Draft health and care workforce strategy for England to 2027

RCS consultation response

Q1. Do you support the six principles proposed to support better workforce planning; and in particular, aligning financial, policy, best practice and service planning in the future?

The Royal College of Surgeons (RCS) broadly supports the six principles proposed to support better workforce planning. However the RCS's Patient and Lay Group has suggested the following seventh principle be added: "Ensuring that patients are informed and engaged as the workforce develops". They point out that as the workforce changes and develops, patients and their families need to be kept abreast of who's who in relation to their care. This particularly applies to new and extended roles within the surgical team. Patients are generally content to have the benefit of a wide range of skills within the team that cares for them. However, they can make best use of the various different roles and be assured about safety and quality if they have a better understanding of who does what and how the team works together.

In addition, the RCS believes there should be further details regarding the next steps for the workforce strategy document. Once the full strategy is drafted, stakeholders should be consulted to make sure it is sensible and realistic, and the plan for implementation should be co-produced.

Q2. What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?

Maintaining and attracting more people to work in the NHS

The RCS believes the key issue facing the workforce is the need to attract more people to work and stay in the NHS. There should also be a focus on understanding issues around recruitment and retention in certain parts of the country which are facing workforce shortages. For instance, we know that hospitals in the north of England and rural areas in particular sometimes struggle to recruit surgeons, especially UK trained surgeons, and this is putting services at risk. Therefore we recommend that Health Education England (HEE) explores ways in which surgeons and other workers might be incentivised to work in less popular regions and areas.

Moreover it is clear the NHS would struggle to provide care without the very skilled healthcare professionals and support staff from outside the UK. With 22% of surgeons having trained in the European Economic Area (EEA) and a further 20% having trained in the rest of the world, surgery is disproportionately dependent on a non-UK trained workforce.[1] Although we welcome the Government's plans to increase the number of UK doctors in training from September 2018, it can take around 15 years for a surgeon to be trained. Therefore we suggest the proposal in the draft workforce strategy to "not plan for continued reliance on overseas doctors" should be more

[1] General Medical Council (2015) *The state of medical education and practice in the UK: 2015*

of a long term ambition as we will still need to continue to attract doctors from outside the UK to address workforce shortages, particularly in light of Brexit. As part of this, we believe there should be more reciprocal arrangements with other countries to encourage their trainees to train in the NHS and vice versa. Overseas experience for UK trainees would allow them to gain an international perspective on health and expose them to a different epidemiology of diseases. It is essential that such experience is recognised in the overall assessment of a trainee.

The sustainability of the surgical workforce is also at risk if the NHS does not do more to attract women into surgery. Latest figures show around 57% of doctors in training are women but only 30% of surgical trainees and 11% of consultant surgeons are female. The failure to attract sufficient and growing female trainee numbers is a factor behind why we are now attracting fewer overall candidates into surgery. Unless we can reverse that trend and encourage and support more women to access surgery as a career, we risk reducing our choice from the overall talent pool which is increasingly female.

To attract more women into the profession, we believe medical leaders need to:

- Talk positively about the benefits of a career in surgery for women;
- Challenge the perception that a surgical career makes greater demands on work/life balance than other postgraduate careers;
- Be prepared to talk openly about these issues and offer practical solutions, including supporting men and women in less than full time training so they can balance their work, social and family commitments;
- Encourage and applaud men and women who sponsor their female peers in surgery.

In addition, we are concerned by the number of doctors who leave their posts during training. We therefore support HEE's plans to address this by improving the experience of work for postgraduate doctors. In surgery, it is particularly important to promote Less Than Full Time Training (LTFT) training as an option to ensure that surgical training is as flexible as possible for our increasingly diverse workforce. The Association of Surgeons in Training (ASiT) and British Orthopaedic Trainees Association (BOTA) undertook a survey in 2017 that found LTFT surgical trainees tend to have low levels of satisfaction with their training due to variable attitudes amongst trainers, fellow trainees and employers, worrying reports about bullying and harassment and difficulties with access to both elective and emergency training opportunities. Following the survey, the Joint Committee on Surgical Training (JCST) made a number of recommendations to improve the approach to LTFT.[2] This included emphasising that LTFT training is not just for women and any trainee may seek to train LTFT for a variety of reasons; ensuring all training environments can, in principle, accommodate LTFT trainees; and simplifying the application process for LTFT training.

We also note the draft workforce strategy highlights the recent debate on the preferred term to describe doctors in postgraduate training. This has been discussed within RCS, with the conclusion that we should return to the traditional terms of house officer, senior house officer and registrar as these are already well-known in the hospital structure.

Finally we believe that the role of senior surgeons could be expanded to keep them in the NHS. Many "leave" or retire early yet are a valuable source of knowledge and experience. Modifications of their clinical roles, education and training activities and mentoring of younger

[2] Joint Committee on Surgical Training. *Less Than Full Time (LTFT) Training in Surgery: JCST Policy Statement* (September 2017)

consultant colleagues as well as trainees are all options, which could be considered in this context.

