Written evidence submitted by the Royal College of Surgeons of England (RTR0049)

Introduction

1. The Royal College of Surgeons of England (RCS England) is a professional membership organisation and registered charity that exists to advance patient care. We support nearly 30,000 members in the United Kingdom and internationally by improving their skills and knowledge, facilitating research, and developing policy and guidance.

2. We welcome the opportunity to provide evidence to the Health and Social Care Committee's inquiry into 'workforce: recruitment, training and retention in health and social care'. The pandemic has put NHS staff under huge pressure, with many feeling disillusioned, overworked and at high risk of burn out. Almost 100,000 vacancies across all specialties[1], rising staff absences due to Covid isolation and a growing backlog of care have compounded the sense of a workforce crisis within the NHS.

3. In surgery the problem is particularly acute due to the record waiting list for surgical treatment. All elective (planned) surgery was cancelled in the first wave and many surgical teams were redeployed to help treat Covid patients. There are now 6 million people on the NHS waiting list, including more than 300,000 waiting over a year and 18,500 waiting over two years.[2] In addition, there is a 'hidden waiting list' of people who have not yet come forward or who have not yet been referred for hospital treatment. Estimates vary, but could mean the waiting list growing to 14 million by the autumn of 2022. [3]

4. However even before the pandemic, a significant waiting list and persistent staff vacancies were putting a strain on NHS teams. We urge the government to develop a fully-funded national strategy to address the workforce crisis and introduce a system for workforce planning.

Summary recommendations

5. RCS England urges the Committee to consider the following summary recommendations to improve the recruitment, training and retention of surgeons. These are expanded upon below:

    5.1 Steps must be taken urgently to prevent highly skilled surgeons at all levels from leaving the NHS. Along with an expansion in the NHS workforce to bolster surgical teams and address excessive workloads, trusts should offer a better work-life balance through measures to accommodate flexible working policies, including less than full time working. The pension tax issue should also be resolved as a priority, to prevent more senior surgeons from leaving the NHS. Additionally there should be a nationally agreed process to enable surgeons to take their pension, retire briefly and return to practice as opposed to the local ad hoc schemes.

    5.2 To increase recruitment in the short term, the NHS should prioritise attracting newly retired surgeons back to work. Experience during the pandemic has shown how complicated this can be and in the short term steps are required to make this easier. Over the longer term, the government should adopt a long-term aim to increase the number of doctors (including surgeons and anaesthetists) from 2.8 to 3.5 per 1,000 population, in line with the OECD average.[4] Better workforce planning is needed, by adopting the amendment that is backed by more than 90 medical organisations, including this College, to forthcoming NHS legislation.

5.3 Surgical services have long been supported by both the medically qualified and non-medically qualified workforce. The roles of those in the non-consultant career grade need to be better integrated to ensure enhanced job satisfaction. Steps should also be taken to enhance the role of non-medical practitioners within the Extended Surgical Team (EST) to make these attractive careers with appropriate resources available to employers.

5.4 The NHS should continue to allow highly skilled healthcare professionals and support staff from outside the UK to take up vacant posts in the NHS, as part of efforts to reduce record waiting lists. We support measures to make it easier for international colleagues to work in the NHS, along with reciprocal arrangements with other countries to encourage their trainees to train in the NHS and vice versa.

5.5 Surgical training has been severely disrupted by the pandemic due to the reduction in levels of elective surgery, which provide surgical trainees with vital experience. We urge trusts to ensure that every elective operation performed on an NHS patient includes a surgical trainee, including those that may happen in the independent sector. The NHS should also make surgical training a funded contractual commitment, similar to the arrangements that already exist for GP training, to ensure trainers are valued and have dedicated time for training within their job plan. Flexible working policies for trainees, and support for longer training placements is also needed, to address low morale among surgical trainees and improve retention.

What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?

Short term

6. In order to increase recruitment in the short term, we recommend the NHS takes further action to attract recently retired, highly skilled doctors back to work. A key element of this should be to make permanent the measures introduced by the GMC during the pandemic to enable doctors to easily re-join the medical register.

