

HEE Workforce Planning 2013/14 – Call for Evidence

To submit your evidence please complete this form. Please make your submissions relevant to the categories provided in the boxes provided. We have categorised the known drivers of demand and supply under the following headings, and believe this to be a comprehensive description of the variable involved.

You can provide extracts of reports into the free text boxes below, or submit a whole report with this form by clicking on the email at the bottom of this form. Please mark clearly in the email which of the below categories the report/evidence relates to, including any relevant page numbers. Where an extract is provided, please reference the source.

Please use Part 3 to submit any information/evidence that does not fit the below categories. You can also leave any comments/observations in the free text box.

Before completing the form below please submit your contact details here:

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Form submission:

Once completed please submit the form via email to hee.workforceplanning@nhs.net making sure all supporting documents are also attached to the email.

Please make the subject of the email: HEE Workforce Planning 2013/14 Call for Evidence-[Insert your organisation's name]

Data Protection and Freedom of Information

The information you send us may be made available to wider partners, referred to in future published workforce returns or other reports and may be stored on our internal evidence database.

Any information contained in your response may be subject to publication or disclosure if requested under the Freedom of Information Act 2000. By providing personal information for this review it is understood that you consent to its disclosure and publication. If this is not the case, you should limit any personal information provided or remove it completely.

If you want the information in your response to be kept within HEE's executive processes, you should make this clear in your submission, although we cannot guarantee to be able to do this.

PART 1 – Future Service and Workforce Models

1. Drivers of Future Service Demand

- Needs identified by patients and the public
- Activity and epidemiology
- Quality. Innovation, prevention and productivity
- Funding
- Other

2. Future Service Models

3. Future Workforce Models

- Associated knowledge and skills – and assessments of the supply and demand position*
- Associated values and behaviours – and assessments as above*
- Workforce structure, team structure, skill mix, new roles.
- Workforce performance and productivity

*nb – this may include views on the efficacy and quality of education processes in equipping staff with these skills, knowledge, values and behaviours.

Introduction

The Medical Schools Council and the Dental Schools Council represent the medical and dental schools educating the future workforce in medicine and dentistry, and representing the interface between health and higher education. Our expertise in response to this consultation relates to education, training and research.

The current and future workforce needs to be flexible and adaptable

Care will be delivered over an increasing range of different settings, and it is likely that there will be a greater pressure on acute care, care of long-standing conditions and co-morbidities, and care of the elderly more generally. Technological developments will make frequent re-training essential. The MSC has made representations to the *Shape of Training* Review that postgraduate training needs to be more generalist, with recognition of training in other specialties. However whilst there needs to be a greater emphasis on more generalism in secondary as well as primary care, this cannot be at the expense of the provision of specialised services. Any focus on training and education to support generalists needs to preserve the highest standards of clinical knowledge and skills allied to the need to ensure that new innovations are adopted.

The workforce will therefore need to be a mixture of generalists (both primary care and secondary care), specialists and multidisciplinary teams. However the proportions of these groups, and the balance of skills required in each group, will need to be responsive to changing circumstances.

HEE and the Royal Colleges need to work with the medical schools to ensure that the curriculum and indeed

careers advice is tailored appropriately to meet the needs of patient care, and to frame expectations of the doctors and dentists in training.

Staffing levels

The NHS employs more than 1.7m people. Of those, just under half are clinically qualified, including, 39,780 general practitioners (GPs), 370,327 nurses, 18,687 ambulance staff and 105,711 hospital and community health service (HCHS) medical and dental staff (www.nhs.uk). Doctors bring to healthcare fundamental and distinctive skills to healthcare through making the diagnosis, which is critical to healthcare pathways. In order to maintain high standards of patient care, there should be a strong Consultant presence in key clinical decisions at the earliest possible opportunity.

Technological advances do not mean that fewer doctors will be needed – but the content of the roles will change. Around 54% of the 8,000 student intake to medical degree programmes are women, and 41% of the 1,200 intake to dentistry programmes (HESA data). This will have implications for staffing levels as more women than men choose to work part time at some stage in their careers. There must be greater flexibility to accommodate Less Than Full Time (LTFT) training. Workforce planning needs to balance the pressures of service delivery and provide a sound training pathway for all trainees and protected research time for clinical academics.

