



THE SCOTTISH MEDICAL WORKFORCE

an outline of challenges and offer of solutions

Produced by the Royal College of Physicians and Surgeons of Glasgow on behalf of the Academy of Royal Medical Colleges and Faculties in Scotland.

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INTRODUCTION

- 1.1 The Scottish Academy of Medical Royal Colleges has considered concerns expressed about the medical workforce in Scotland and the issues related to these. The workforce challenges in the NHS now present a greater threat to health services than the funding challenges. This paper is an attempt to set out and explain factors that are combining to create a situation where the imbalance of workforce and workload is unsustainable. It is intended as a working document to which additions and retractions can be made as the workforce climate changes in a politically unpredictable time.

EXECUTIVE SUMMARY

- 2.1 There is a shortage of doctors in the UK. The supply of undergraduates is insufficient to meet the demand of Foundation and subsequent training places and, as a result, there are vacancies at consultant and General Practitioner (GP) principal/salaried GP level.
- 2.2 The overall pattern of medical workforce in Scotland continues to be one of growth. Over the past 5 years, consultant numbers have increased by about 15 per cent.
- 2.3 Senior posts are advertised but filling these is inconsistent. In 2018 38 per cent of advisory appointments panels were cancelled, 88 per cent of these were applicant related (no suitable applicant).
- 2.4 Information Services Division (ISD) figures show in June 2018 there were 428.6 Whole Time Equivalent (WTE) medical consultant vacancies and of these 62 per cent have been vacant for greater than 6 months. These figures represent an underestimate of the true situation. More worryingly since June 2017 there has been an 18.8 per cent increase in the number of consultant posts vacant for greater than 6 months.
- 2.5 UK and Scottish governments have attempted to redress this imbalance by increasing the number of undergraduate places in medical schools. Between 2015-16 and 2020-21 the annual intake of medical places in Scottish Universities has increased from 848 to 1038 (22 per cent increase) including Scotland's first Graduate Entry Medical Programme.
- 2.6 This is a long-term fix, however, as it will take a minimum of 9 years for these expansion posts to achieve the shortest UK postgraduate medical training programme completion (General Practice) whilst most programmes anticipate 12-14 years from starting medical school until certification of completion of training.
- 2.7 In the meantime, there is a recorded reluctance of doctors in the European Economic Area (EEA) to come to the UK or stay here related to Brexit.
- 2.8 Visa restrictions and loss of permit free training have been associated with a massive decline in numbers of non-EU doctors who gain entry to the UK for training.
- 2.9 In Scotland, there is literature illustrating that home domiciled students are more likely to stay in Scotland for Foundation and later training (Kumwenda et al, 2018ⁱ). This is especially true for students who have a widening participation background (Kumwenda et al, 2018ⁱⁱ). Scottish Government has acknowledged this by requiring the expansion to medical student numbers is predicated by demonstration of increased proportions of students who are Scotland based.
- 2.10 Beyond Foundation, we have seen declining numbers of doctors progressing directly to core and specialty training: UK Foundation Programme (UKFPO) reports show this decline has been consistent over the last seven years with a little over 37 per cent taking this route in 2018. The remaining 63 per cent chose to spend time in a variety of posts not currently recognised by the General Medical Council (GMC) for training, for example, clinical fellow posts, locum service posts in Foundation (mostly Foundation Year 2), or work abroad. The reasons for the decline in numbers progressing directly to training are unclear. 90 per cent of previous Foundation Year 2 (FY2) doctors are back in training within four years.
- 2.11 A small number (0.4 per cent) will leave medicine permanently (UKFPO, 2018).
- 2.12 Whilst graduate and foundation output has been static or falling the numbers of specialty training posts being recruited to has been rising. In 2018, there were 9,376 ST1 posts advertised in UK – and 7,563 doctors completing FY2 in the same year. In addition to growth in training opportunities, we are also seeing significant growth in non-training posts, competing for the finite supply of doctors.