Extend workforce flexibility

In line with other craft specialties, working flexibly in surgery is challenging because of the need to maintain technical skills. As described above, there have been initiatives to improve support and advice for LTFT training. The RCS recommends this should be supported by robust return to work programmes, which could be enhanced by training through, for example, simulation. Although the opportunity to develop new skills out of training has been actively encouraged in surgical training, it is important to ensure the recognition of such skills.

We also believe there should be flexibility for trainees to transfer between specialties. Although it is unusual for trainees in higher training to do this, change in surgical specialty career choice does sometimes occur in core training. While the RCS and HEE's *Improving Surgical Training* pilot includes run through training, there must be a mixed economy to allow movement for those trainees who want more time to make their career choice.

Finally in a broader sense, skills gained in core training need to be transferable and interchangeable such that trainees can move to other specialties with credit for their experience if they decide surgery is not for them. This begs the question of a common stem of competences, particularly in emergency care, which are gained in early postgraduate years across all specialties.

Shape of Training and credentialing

We fully recognise and support the principles developed in the final *Shape of Training* report to ensure trainees have the full skill set required to meet the spectrum of patients' healthcare needs. This includes both general and specialist skills, and the ability to manage unselected emergencies is fundamental in all surgical specialties. It is particularly important that future surgeons have time to develop and practice operative skills, which has latterly been eroded by a combination of external pressures from service priorities. This however does need to meet workforce requirements and we recommend a better longitudinal approach to planning recruitment into both training and consultant appointments. This lack of planning is highlighted by the increase in Emergency General Surgeon posts, which are largely staffed currently by non-UK graduates and have been created to meet an acute problem. Such posts are not attractive to trainees and in their current form are not sustainable in the longer term. The definition of service need is a key theme in the GMC *Excellence By Design – Standards for Postgraduate Curricula* and this must be linked to workforce requirements.

In addition, generalism must be developed in parallel with specialist surgery. In some surgical specialities (e.g. vascular and cardiothoracic surgery), emergency work is a large proportion of the workload and is made up of some the most complex cases both in terms of decision making and interventions. In these situations, patient outcomes are dependent on experience. For these reasons, emergency work in these specialties is largely consultant delivered and as the specialities are relatively small, all consultants will be involved with delivery of emergency care. There is little scope for a "generalist" in these areas and we believe the future lies in run through training, delivering highly trained specialists in a shorter period. These specialist surgeons will be able to deliver both emergency and elective care working in teams in their specialist area.

Furthermore areas of complex surgery need additional training to meet service need but may be simpler to workforce plan as the numbers of trained specialists required are smaller. This would

be consistent with the development of credentials, which should be available to those completing training as well as those trained surgeons who wish to expand their area of practice. Credentialing would also ensure that as service needs evolve and new technologies improve, established surgeons can demonstrate that they are trained and competent to undertake them. While some legitimate concerns have been expressed that credentials could lead to the fragmentation of medical training, we would envisage that credentials would only be established in areas where there is clearly growing surgical and medical practice outside of a defined specialty, such as cosmetic surgery and complex cancer surgery. If specialist credentialing is introduced, the numbers should link to the numbers of consultants in that specialty that the service needs.

The RCS has already developed a certification system for surgeons wishing to undertake cosmetic surgery and this is the first "credential" that the General Medical Council (GMC) is now looking at supporting. We have been urging the Government to enhance patient safety alongside this by updating legislation to allow the GMC to note on its register which surgeons have completed our certification system. This would enable patients and employers to check with the GMC to see if a particular surgeon is sufficiently qualified and experienced to undertake surgery in specialist areas of practice, including cosmetic surgery. To support this, we would also like to see greater alignment between the credentialing system and revalidation process.

Workforce numbers

Determination of consultant workforce numbers is a complex process. However this needs to be carefully calculated to minimise over or under supply. A common problem has been that following estimates of numbers required for annual recruitment into higher surgical training, the final number recruited is significantly different from the original estimate largely to fill approved training posts. Secondly, the skill mix of a new or replacement consultant post can be determined by a variety of factors, which do not necessarily reflect the output of training programmes and are influenced by local factors as opposed to service need.

To help forecast workforce numbers more accurately, we call on the Government to provide a single robust data source that brings together the various sets to inform us how many people are in the system and how they move within it. In addition, the implementation of the workforce plan needs support from all stakeholders to ensure the product of training meets service need.

Q3. How can we ensure the system more effectively trains, educates and invests in the new and current workforce?

Improving Surgical Training

The GMC's annual trainee survey consistently finds that surgical trainees are the least satisfied of all the medical specialties. Many have concerns about the time available for training, the demands placed upon them to cover the service, and their exposure to common surgical conditions. As noted in the draft workforce strategy, the RCS and HEE have developed the *Improving Surgical Training* initiative to pilot a new surgical training programme for general surgery that seeks to address these issues.

The pilot will trial improvements in the quality of training, creating a better training-service balance for trainees, professionalising the role of trainers and developing members of the extended surgical team to work alongside surgical trainees to improve patient care. It also provides the ideal opportunity to develop the concept of the "Modern Firm", where multi-disciplinary teams provide junior doctors with the support they require in a positive and

collaborative environment. Ultimately we hope this will serve as a model for training across all other surgical specialties.