Clinical academics make up around 6% of the Consultant workforce – numbering 3,467 (3,167 FTE) in medicine and 476 (388 FTE) in dentistry at Lecturer, Senior Lecturer and Professor grades (www.medschools.ac.uk and www.dentalschoolscouncil.ac.uk for the annual *Survey of Clinical Academic Staffing Levels*). In funding 42% of clinical academics, the NHS has recognised that their function and purpose is national and international rather than simply local - although clinical academics certainly do make a substantial contribution to direct, innovative medical care. Almost all clinical academics commit 50% of their job plans to direct clinical care and supporting activities. They play a key role in contributing to the life sciences strategy and to UK plc. They identify tractable problems in their patient population, undertake the research to resolve the issues and introduce innovative approaches and solutions. It is a role to be protected and nurtured.

The EU predicts that there will be a shortage of 230,000 doctors by 2020. See p6 of http://ec.europa.eu/dgs/health_consumer/docs/swd_ap_eu_healthcare_workforce_en.pdf. There will also be a shortfall of 150,000 dentists, pharmacists and physiotherapists and 590,000 nurses making a total EU shortfall of 970,000 clinicians.

There should be an academic underpinning to all training programmes, both generalist and specialist.

Academic values and a spirit of enquiry must pervade the medical workforce. Scientific advances, made possible by medical research, have brought about a greater understanding of the molecular basis of disease, which together with rapid technological developments offer significant opportunities to evolve clinical practice. The MSC has made recommendations to the *Shape of Training* Review that robust training in research awareness, critical appraisal, and the evaluation of evidence should be a fundamental component of all foundation training programmes to embed a greater awareness of how to apply research across the medical workforce. This will allow doctors to interpret data to plan investigations and treatment and explain the advice to patients, and to

evaluate the effectiveness of healthcare delivery in the modern health service. Whilst it is difficult for academics in sub-specialties to maintain a community footprint, all practitioners need to be involved in research into the clinical and health service implications of generalist practice for example helping to recruit patients for clinical trials.

PART 2 – Forecast of future supply and demand – volumes

If you want to input evidence into the forecasting of future numbers you can report your perspectives on either;

- i) the high level indicators; supply, demand, and any forecast under / over supply, or if available - Part 2.1
- ii) the more granular components of these three components e.g. retirement rates, output from education relative to attrition – Part 2.2

2.1 Summary forecasts

- Forecast Workforce Demand
- Forecast Workforce Supply and Turnover
- Forecast Under / Over Supply

The MSC and DSC *Survey of Clinical Academic Staffing Levels* indicate that the current rates of retirement and attrition are greater than the number of clinicians joining the clinical academic pathway. This is despite a slight increase in the number of Lecturers in post – the number of academics aged under 45 is unchanged, whilst the number of those aged over 45 has increased every year for the last 10 years.

Career progression takes longer in clinical academia, than in run-through clinical training, as the same clinical competences need to be achieved alongside establishing a research track record and usually a doctorate degree. A comparison between the age of NHS and clinical academic Consultants indicated the average ages to be 47.4 years (2011) and 51 years (2012) respectively.

Both the MSC and DSC reports of *Clinical Academic Staffing Levels* show an increase in the age profile of clinical academic doctors and dentists. Between 2004-2012, the average age of clinical academic doctors has increased by nearly 3 years – from 47 to 50 – and the proportion of clinical academics at Consultant grade has increased. In dentistry the trend is mirrored for Lecturers, Senior Lecturers and Professors. In 2004, there were just under 1,600 (53%) clinical academic doctors aged over 45. In 2012, there were 2,200, closer to 64% of the clinical academic team.

2.2 Detailed / Component forecasts

Forecast Workforce Demand

- Service Demand drivers
- Change in use of temporary staff
- Addressing historic vacancies
- Skill Mix / New Roles
- Workforce Productivity

All clinicians are under increasing scrutiny, and the requirements for CPD and further training are the same irrespective of the number of contracted clinical hours. Whilst this is good and should be protected, the effect is often that teaching and research time is 'squeezed', or that staff work significantly beyond their contract hours. The effect on work-life balance, and the perception of these expectations, is a contributing factor to the comparatively small number of women at senior positions in the clinical academic workforce.