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- 2.13 In Scotland, the recognised training establishment has grown by some 370 posts since 2014 (Specialty Trainee (ST) growth, foundation growth, and GP Specialty Trainee (GPST) expansion), and currently in Scotland we have some 360 unfilled training posts across all levels.
 - 2.14 Once in training, many trainees will seek less than full time training. The proportion varies by specialty but must be factored into planning training numbers. Use of Whole Time Equivalents rather than headcount figures is important for more accurate prediction. Specialty numbers are workforce planned using consultant establishment numbers and demographics provided by ISD. There are concerns about the accuracy of the consultant data held which may result in flawed assumptions.
 - 2.15 33 per cent of the Consultant Physician workforce will reach planned retiral age (mean 63 years) in the next decade.
 - 2.16 However a recent British Medical Association (BMA) survey highlighted that 60 per cent of consultants in the UK plan to retire before the age of 60 years.

Some issues highlighted are hard to control as they reflect UK policy and regulation. There are, however, some components which we might be able to influence beneficially.

This paper examines the current processes related to medical staffing and shows areas of mismatch at interfaces, for example, between University and Foundation, Foundation and Core Training (CT)/ST1 and between trainee and career grades. We make some suggestions and recommendations which we might be able to consider collectively to understand the Scottish medical workforce better than we do now and to use this to think about adaptations to systems and processes to try to achieve a smoother dynamic across the development of Scottish doctors.

SINGLE PLANNING AND OVERSIGHT GROUP

- 3.1 Some elements of workforce planning are based on data and assumptions, though there is real concern about the accuracy of these, as we outline below. It is clear that a more sophisticated and cohesive approach is required which takes into consideration the need for flexibility; incorporates less traditional training routes; and covers the full spectrum of the medical workforce from undergraduate to consultant.

1

RECOMMENDATION:

Our first and key recommendation is that the Scottish Government establishes a single planning group with representation from the Universities, Deaneries, NHS Employers, BMA, Colleges, Faculties, and Specialist Societies to advise on and oversee medical workforce planning in Scotland. Only by adopting a coordinated, whole-system approach can we hope to plan and provide a medical workforce which is fit for the future.

MEDICAL SCHOOLS

- 4.1 All universities have their own processes for selecting and recruiting students. The standards for success require a high level of achievement in high school examination grades or in an undergraduate programme (honours 2.1 or above). Most Scottish schools run five-year programmes although one (Edinburgh) has lengthened its programme by a year to include mandatory intercalation.
- 4.2 The Scottish Graduate Entry Medicine (ScotGEM) programme is a collaboration between the Universities of Dundee, St Andrews and Highlands and Islands which accepts postgraduates to a four-year accelerated programme.
- 4.3 Schools have quotas of UK/EEA student numbers. There is also a funding ceiling around 45-50 per cent of students in Scottish schools being funded by Scottish Government which explains the change (above) to increase the proportion of places allocated to Scots before the absolute numbers are increased.
- 4.4 Beyond this, the majority of places will be taken by suitably qualified students from the other three UK nations and EEA. Universities also attract overseas students who are keen to acquire UK medical degrees and do this by hosting students in Scottish campuses and increasingly in overseas locations.
- 4.5 Other UK universities have been doing this for some years, the advantage for students being that the degrees conferred will be from UK universities and thus provide eligibility to work in the UK. These campuses are regulated and approved by the GMC.
- 4.6 Each year, UK medical schools currently graduate around 7000 (7129 in 2018, GMC) medical students in the UK, including 774 in Scotland in 2018 (GMC). That total is set to rise by about 1500 across the UK and by 190 in Scotland over the next five years. Of these students, most will apply for one of the 7500 Foundation places. The number of Foundation places is aligned to medical school output because it is a requirement to ensure that there are places in programmes to enable students to complete full registration with the GMC after Foundation Year 1 (F1).
- 4.7 Scottish Medical Career Cohort Study (SMCCS) data showed that approximately 95 per cent of Scottish domiciled students intended to train in Foundation in Scotland. This figure was borne out by the follow up data in the subsequent UKFPO report.
- 4.8 Further, 40 per cent of non-Scottish domiciled students planned to go to other UK countries for Foundation training.
- 4.9 SMCCS further predicted that 90 per cent of the Scottish group of the cohort would stay in Scotland for Core or Specialty Training (C/ST) with attrition of non-Scots rising to 60 per cent.
- 4.10 Students from widening access programmes and graduate entry medical School are also more likely to remain and work in Scotland.
- 4.11 Interestingly, overseas graduates staying in Scotland almost equate to Scottish natives. Without this group of doctors, it would be very hard to approach fill in Foundation and later programmes in Scotland.