7. We urge trusts to ensure clarity and consistency around 'retire and return' policies so that senior surgeons can 'return' to appropriate roles and work flexibly. For example, older consultant surgeons may be more able to work on shorter rotas performing planned surgery in Covid-light surgical hubs, without being part of acute rotas. Following the government's stated support for surgical hubs – including hubs that focus on achieving high volumes of planned surgery such as hip and knee replacements – supporting arrangements to allow flexible working on these sites should be developed. This should be more easily accommodated, as emergency admissions are on a separate site.

8. Trusts should be encouraged to release and recruit to existing consultant vacancies to expand the trained workforce. Anecdotally, we have heard that consultant surgeon vacancies are higher than vacancy data suggests as fewer posts are advertised than are available. This may be due to budgetary constraints, or uncertainty around funding. However, given the high volume of surgical activity that needs to be delivered to address the elective backlog, and the additional problem of COVID-related absence among surgical teams, there is a greater need than ever to address vacancies and recruit to more sustainable staffing levels.

Medium term

9. In the medium term, the roles of non-medical practitioners within the extended surgical team, such as surgical care practitioners, physician associates, advanced clinical practitioners and surgical first assistants, should be enhanced to make them attractive career choices. These roles are key to efficiently functioning surgical teams, helping to improve the continuity of patient care by providing a link between patients, consultants and trainees. They can help free up trainees' time for training, attending theatre and teaching, which has the added benefited of supporting the total volume of elective surgery undertaken.

10. Surgical care practitioners (SCPs) are healthcare professionals who have undertaken a two-year accredited, Masters level training programme to perform surgical intervention, pre-operative and post-operative care, under the direction and supervision of a consultant surgeon. SCPs have the potential to take on more enhanced clinical roles, such as the delivery of out-of-hours care and prescribing. But to do so, they need to be regulated and trained appropriately. We are working with other surgical bodies to update the SCP curriculum and create a managed voluntary register in support of this. Although physician associates are due to be regulated by the GMC, the government has not agreed GMC regulation for SCPs, so the risk is they will not be regulated to the same standards as surgeons. As the majority of SCPs come from a nursing background and already have the NMC as a regulator, we recommend they should have dual regulation with the GMC and NMC, similar to the arrangements held by paramedics and oral and maxillofacial surgeons. This would enable SCPs to fulfil their potential, making the career more attractive and improving the efficiency of surgical teams.

11. In a similar vein, the NHS should give greater recognition to non-consultant career posts. These doctors have been major contributors to service provision but have often not been considered formally in workforce planning, with potentially detrimental effects on career progression and job satisfaction. The NHS should ensure these posts are valued and that this cohort is supported to achieve new skills that are appropriately recognised.

12. The NHS should develop a strategy to attract more women into surgery (in addition to taking action to retain them, as outlined in paragraph 25). Figures show 34% of surgical trainees and 14% of consultant surgeons are female. This compares unfavourably to the broader medical population where over half of trainees are female (56.6%) and the proportion of consultants who are female increased from 31% in 2013 to 37% in 2020.[5] The failure to attract sufficient female medical students to surgical careers is a shared responsibility of course with our College, and the driving force behind the establishment of our Women in Surgery Forum and support for the Lady Estelle Wolfson Emerging Leaders Fellowship programme. While some progress has been made in improving the diversity of the surgical workforce, progress has been too slow. A national strategy is needed, along with consistency in support for more flexible working patterns, which is one factor cited in choice of medical specialty.

Long-term

13. In the long term, we urge the government to increase the number of doctors (including surgeons and anaesthetists) from 2.8 to 3.5 per 1,000 population, in line with the OECD average.[6] More surgical and anaesthetic staff, such as theatre nurses, would help increase the number of operations that can be carried out and enable teams to work more flexibly We note the Royal College of Anaesthetists has raised concerns that there is currently a shortage of 1,400 anaesthetists across the UK.[7] Surgery relies on a team, including of course anaesthetists, so shortages in related specialties must be addressed if we are to increase surgical activity to

pre-pandemic levels (and indeed beyond pre-pandemic levels, to catch up with the backlog and address growing demand for surgery from our ageing population).

