RCPCH response to Facing the facts, shaping the future shaping the future: A draft health and care workforce strategy for England to 2027

March 2018

1. Introduction

The Royal College of Paediatrics and Child Health (RCPCH) welcome the opportunity to respond to the consultation on the draft health and care workforce strategy for England to 2027 published by HEE, NHSE and PHE in December 2017.

It would be no exaggeration to say that the NHS is facing particularly testing times, with stretched resources and increased demands. The workforce crisis has been highlighted in the media and by think tanks such as The King's Fund, The Nuffield Trust and the Health Foundation in addition to multiple reports produced by the Royal Colleges, the BMA and GMC which all highlight workforce shortages, retention and recruitment problems. The strategy document is therefore timely in that it highlights many of the concerns of those in workforce planning, both those working directly for the NHS or for those in the Royal Colleges with a duty to their members working in the NHS. The consultation document raises many important issues but is light on new initiatives and finding solutions. It is somewhat disappointing that there is little reflection on the workforce planning which has resulted in the current situation, nor is there discussion of lessons learned from the past. Further, where solutions are discussed, e.g. new service models on page 104, it is not clear how the workforce strategy will align and impact on these proposed solutions.

The added complexity of a fragmented system means that there is a lack of clarity as to how the parts of the system will join up, and who is responsible for developing and maintaining the NHS and its workforce. STPs and ICS models do not have a mandate and rely on effective collaborative leadership and partnership working. Furthermore, these models highlight the much-needed step to have health services integrated with social care. The strategy document does not coherently address a future integrated service for children.

The structure of this response from the RCPCH is as follows:

1. Introduction
2. Key points for the system overall
3. Key workforce planning issues for paediatrics and child health
4. Responses to the 8 consultation questions
5. Identification of areas where greater clarity is needed in the strategy
6. References

2. Key points for the system overall

2.1 Data

It is pleasing that HEE acknowledge better data are needed (page 79). There needs to be a single, robust source that brings together the various data sets that tell us about how many people are in the system, how they move within it, retention, etc., to enable us to plan well for the long term.

The RCPCH and other royal colleges collect large amounts of data about their workforces and we are happy to share and discuss what we have found to inform future planning. There needs to be more data sharing and a definite plan for the system i.e. HEE, NHSE and/or NHSI, should work with the Royal Colleges and other stakeholders to co-produce a strategy.

HEE's commitment to routinely publish profession specific monitoring reports from December 2017 (page 82) to ensure more informed local and national policy is welcome. We look forward to being able to help produce, review and advise on this information.

2.2 Short term numbers

There needs to be more staff now to reduce the pressure and improve staff wellbeing/morale, and recruiting people from other countries is key to that, so the UK needs to be accessible. International recruitment is part of the short-term solution and as part of that, there should be a simplification of the registration process for non-EEA GPs and specialist doctors alongside a review of the rules and processes granting tier two visas. The current visa application process is currently having a particularly detrimental effect on the ability of paediatric services to recruit to middle grade vacancies.

The significant growth in vacancies alongside a commitment to increase training places to make NHS employer of choice (page 21) is a positive step. While there is a commitment to a long-term workforce strategy (page 58), there needs to be more evidence in this document to provide an implementation plan of the future vision for health care and services.

It is an important point that the increase in medical school places will not result in consultants or GPs until 2030-32 (page 6). As this is outside of this plan, it begs the question: what is the plan for these groups until 2027?

2.3 Next steps

Once a first version of a strategy is drafted, stakeholders need to be consulted on it to make sure it is safe, sensible, sustainable and realistic, and the operational plans coproduced.

What was published in December is not seen as a 'draft strategy', rather a collection of data etc that was already known and in the public domain. While the public nature and accessibility of the feedback process was appreciated, it is not clear what will happen after the consultation period closes on 23 March. A more iterative and quality driven improvement approach is requested with further detail on how exactly engagement will work with stakeholders on the next steps. This is crucial to maintain the goodwill and engagement of all stakeholders.

2.4 Patient-centred vision

"Putting staff at the heart of a patient centred service vision" (page 12) is a somewhat confusing aim. RCPCH believe that putting patients at the heart is right, and we are disappointed that there are remarkably few, if any views of patients in this strategy and a lack of evidence of patient involvement in drawing up of the strategy document.

2.5 Primary Care

It is concerning that the headcount number of GPs recorded in September 2017 (page 23) has fallen below 2012 levels and then equally concerning that on page 59 HEE investment in growing GP numbers and the planned growth to produce 5,000 additional GPs is not subject to greater analysis, i.e. to question whether the current strategy, or indeed the current primary care model, is working or not.