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RECOMMENDATION:

The proportion of Scottish domiciled entrants to Scottish medical schools should be increased

3**RECOMMENDATION:****The number of medical school entrants should be further increased****4****RECOMMENDATION:****The proportion of medical students from widening access programmes and Graduate entry programmes should be increased**

FOUNDATION PROGRAMMES

- 5.1 The number of doctors in Foundation programmes is aligned to output from medical schools as there must be sufficient places for students to complete the programme and register with GMC after FY1.
- 5.2 The numbers of Foundation programme doctors progressing directly into training has dropped from 83 per cent in 2010 to 38 per cent in 2018.
- 5.3 Following Foundation programmes, those not entering formal training schemes follow a variety of paths, although the vast majority return to specialty training within 3 years.
- 5.4 Many doctors seek non training posts in the UK which may be largely service-provision oriented or incorporate development; medical education; or quality improvement elements. Broadly, however, these posts are not developed in a strategic, coordinated manner.
- 5.5 The rapid and marked rise in doctors not choosing to enter formal training programmes has significant implications for workforce planning.
These clinicians, whilst often contributing significantly to clinical service provision (as well as academia, medical education, and service development), tend to do so based on local planning needs. They are often recruited at relatively short notice, and appointments often vary significantly in duration.
Whilst increasing numbers of these posts include significant training and education components (beyond that gained simply by experience), there may not be a clear curriculum and recording training experience and achievement is not standardised (e.g. by Portfolio).
- 5.6 Around 11 per cent of those completing Foundation seek employment overseas. Whilst return to training in the UK is still frequent, barriers to doing so include lack of recognition of training outside the UK (including examinations), and logistical challenges of returning to the UK for interviews.
- 5.7 The reasons for not choosing formal training post-Foundation are not fully understood. Family duties, further studies, desire to travel or volunteer and increased flexibility are all cited. More flexible broad-based training programmes are being piloted. Evaluation of the English programme has taken place and is ongoing in Scotland.

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- 5.8 There may be value in keeping contact with and following progress of junior doctors taking up roles outwith formal training programmes, both in the UK and overseas. This may contribute to useful workforce intelligence for planning purposes (particularly related to intention to return to training data), and may also facilitate efforts to improve recruitment into training programmes, particularly for those overseas.
- The desire for flexibility and autonomy may limit the enthusiasm of junior doctors to be “tracked”, and so novel ways of establishing mutually beneficial engagement should be considered, for example, access to an ePortfolio; deferred appointments to training posts; flexible recruitment; shortened recruitment time-frames; centralised (online) resource for advertising LED roles and coordinating applications/appointments (including for overseas posts).

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RECOMMENDATION:

A better understanding of the attributes of Foundation Programme doctors who do not directly enter training is required

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RECOMMENDATION:

More flexibility is required at early stages of career and recognition of various types of training needs to be developed

CORE AND SPECIALTY TRAINING

- 6.1 **In 2018 there were 9,376 ST1 posts advertised across the UK, compared to 7,563 doctors completing FY2 the same year.**
- 6.2 The interface between Medical School and Foundation and Foundation and Core/Specialty training is different. Rather than being tied to the available doctor numbers, these numbers are workforce planned using consultant establishment numbers and demographics.
- 6.3 Strengths in this system are that NHS Education for Scotland (NES) has accurate data on each medical trainee in programme, their progress and expected core completion of training (CCT) date.
- 6.4 Data relating to consultants is more variable. Comparison by specialty of ISD data with specialty-collected figures has highlighted significant discrepancies. This is largely because of coding issues. For example, posts coded as general physician in the past may now be in reality acute medicine, general internal medicine, and a variety of other specialties dealing with acutely ill patients. Some data are simply inaccurate - investigations by the Scottish Specialty Training Boards (STBs) in Diagnostics and Anaesthesia, Emergency Medicine and Intensive Care Medicine showed discrepancies of up to 100 per cent. This poses issues for workforce planning that rely on an accurate baseline for future predictions.
- 6.5 In addition, currently held data may not include Entrustable Professional Activity (EPAs).