New roles will not be able to replace doctors' central role in diagnosis. A YouGov survey of a representative sample of 3,000 UK adults showed that over 95% agreed or strongly agreed that 'My top priority is having confidence that my doctor will achieve an accurate diagnosis of what is wrong with me'.

Multidisciplinary working needs to be encouraged in a more sophisticated way. Each professional group should use its skills to complement rather than overlap. The Cavendish Review into Healthcare Assistants and Support Workers in the NHS and social care settings showed the risks of unclear roles without professional pride¹. Increasingly, the workforce will need to be educated about health and social care as a system and the role of colleagues in that system. Encouraging flexibility to adapt to patient needs, new technology and service design will be vital within this.

The same YouGov survey referred to above showed that 72% of respondents agreed that 'There should be no uncertainty about what might happen to me during the proposed course of treatment' This cannot be a realistic expectation and so more needs to be done to raise the level of understanding within the population.

¹[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212732/Cavendish_Review_ACCESSIBLE - FINAL VERSION 16-7-13.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212732/Cavendish_Review_ACCESSIBLE_-_FINAL_VERSION_16-7-13.pdf)

Forecast Supply from HEE commissioned education

- Assumed training levels
- Under recruitment
- Attrition
- Employment on completion of training

Number of training posts

National governance and strategic control are necessary in determining the number of training posts and for quality control and selection processes. It is critical that short-term service pressures do not detract from the importance of postgraduate training. The current changes to education and training structures are a valuable opportunity to generate greater consistency in best practice by promoting academic flexibility as a right at a national level. Rotations must allow for this flexibility.

Difficulties in recruiting to senior clinical academic posts

Feedback from medical and dental schools – documented in the *Survey of Clinical Academic Staffing Levels* – relates to a shortage of suitably qualified candidates for clinical academic positions, and a lack of trainees coming through the system.

Forecast Supply – Other Supply and Turnover

- From other education supply
- To/from the devolved administrations
- To/from private and LA health and social care employers
- To/from the international labour market
- To/from other sectors / career breaks and 'return to practice'
- To/from other professions (e.g. to HV or to management)
- Increased / decreased participation rates (more or less part time working)
- Retirement

Clinical Excellence Awards (CEAs)

The future of CEAs will impact on the ability of England to recruit the highest calibre of clinical academics, both in comparison to the rest of the UK – where similar schemes operate (Distinction Awards in Scotland, CEAs in Wales and Northern Ireland) – and the rest of the world.

Flexibility to move between a clinical academic and a clinical career

Managing the dual workload of specialty training with gaining momentum in research through postdoctoral work can be exceptionally challenging; obtaining and maintaining postdoctoral research experience should not act as a deterrent to those keen to pursue this pathway. In the current system, this has created a 'pinch point'. Limited postdoctoral experience can prevent individuals from developing sufficient expertise to be competitive for prestigious externally funded Intermediate Fellowships/ Clinician Scientist Fellowships, which enable the transition from postdoc to independent researcher.

A well-defined yet flexible career path is essential to nurture future clinical academics. We have seen significant improvements in the structure of postgraduate academic training, such as those provided by the National Institute for Health Research Integrated Academic Training Programme.

Consideration needs to be given to the volume of postdoctoral opportunities available. The recommendations of the *Shape of Training* Review in medicine has the potential to be a catalyst for change, ensuring that the attrition of clinical academics at this point is reduced. Consequently, this limits the number of individuals who go on to apply for senior clinical academic posts.

PART 3 – General / Other Evidence not included elsewhere

The Medical Schools Council and Dental Schools Council have published data on the number of clinical academics since 2000 (full registration with the regulator, substantive contract of employment held by the university, honorary contract held by the NHS or nominated body i.e. Public Health England). The reports, monitoring trends in staffing level by specialty, region, age group, gender, Clinical Excellence Award, and others, are available from: <http://www.medschools.ac.uk/AboutUs/Projects/clinicalacademia/Pages/Promoting-Clinical-Academic-Careers.aspx> and http://www.dentalschoolscouncil.ac.uk/clinical_academic_staffing_survey.htm.

We have a data sharing agreement in place with the Centre for Workforce Intelligence and with HESA, and we would be happy to provide the raw data or further analyses to HEE.