What is the correct balance between domestic and international recruitment of health and social care workers in the short, medium and long term?

14. It is clear the NHS would struggle to provide care without the skilled healthcare professionals and medical support staff who come from outside the UK. With 17% of surgeons having trained in the European Economic Area (EEA) and a further 21% having trained in the rest of the world[8], surgery is dependent on, and greatly benefits from, a non-UK trained workforce. We continue to support the Medical Training Initiative (MTI) scheme, as it benefits international doctors, the NHS and their home country to which they (later) return. Through the Academy of Medical Royal Colleges, we have recommended expanding the MTI scheme as it would bring even greater benefits to both the UK and overseas health services. However MTI doctors coming in on Tier 5 visas currently have to pay the NHS surcharge and then seek to reclaim unlike all other healthcare staff from overseas, and this inequity should be rectified.

15. We would also like to see clarity from the government as to whether the post-Brexit transition arrangements for EU doctors to be treated differently to non-EU doctors will continue after the end of 2022. We understand there are plans for a single qualifying route for all doctors (UK and non-UK) but that negotiation of bilateral trade deals may include rights to work for qualified individuals in specific sectors such as healthcare. The GMC requires clarity on this point to establish mechanisms to ensure that only appropriately qualified individuals are able to register, and thus protect patients.

What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors?

16. Surgical training has been severely disrupted by the pandemic and morale is low, as many trainees are worried about their career progression. The reduction in levels of elective surgery has impacted the amount of experience trainees have had in outpatient clinics, theatre, ward work and multidisciplinary meetings. Surgery is a specialism that depends on large amounts of practical experience, and surgical trainees, who already have both a medical degree and several years' experience working in the NHS, play a key and often leading role in NHS operations. A recent GMC report showed that more than half of surgical trainees felt they had not been able to compensate for lost training opportunities, and 25% felt they were not on course to progress towards curriculum competencies. [9] Additionally, the Joint Committee on Surgical Training has found that more than a million elective training opportunities where trainees would have gained vital experience have been "lost" in the UK to the pandemic. Trainee logbooks show the monthly number of cardiothoracic training opportunities dropped by approximately 60% from September 2019 to September 2021. The monthly number of training opportunities for ear, nose and throat surgeons, and trauma and orthopaedic surgeons also dropped by approximately one third during that period.[10] If surgical trainees continue to be starved of opportunities to train and progress, there is a risk they will seek employment overseas or switch specialty. Every effort must be made to prevent this happening.

17. To address this, every opportunity must be taken to free trainees from non-essential administrative work, and ensure job planning supports increased theatre time that speeds up training and supports trainees on their career path to becoming consultants. Training recovery must go hand-in-hand with service recovery, which means that every elective NHS operation

should include a surgical trainee, including those in the independent sector. Although steps have been taken to increase surgical training in the independent sector, with a substantial volume of NHS work (such as hip and knee replacements) taking place there, access for trainees remains patchy. National agreements between Health Education England (HEE) and the independent sector are not necessarily being implemented at the local level, with examples of hospitals, even within the same independent sector group, applying the guidance variably. We urge the Government to publish its elective recovery plan and establish covid-light surgical hubs in every region, where elective surgery is protected from emergency admissions.

18. Since 2018, RCS England has been working with HEE on the Improving Surgical Training (IST) project to pilot better training programmes in a number of surgical specialties. The pilot trials approaches intended to improve the quality of training, providing a better balance between service and training for trainees, and professionalising the role of surgical trainer. An independent evaluation of the pilots has made a number of recommendations, including 12-month (as opposed to 4-6 month) placements to enable trainees to build relationships with supervisors and understand systems, better rota design to balance training time with service delivery, and equitable resourcing and support for trainers across trusts. We would like to see these recommendations implemented and also suggest the NHS makes surgical training a funded contractual commitment for trainers, similar to the arrangements that already exist for GP training, so that trainers have dedicated time for training

19. Another measure to help improve trainee morale and retention would be for trusts across the country to consistently promote flexible working and accommodate Less Than Full Time (LTFT) training. We must ensure that surgical training is as flexible as possible for our increasingly diverse workforce. It should be emphasised that LTFT training is not just for women. Any trainee may seek to train LTFT for a variety of reasons.