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- 6.6 There is a measure of unpredictability added to these demographics as retirement age is predicated by issues such as pension planning and tax liability as well as wishes to reduce hours or retire early. The demographic data do not directly relate to these factors.
 - 6.7 The body responsible for advising on Specialty training numbers is the Scottish Shape of Training Transitions Board, (see Appendix 1 for full membership) jointly comprising NES and Scottish Government Health Department.
 - 6.8 This Group receives cases for changing trainee numbers via NES from each of the Specialty Training Boards annually. The Specialty Training Boards (STBs) use detailed specialty knowledge, workload, and service changes to advise on what they see as emerging needs, most commonly to increase trainee numbers.
 - 6.9 Requests for less than full time training in a specialty are factored into trainee numbers, though it is important that WTE are used in calculations.
 - 6.10 95 per cent of established training posts are filled, but unfilled posts are clearly a concern. The main reason for unfilled posts is failure of supply.
 - 6.11 The recognised training establishment has grown by 370 posts since 2014. There are currently 360 unfilled training posts but marked specialty and regional variation.
 - 6.12 Failure to fill CT/ST posts in a recruitment cycle will reduce the eagerness to expand trainee numbers as it is considered pointless to expand a specialty where there are already vacancies. This can widen the gap between likely or existing consultant vacancies and the supply of certified doctors to fill these.
 - 6.13 The Scottish trainee funding envelope has been fixed for several years. The establishment of trainee posts has expanded, producing a risk that if all posts are filled, about 4 per cent of posts will be left unfunded.
 - 6.14 Furthermore, there is no inbuilt capacity to increase posts in line with service demand. Specialties which count activity (e.g. histopathology) can show that whilst specimen numbers increase by around 2 per cent per year, sampling of specimens increases by twice that number and slide numbers by twice that. This increased work is a result of compliance with national best practice guidelines and is set to increase further because of the linkage of laboratory findings to specific gene targeted therapy. Sharma et al showed that the information conveyed in reports doubled between 1991 and 2001 and again between 2001 and 2011. This is reflected neither in trainee nor consultant establishment in the specialty.
 - 6.15 Similar mismatches have emerged as an unforeseen consequence of tying trainee number to consultant number rather than workload. Boards, on the other hand, will try and attract additional trained doctors to deliver an expanded service and will do so from, at best, an unexpanded trainee pool.
 - 6.16 Other than increasing the number of medical school places, vacant ST posts may be filled by doctors from EU or by other international medical graduates. Currently 10 per cent of doctors working in NHS are EU nationals, but there is great geographical variation e.g. remote and rural services may employ up to 10 per cent of the medical workforce as International Medical Graduates (IMGs) (SOMEPE Report, GMC 2018). The uncertainties over Brexit are likely to impact on migration of doctors from EU.
 - 6.17 The cap on Tier 2 visas has recently been removed to facilitate migration of international doctors from outwith EU using the Medical Training Initiative (MTI) in particular.
 - 6.18 Doctors are sponsored by individual Colleges and assisted with GMC registration. However, there is often difficulty in identifying appropriate posts for these doctors, despite the existence of vacancies and the block is often at individual hospital/employer level.
 - 6.19 The Medical Training Initiative (MTI) could provide useful additional doctors in training to the mutual benefit of doctor and service.

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- 6.20 Permit free training under which a postgraduate dean could provide a 2-year visa and training offer to international graduates was abolished in 2006 and could be reviewed.
- 6.21 The Migration Advisory Committee's report in May 2019 recommending all medical roles be on the shortage occupation list is welcomed, and it is hoped that the UK Government will follow this recommendation.

In essence, whilst there are thoughtful methods of linking trainee numbers to likely consultant vacancies, there are confounding factors that tend towards mismatch, in addition to a fundamental undersupply.