Beyond the pilot, the RCS has been working with the Joint Committee on Surgical Training (JCST) to improve the recognition of trainers. This has included advocating time for trainers to train within the context of the GMC's *Promoting excellence – standards for medical training,* ensuring training is appropriately valued by developing the JCST Trainers' survey within the JCST's quality programme and developing the trainers' site on the Intercollegiate Surgical Training Curriculum Programme (ISCP) e-portfolio to record their teaching activities.

Role of the independent sector

The RCS has become increasingly concerned that the independent sector is still not contributing as fully as it should to educating and training the healthcare workforce. With an increasing number of surgical procedures (such as hip and knee replacements) being done in the independent sector to relieve the pressures on the NHS, trainees are being denied access to core procedures. We believe that independent providers should play a larger role in providing and delivering education and training opportunities.

Doctors-in-training need to be exposed to a variety of different experiences and this can only be ensured if they are rotated through different organisations. Moreover the surgical procedures that are typically being undertaken in the independent sector are often ideal training cases as they are routine procedures associated with fewer complications. Therefore we believe that HEE should encourage the independent sector to permit surgical trainees to undertake more training in their hospitals

Innovation and technology

The RCS has launched an independent *Commission on the Future of Surgery* to explore innovations that will likely affect surgical treatment, their implications for patients, the training and role of future surgeons and clinical outcomes. The Commission aims to report by autumn 2018 and we will keep HEE updated with its work.

Initial findings suggest that developments in surgical robotics, imaging, artificial intelligence and virtual reality mean that the medical workforce of the future will have to be savvy not only in medicine, but also in new technologies, and perhaps even in engineering and biology, to be able to innovate. These new technologies may also influence the way training is delivered as apps and virtual reality may mean that more training takes place away from hospital sites. However it appears unlikely that autonomous machines will substitute surgeons anytime soon. The direction of travel may instead point towards greater synergy between robots and surgeons, aided by the use of artificial intelligence and machine learning algorithms.

Q4. What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

Non-consultant career posts

Surgery has traditionally had significant numbers of its workforce working in non-consultant career posts. These surgeons have been major contributors to service provision but have often not been considered in workforce planning, with potentially detrimental effects on career progression and job satisfaction. Although the proposals implicit in the "Blue Triangle" on the

medical workforce in the draft workforce strategy (page 102) are welcome, there needs to be a pragmatic structure to ensure not only that these posts are attractive with recognition of the value of the postholders but also that there is equivalent governance to training, for example in achieving new skills which are appropriately recognised. This could also be used by this group of the workforce to progress and gain equivalence to specialist recognition. The support for such progression needs a defined structure similar to that for formal training but also must be similarly quality assured to ensure the same standards for overall confidence and patient safety.

Non-medical practitioners

We believe the role of non-medical practitioners, such as physician associates, surgical care practitioners and advanced nurse practitioners, should be expanded to improve patient care and establish it as an attractive career in the NHS. The RCS commissioned the report *A question of balance: The extended surgical team*[3] to understand how these non-medical practitioners in extended surgical teams can support patient care. The report found that non-medical staff often improved the coordination and continuity of patient care, providing a link between patients, consultants and trainees. They also helped free up junior doctors' time for training, allowing them to leave wards to attend theatres and teaching. The report shows that growing numbers of non-medical staff can, with appropriate training, provide services to patients.

However legislation is needed to regulate these roles and the RCS urges HEE to support our call on the Government to introduce this. Without regulation, hospitals are limited to the tasks these roles can perform, especially in the delivery of out-of-hours care and prescribing. For example, as physician associates are entirely unregulated they cannot prescribe or order radiological studies – both patients and the surgical team would benefit from physician associates being given this right. Regulation would also assure the public, and help employers to be clear about accountability and indemnity arrangements.

Our report *A Question of Balance*[4] also highlighted that doctors in training spend too much time on tasks that do not require a medical degree; 55% of Foundation Doctors' time and 22% of surgical trainees' time is on administrative tasks or discharge paperwork of limited educational value. There are two distinct workforce opportunities. 'Practitioner' roles provide experienced autonomous practice. There is a strong case in addition for development of support worker roles, such as Doctors' Assistants to help with delegated tasks including administrative duties and basic clinical skills. There have been successful pilots of developing Healthcare Assistants into Doctors' Assistants[5] at Band 3 on the NHS pay scale freeing up doctors' time for education, patient care and decision-making. Consultant surgeons also require secretarial support to ensure maximum efficiency of their time with patients.

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[3] Royal College of Surgeons. *A question of balance: The extended surgical team.* May 2016.
[4] Chart 7 in: RCS (2016) A question of balance The extended surgical team. https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/question-of-balance/
[5] McNally S, Huber J (2018) https://healthmanagement.org/c/healthmanagement/issuearticle/award-winning-new-doctors-assistants-freeing-time-in-acute-nhs-hospitals