- **To what extent is there an adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need?**

20. We are concerned that there is no adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need. Improved workforce planning is critical to increasing the number of operations that can be carried out in the coming years. A survey of our members in September 2020 found 53% of surgeons pointing to a lack of staff as a significant barrier to resuming planned procedures after the second Covid wave.[11] Without an increase in workforce, planned surgery is likely to continue to be affected during periods of pressure, the waiting list will continue to mount, and the flexibility that we need to offer surgical staff to retain them will be impossible to achieve.

21. Along with a number of other organisations, we support the Committee's recommendation that forthcoming NHS legislation includes a statutory duty for government to undertake regular independently verified assessments of future health, social care and public health workforce numbers, based on the projected health and care needs of the population. This should be underpinned by a fully-funded long-term workforce implementation strategy to improve recruitment and retention.

What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?

22. Prior to the pandemic the NHS workforce faced a perfect storm of consultants choosing to retire earlier, a significant proportion approaching retirement age and a growing trend of

younger doctors walking away from a career in the NHS. Covid has added significant pressure on the workforce, with the exhaustion of working in PPE, re-deployment and the emotional impact of the pandemic taking its toll. We are concerned by the GMC's recent findings showing 30% of doctors often feel unable to cope with their workload (up from 19% in 2020), 17% are at high risk of burnout (up from 10% in 2020) and 23% are planning to leave the profession (up from 19% in 2020). [12] Expansion of the NHS workforce to reduce vacancies and enable staff to work flexibly where they wish is vital to staff welfare and morale, and in turn to patient care. With fatigue and demoralisation from the experience of the COVID-19 pandemic to counter, we must address excessive workloads and ensure staffing is sustainable over the long term.

23. The GMC found that the top two reasons for doctors intending to change their careers in the coming year were wellbeing concerns and a desire for more non-working time. We strongly support measures to accommodate less than full time working and flexible working practices to allow a better work life balance. This would help to retain staff, particularly those with caring responsibilities and the senior workforce.

24. In December 2021, we asked our network of regional surgical representatives about the main reasons for staff leaving the NHS. Many cited inadequate resources, overworking and disillusionment with the growing backlog of elective care. Our members have also spoken about the emotional stress of not always being able to treat patients in a timely fashion, and the 'moral distress' of knowing that protracted delays are adversely affecting their patients. We support the Academy of Medical Royal Colleges' recommendation to utilise 'stay' (not just exit) interviews to identify staff at risk of leaving and devise solutions which might encourage them to stay (e.g. careers mentoring).[13]

25. There has been a consistent issue with retaining women in surgery. There is an approximate 50% attrition in female doctors between core and higher surgical training, which may be partly due to the difficulty in completing training within an appropriate timescale while working less than full time. RCS England has launched a 'Parents in Surgery' project to understand the barriers that parenthood brings to pursuing a career in surgery. Feedback, so far, is that a lack of flexibility in training schedules and rotas, and negative attitudes to LTFT training play a role, which may disproportionately affect women. The College plans to publish its findings next June and use these to guide trusts, and those who deliver surgical training programmes, to improve the working lives of surgeons who are, or aspire to be, parents.

Are there specific roles, and/or geographical locations, where recruitment and retention are a particular problem and what could be done to address this?

26. Hospitals in the north of England and rural areas sometimes struggle to recruit surgeons. Therefore we recommend that the NHS explores ways in which surgeons and other workers might be incentivised to work in less popular regions and areas. For instance, there could be financial incentives for relocation to make a move more appealing.