7 **RECOMMENDATION:**
The accuracy of consultant data held by ISD should be improved. Electronic job planning should improve this

8 **RECOMMENDATION:**
Specialties should have access to data to facilitate their input into workforce planning

9 **RECOMMENDATION:**
A process for data confirmation is required and a pathway specialty should be used as a pilot

10 **RECOMMENDATION:**
The MTI should be expanded and process of matching improved

11 **RECOMMENDATION:**
While immigration is a reserved power, the possibility of reinstating permit free training should be reviewed

WORKING CONDITIONS AND WELLBEING

It is in the interest of doctors and the patients they care for to ensure working and training environments promote wellbeing. Developing the right type of workplace requires a multifaceted approach involving clinical leadership, educational governance and physical environment.

- 7.1 Geography is a key driver in determining choices for doctors in training.
- 7.2 Working conditions are also pivotal factors in determining career choices for medical students (Cleland et al 2016ⁱⁱⁱ) and trainees (Cleland et al 2017^{iv}).
- 7.3 The components of good working conditions include feeling valued, feeling part of a team, having rotas that are predictable, produced well in advance and without gaps (Cleland et al, 2016, 2017).
- 7.4 Other basic “hygiene factors” can contribute significantly, e.g. availability of workstations and reliable IT, secure lockers, changing facilities, food and refreshments (including out of hours), car parking/transport links.
- 7.5 Being recognised as good training programme is important but less so than the working environment. The culture of shared standards of training, valuing trainees and their education and consistent supportive team-based behaviours is important in establishing that environment (Roberts et al 2016^v).
- 7.6 Misalignment of priorities within units can be detrimental to the working environment. Cleland et al (2016) described the tensions arising from misaligned priorities and their consequences in a single unit. The effects on trainees and other staff were considerable, difficult and damaging. We have already noted the importance of feeling supported in the workplace (Scanlan et al 2018^{vi}).
- 7.7 Fatigue has rightly been recognised as having a major influence on wellbeing of clinicians. Work by the Association of Anaesthetists of Great Britain and Ireland has led the way in highlighting the importance of this issue and seeking ways to address it.
- 7.8 Bullying, harassment and undermining were reported by 22 per cent of medical staff in a recent BMA survey, but in only a third of cases were incidents reported. A number of initiatives are attempting to tackle workplace culture led by BMA, Royal College of Surgeons of Edinburgh (RCSEd) and Royal College of Obstetricians and Gynaecologists (RCOG).
- 7.9 Burnout, physical and psychological ill-health are all increasing. In the 2018 GMC National Training Survey, 1 in 4 trainees and 1 in 5 trainers reported feeling burnout to a high degree.
- 7.10 Improving the training and working environment and culture is a joint responsibility of all stakeholders. Importantly, this is relevant to all members of the workforce, and improvement efforts should not be focused on any one group.
- 7.11 NES and GMC are hosting a Wellbeing Advisory Group, inviting high level stakeholders to contribute to a coordinated strategy intent on taking action as well as preparing recommendations for improvement.

SAFE STAFFING

- 8.1 The Health and Care (Staffing) (Scotland) Bill 2019 is a welcome move in promoting statutory safe staffing requirements. The recognition of the role of clinical leaders and promotion of an evidence-based approach, incorporating technological solutions, is laudable. Ultimately, the real value of this will be determined by the supporting tools, guidance and regulations, and real consideration and consultation here will be necessary.
- 8.2 Although welcome, the Bill will not itself materialise a workforce, however.

