST4' as a positive move. It is not clear how this benefits the trainee. It may help to consolidate previous training and experience but there is no definite long-term benefit from a trainee's perspective if their colleagues can complete training and achieve CCT within a shorter time-frame. Does 'opportunity' mean compulsion and how will trainees be selected (or deselected)? It risks creating two tiers of trainee. Further, these doctors will function at junior decision making level, are not capable of working autonomously and as such continue to require supervision. We are therefore unclear as to how this helps service provision. How will trainees' job descriptions in consolidation years differ from those of their colleagues? Ultimately the throughput numbers will remain the same so no money will be saved on consultant salaries. The problem is only deferred by a year. The assumption of 0% attrition rates has no basis. The T&MC does not support any periods of consolidation within training, however if it is deemed fair that working for a year at this level is required, should it not be applied to all trainees?

The RCPE T&MC does not support this scenario.

Scenario 6 (consultant present service)

This is desirable as consultant delivered care has consistently been shown to benefit patients. It is unclear how many SPAs this model, based on 10 PAs, allows. If trainees are indeed to be supernumerary there needs to be adequate provision within consultant job plans for training, management, service development etc as outlined in the RCPE Charter for Medical Training[1]. This scenario would require a wholesale change in how the service is run. Full buy-in from all relevant specialties would be required to support this (radiology, pathology etc) as well as expansion in non-medical staff numbers to support medical staff, investigations and treatment seven days a week. The benefits of consultant delivered care and seven day a week care are clear as regards quality of care and patient safety and in the long term would also prove financially sound.

This is the only scenario supported by the RCPE T&MC as it is the only scenario which ensures high quality, safe patient care. Additionally it ensures return on investment and offers realistic and reasonable career opportunities for medical staff.

Scenario 7 (graded career structure)

This scenario plays a double dynamic by introducing a subconsultant grade and decreasing the value of all consultant salaries. It essentially represents a pay cut for the majority of consultants. There is also ambiguity within the scenario. 'As consultants retire from the middle and upper bands they are not replaced; new consultants enter and remain on the entry band'. This statement appears to contradict 'no automatic progression in this model [;] doctors will progress based on the roles they have'. The first statement appears to make it explicit that all higher paid consultants will work their way out of the system and not be replaced and that newer consultants will stay on the entry level with no potential for progression. This therefore offers no reward or incentive for increased experience, knowledge, competence or taking on of additional roles within teaching, management, research etc. The second statement suggests the introduction of performance-related pay if progression remains possible but is not automatic. How will standards for progression be set and by whom, and who would oversee and manage this? We strongly believe that this scenario devalues the consultant grade, disenfranchises trainees and risks creating a demotivated consultant workforce which works to time and takes on no additional roles or responsibilities. It would almost certainly result in higher attrition rates with attendant loss of investment and experience. Furthermore, this scenario does not itself answer the problem of increasing numbers of trainees reaching CCT/consultant level. All it does is say they will be paid less for doing the same job that existing consultants do. It creates a 2 or 3 tier structure which is beneficial neither to doctors nor patients. Patients should be assured that responsibility for their care lies in the hands of senior, fully trained consultants who are motivated to and encouraged to develop their knowledge and skills and expand and develop their services.

The RCPE T&MC does not support this scenario in any form believing it to be detrimental to quality of patient care and the morale of the medical profession.

ADDITIONAL CONCERNS

Trained Doctor versus Consultant

The T&MC is surprised that a 'trained doctor' (as opposed to consultant) led/present service is referred to when to date there is no universal agreement on the definition of 'trained' doctor or on what a trained doctor constitutes. A 'staff' (sic) grade doctor is by definition 'non-training' and therefore NOT trained. A 'staff grade' (correctly, specialty doctor) could be appointed 4 years after graduating with no postgraduate qualifications and no experience within Higher Specialist Training posts. Many within the SAS grade are highly experienced, skilled doctors who work with a high degree of autonomy. However, a significant proportion (and probably the majority) do not have structured, supervised access to training or the resources and support available to trainees. There is no clear structure, training provision or hierarchy within the grade. Many are not trained for the roles they perform but develop knowledge and skills over time with no access to feedback or formal supervision. SAS doctors are not obliged to keep logs of the patients they see or the procedures they perform and do not undertake workplace based assessments to demonstrate competence. Some will choose to do so but the record keeping and assessment processes of trainees are not mandatory for the SAS grade. Furthermore, many SAS doctors have chosen the grade precisely because they do not want the overarching responsibility for patient care or to assume some of the other roles and duties expected of a consultant. The fact is that at present there is no clear structure or method of identifying which SAS doctors are capable of working autonomously at consultant level other than application for a Certificate of Eligibility for Specialist Registration via the GMC. This is a lengthy and complex process which is currently under review by the GMC and Colleges.
The structure, training provision and supervision of the SAS grade would need extensive re-thinking and re-working if the grade is to be considered a serious alternative to CCT holders as independently functioning practitioners with overarching responsibility for patient care. Any change to the structure and function of the SAS grade needs significant input from all major relevant bodies and will require a substantial investment of time and money. In the meantime employment as an SAS doctor alone cannot be held to be equivalent to having completed HST training (or equivalent), being entered on to the Specialist Register and selection to consultant post. Entrance on to the Specialist Register is a benchmark of competence and a marker of ability to work independently.

The RCPE T&MC strongly advocates that patient care continues to be led by consultants who have demonstrated their competence by being entered onto the Specialist Register via CCT or CESR and have undergone the rigorous selection to consultant post.

Data

It is unclear how much of the data within the cfWI document relates to the UK and how much is England and Wales specific. Some data is explicitly labelled as UK, others not. Whilst the consultant workforce continues to rise in England there has been close to zero expansion in Scotland in the last two years. By its own admission much of the data in the cfWI document is up to three years out of date, and where accurate data could not be gathered assumptions have been made. In terms of projected consultant numbers, headcount rather than consultant FTEs have been used, however the number of consultants required reflects the number of PAs required/available which is the basis upon which Boards/Trusts decide whether and how many consultants they need.

Poor Understanding of Structure and Training of Medical Profession

There are several references within the document suggesting a poor or incomplete understanding of medical structure and training including the use of terms such as 'staff grade' and 'during CCT training'. This does not inspire confidence that a thorough understanding of the issues affecting the medical profession is grasped nor that the implications of the proposed solutions are fully understood. There are also inconsistencies within the document in particular regarding the graded career structure, with different percentages allocated to each band on pages 21 and 36.

Management of Career Expectations of Medical Students and Trainees

It is of paramount importance that medical students and trainees are involved in discussions relating to the future direction of the medical profession and are able to contribute to potential solutions and directions of travel. Medical training requires considerable personal and financial investment and those undertaking it do so have historically done so on the basis of relative job security and reasonable prospects for career advancement. If this is to change significantly it is essential that the proposed changes are filtered through to trainees, medical students and indeed school-leavers considering their choice of degree, as people need to make informed decisions about the careers they are following particularly when so much is at stake personally and financially.

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References:

1. RCPE. *Charter for Medical Training*. 2011; Available from: http://www.rcpe.ac.uk/policy/charter-for-medical-training.php