27. Surgery relies on a surgical team, including trained nurses working as theatre staff. Our network of regional representatives has told us that since the pandemic, there has been an exodus of theatre staff. Many were redeployed to support critical care, and, following the emotional trauma of working on COVID wards, there is a risk they will leave the NHS. The Health Foundation flags that nursing is the most significant workforce shortage area in the NHS already and represents a 'major long-term and growing problem'.[14] Recruitment drives should therefore target nurses, including for theatre staff roles.

To what extent are the contractual and employment models used in the health and social care sectors fit for the purpose of attracting, training, and retaining the right numbers of staff with the right skills?

28. We remain seriously concerned about the impact of the contractual pension taxation rules on the delivery of NHS care and on surgeons themselves. In 2019, we commissioned YouGov to survey our members to understand the scale of the problem and published a report of the findings. 1,890 surgeons responded, with 69% of consultant surgeons saying they had reduced the amount of time they spent working in the NHS as a direct result of changes to pension taxation rules[15] To get a snapshot of the picture now, in December 2021 we asked our network of regional representatives if they still knew of colleagues retiring earlier than planned this year because of concerns over the pension tax. Of the 44 regional representatives that responded, only one answered no. Respondents said that the policy has driven them and their colleagues to decline extra sessions to help reduce NHS waiting lists, with one saying that 'this has added pressures on the rest of the team'. Other comments about the pension tax were that it was 'punitive, complex and unfair', it has 'hit morale of the consultant workforce immeasurably', and it will lead to 'a severe workforce shortage of consultants'.

29. With 4.8% of all NHS medical posts vacant[16], we are concerned that even more senior doctors may consider leaving the NHS if the pension tax issue is not resolved urgently. Therefore we support the Academy of Medical Royal Colleges' recommendation that the NHS should promote ameliorative actions such as salary replacement schemes, and facilitate and fund access to independent financial advice on pensions. This will help doctors to make informed choices about retirement dates and consider available options if they wish to remain in the NHS.[17]

30. In response to the pandemic, the government introduced emergency legislation to suspend the NHS Pension Scheme regulations for retired staff who returned to the NHS. However these regulations are due to end on 24 March 2022. We urge the government to make this suspension permanent to attract retired surgeons back to the NHS, who can in turn help with waiting list initiatives.

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[1] NHS Digital, 'NHS Vacancy Statistics England, April 2015-September 2021
[2] NHS England, 'Consultant-led referral to treatment waiting times', 13 January 2022
[3] Institute of Fiscal Studies, 'Could NHS waiting lists really reach 13 million?' 8 August 2021
[4] Organisation for Economic Co-operation and Development (2019), 'Health at a glance 2019', p 173
[5] RCS England, 'The Royal College – our professional home: an independent review on diversity and inclusion for the Royal College of Surgeons of England', August 2021
[6] Organisation for Economic Co-operation and Development (2019), 'Health at a glance 2019', p 173
[7] RCoA, 'A shortage of 1,400 NHS anaesthetists already means that more than one million surgical procedures are delayed every year', 30 September 2021
[8] GMC, 'The state of medical education and practice in the UK', December 2021
[9] GMC, 'The state of medical education and practice in the UK', December 2021
[10] Joint Committee of Surgical Training, Association of Surgeons in Training, British Orthopaedics Trainees' Association, Confederation of Postgraduate Schools of Surgery. 'Maximising training: making the most of every training opportunity. 2021' https://www.jcst.org/key-documents/
[11] RCS England, 'Protecting surgery through a second wave', October 2020
[12] GMC, 'The state of medical education and practice in the UK', December 2021
[13] Academy of Medical Royal Colleges, 'A dozen things the NHS could do tomorrow to help the medical workforce crisis', December 2021
[14] Health Foundation, 'Building the NHS nursing workforce in England', December 2020

[15] Royal College of Surgeons of England, ‘RCS Survey on the NHS Pension Scheme’, November 2019
[16] BMA, ‘Medical staffing in England report’, July 2021
[17] Academy of Medical Royal Colleges, ‘A dozen things the NHS could do tomorrow to help the medical workforce crisis’, December 2021