FLEXIBILITY

- 9.1 The GMC has recognised the merits in a flexible approach to postgraduate medical education (Flexibility review 2017). This includes the transferring of generic clinical and professional skills from one programme to another to avoid the need to duplicate experience.
- 9.2 This is a major driver in the discussions with the Junior Doctors' Committee (BMA) which continues to press for flexible approaches to training. The issue was part of the dispute between trainees and the NHS Employers in England in 2015-16.
- 9.3 Many trainees have opted to take up positions that have emerged to fill the vacant training posts. Some of these are locum posts for service (LAS) and in Scotland, we still allow locum posts for training (LAT). These are helpful in providing learning opportunities that count towards a CCT, allow trainees to sample specialties to which they may not have been exposed as well as delivering clinical care and allowing rotas to run more smoothly.
- 9.4 The innovation of the clinical development fellow post (CDF) combines elements of service delivery in hard pressed clinical areas and is combined with opportunities for doctors to develop an aspect of practice in which they are interested, for example teaching or quality improvement. These may also be viewed as sampling opportunities in the same way as many doctors used senior house officer (SHO) posts before the abolition of the grade with Modernising Medical Careers (MMC; Donaldson Report, 2004^{vii}).
- 9.5 The fact that the proportion of doctors moving directly into training posts on completion of Foundation programme continues to fall, indicates that doctors are seeking more flexibility at this formative stage of their careers.
- 9.6 While building in flexibility presents its own challenges, planning for this within workforce development may allow more accurate workforce planning.
- 9.7 11 per cent of doctors in training work LTFT (GMC NTS 2017), and the proportion varies by specialty. There is increasing recognition of the role and value of Less Than Full Time Training (LTFT) training in terms of improved work-life balance and the likely long term retention benefits for doctors within the workforce. The LTFT proportion must be factored into calculation of ST numbers.

12**RECOMMENDATION:****Ensuring positive workplace culture and wellbeing of medical staff is a priority action****13****RECOMMENDATION:****- Employers should appoint a Non Exec Director with responsibility for workplace culture/ wellbeing and one for educational governance****14****RECOMMENDATION:****The findings from the GMC Wellbeing Advisory Group should be implemented in full****15****RECOMMENDATION:****LTFT and flexible training opportunities must have wider access, and the impact on training and consultant numbers addressed**

SPECIALTY AND ASSOCIATE SPECIALISTS (SAS) GRADES

- 10.1 Staff grade, Associate Specialist, and Specialty doctors grade doctors contribute enormously to the medical workforce.
- 10.2 It's important to recognise the difference between SAS grades, who are often highly experienced senior clinicians, possessing individual and often highly specialised skill, entirely capable of independent or near-independent practice and often in post for prolonged periods of time, and more junior locally-employed doctors (LED) who may have stepped off the training pathway and who are often working in relatively temporary service-provision roles with an intention or likelihood to return to training in future.
- 10.3 Recruitment and retention of SAS and LED grade doctors (which represents one-fifth of the medical workforce) is known to be significantly challenging. Career progression, pay, morale, and career development are all cited as reasons for leaving these roles.
- 10.4 The 2014 BMA, Management Steering Group, and NES Charter for SAS doctors gives recommendations on recognition, job planning, support, development, involvement in organisational structures and recruitment. Implementation of the Charter has been shown to improve recruitment and retention, and is of clear merit and value to employers and the workforce as a whole.
- 10.5 Access to College ePortfolios for SAS doctors might facilitate application and re-entry to formal training programmes as well as providing evidence towards Certificate of Eligibility for Specialist Registration (CESR)/Certificate of Eligibility for GP Registration (CEGPR) applications, which are of value in developing the skills and maintaining the workforce benefits of these clinicians.

CONSULTANT RETENTION

- 11.1 At a time when consultant recruitment is limited, as highlighted above, it becomes all the more important that consultant staff are retained in the workforce.
- 11.2 Consultant posts are advertised but filling these is inconsistent. In 2018 38 per cent of advisory appointments panels were cancelled, 88 per cent of these were applicant related (no suitable applicant).
- 11.3 Some health boards continue to advertise contracts with a split of 9 Direct Clinical Care (DCC) to 1 Supporting Professional Activities (SPA). These posts are unattractive, leave no time for other professional activities and are in direct contradiction to the Consultant contract and letter of advice from 4 nation Consultant Chief Medical Officers (CMOs).
- 11.4 ISD figures show in June 2018 there were 428.6 WTE medical consultant vacancies and of these 62 per cent have been vacant for greater than 6 months. These figures represent an underestimate of the true situation. More worryingly since June 2017 there has been an 18.8 per cent increase in the number of consultant posts vacant for greater than 6 months.
- 11.5 A recent BMA survey of 4000 consultants, 58 per cent over 50, 10 per cent over 60, 83 per cent working full time, highlighted that 60 per cent intended to retire before the age of 60.
- 11.6 For 70 per cent work/life balance was the most important factor influencing their decision, but for 56 per cent of respondents the second most important factor was pension regulations.
- 11.7 50 per cent of consultants are less likely to take up or have already given up doing extra Professional Activities (PAs).
- 11.8 The changes in tax law have imposed penalties on many doctors who have worked hard over many years to find their pensions are subject to tax leakage. The scale of the tax bills has contributed to decisions about staying in work and decisions to retire, sometimes very prematurely.
- 11.9 An unintended consequence of imposition of these measures, devised to raise money in a time of revenue weakness, has been to discourage senior doctors from continuing to work when they might well do so.
- 11.10 Sustaining a full consultant workload including on call becomes increasingly difficult as we age. Sleep physiology becomes less resilient with resulting increases in the recovery phase after a sleepless night. Older doctors are thus increasingly challenged physically by night time and out of hours working. Not only is there risk to the doctor, there is a risk to safety of service delivery.
- 11.11 It is interesting to observe that employment law requires employers to make reasonable adjustments for a number of health-related conditions yet ageing is not one of these.
- 11.12 While in principle the consultant contract should be flexible enough to allow consultants to withdraw from on call work, in practice due to workplace shortages and rota gaps at senior level, it becomes impossible for them to do so.
- 11.13 The default is therefore to retire, thus losing considerable expertise from the workforce and further compounding shortages of staff.
- 11.14 A growing proportion of consultants will seek to “retire and return” to ensure their pensions do not shrink while their tax burden increases. This provides a mechanism for retaining their expertise in the workforce. They require continuing annual appraisal and a Responsible Officer for revalidation which may be difficult to access.

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RECOMMENDATION:

No consultant post should be advertised as a 9:1 contract

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RECOMMENDATION:

Improved flexibility of job plans is required in later stages of consultant career with options to reduce to LTFT and withdraw from out of hours work

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RECOMMENDATION:

Pension and tax regulations require urgent reform: a reasonable solution to the current impasse is essential

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RECOMMENDATION:

Further research is required to identify factors which would help retain consultants in the workforce

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RECOMMENDATION:

Process of appraisal and revalidation should be facilitated for consultants who wish to retire and return

CONCLUSIONS

NHS activity is continuing to grow at around 3.6 per cent annually (RCP Double or Quits, 2018) and the medical workforce in Scotland needs to reflect that. While we recognise the value of multidisciplinary working and of emerging roles, to maintain a safe and high quality service it is essential that we have adequate numbers of doctors with appropriate training, skills and experience.

We make the following recommendations regarding workforce planning:

- 1 A single workforce planning group should be established.
- 2 The proportion of Scottish domiciled entrants to Scottish medical schools should be increased.
- 3 The number of medical school entrants should be further increased.
- 4 The proportion of medical students from widening access programmes and Graduate entry programmes should be increased.
- 5 A better understanding of the attributes of Foundation Programme doctors who do not directly enter training is required.
- 6 More flexibility is required at early stages of career and recognition of various types of training needs to be developed.
- 7 The accuracy of consultant data held by ISD should be improved. Electronic job planning should improve this.
- 8 Specialties should have access to data to facilitate their input into workforce planning.
- 9 A process for data confirmation is required and a pathway specialty should be used as a pilot.
- 10 The MTI should be expanded and process of matching improved.
- 11 While immigration is a reserved power, the possibility of reinstating permit free training should be reviewed.
- 12 Ensuring positive workplace culture and wellbeing of medical staff is a priority action.
- 13 Employers should appoint a Non-Executive Director with responsibility for workplace culture/ wellbeing and one for educational governance.
- 14 The findings from the GMC Wellbeing Advisory Group should be implemented in full.
- 15 LTFT and flexible training opportunities must have wider access, and the impact on training and consultant numbers addressed.
- 16 No consultant post should be advertised as a 9:1 contract.
- 17 Improved flexibility of job plans is required in later stages of consultant career with options to reduce to LTFT and withdraw from out of hours work.
- 18 Pension and tax regulations require urgent reform.
- 19 Further research is required to identify factors which would help retain consultants in the workforce.
- 20 Process of appraisal and revalidation should be facilitated for consultants who wish to retire and return.

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