2.6 Nursing

The problems regarding nursing numbers are made clear, i.e. that we are at a low point in supply at the time of the highest demand (page 6), that there are high vacancy rates (pages 106, 107, 110) and that there is an increase in nurses leaving the NHS to 8.7% in 2016/17 (page 7). The challenges are set out well, but there are few solutions presented. The vacancy rate of 10.9% (2430 FTE) in paediatric nursing is a serious issue, yet Figure 11 in the document does not show any increase in the number of nursing places in this branch of training.

2.7 Demand

The recognition that aggregated employer demand underestimates future demand (page 9) is key. Workforce growth projections should include consideration of population health and inequality indicators. There are 15.5 million people aged under 20 years in the UK, which has a higher birth rate and a higher proportion of young people in its population than almost all other European countries[1]. This impacts directly on paediatric services – patients aged 0-18 years accounted for 25% of emergency services[2]. The NHS must prioritise the health of children and young people.

Any analysis of demand in the current document is not particularly detailed. Very little information is provided about the "do nothing" modelling scenario and other potential scenarios are not discussed. It is of concern that the scenario shows demand exceeds supply by some 118,000 staff (190,000 – 72,000) but a breakdown of demand by professional group is required to determine future priorities. There is no information about how such an increase in staff is to be funded.

It is important that reviews of demand involve Royal Colleges and other stakeholders who have detailed knowledge of national, regional and local service requirements and details of how services are organised into networks and pathways.

There is recognition that workforce planning requires adequate knowledge of service delivery models and commissioning intentions (page 8), but it also needs to include the number of patients and prevalence of conditions and disease. Commissioning and delivery for services and workforce needs to be an integrated exercise.

Quantification of demand and impact is scant in the document e.g. regarding long term conditions (page 6), growing care needs (page 13), mental health conditions (page 57), endoscopists and radiographers (page 58) and variations in geography (page 99)

2.8 Self-sufficiency

The Contribution of overseas staff is rightly highly valued (page 49) but the caveat that this is only "until new [UK] graduates… are available" is a somewhat disconcerting message for overseas staff and no evidence is put forward that recent increases in education programmes will make England self-sufficient. With the current size of the international workforce, self-sufficiency is an unrealistic aim and undermines the diversity in experience and the benefits of expertise which this part of the workforce brings and is particularly important at tertiary specialist level.

2.9 System responsibilities

The system responsibilities diagram (page 17) does not include the role of Royal Colleges. The Colleges set standards and develop medical curriculums and are therefore a key player in the career pathway for medical professionals.

3. Specific concerns regarding paediatrics and child health

3.1 A strategy for children and young people

Paediatrics is only mentioned twice in the document and children only rarely. Additionally, there is little consideration of young people (up to the age of 25) with ongoing health needs that are not provided by adult services. Good health when young, effective healthy living, health promotion and illness prevention strategies for children are important, saving on the cost of long term health care and producing a healthier and more productive society, with a positive wider economic impact. Far more specific attention needs to be given to the development and integration of the child health workforce. In paediatrics, training needs to be highly integrated particularly with mental health and primary care.

3.2 Engagement of CYP

Article 12 of the UN convention on the Rights of the Child states that a child or young person's opinion should be always taken into account. Further, in "Engaging local people – A guide for local areas developing Sustainability and Transformation Plans"[3], public bodies with responsibility for Sustainability and Transformation Partnerships have a variety of legal duties including to involve the public in the exercise of their statutory functions and workforce planning will be one of their essential work streams.

3.3 Children's social care workforce.

The strategy contains nothing about children's social care workforce. It should.

3.4 Workforce Shortages

While there has been substantial growth in paediatric consultant numbers over recent years and vacancies at consultant level remain relatively low (page 99), our analysis of demand[4] shows that consultant numbers still fall short of the numbers required to meet national standards for service[5,6]. Less than full time working has risen to 22% of the paediatric consultants[7], thus reducing the impact of the numerical rise. Further, the numbers of SAS doctors in paediatrics has continued to decline over recent years. RCPCH's survey of rota gaps[4] showed a 23% vacancy rate on middle grade rotas early in 2017: a considerable risk to patient safety. Locum cover for vacant paediatric service posts is at a lower rate than the averages quoted in this report (page 7). RCPCH strongly believe that, for all medical staff levels, paediatrics should be included in the National Shortage Occupation List and is developing a case for submission to the Migration Advisory Committee of the Home Office.

3.5 SAS Doctors

SAS grade doctors are an important and valued part of the paediatric workforce both in acute and community care. Many SAS doctors are in lead roles such as designated doctor for looked after children. The College is encouraging the development, training and education for these roles and support is also needed on a national basis.

3.6 Physician's Associates

We have an ongoing concern with the development of the Physician Associate role (page 60), particularly regarding working in primary care where the supervising general practitioner has not undertaken paediatric training. Further the curriculum for physician's associates currently only contains one week of specific paediatric training and 90 hours placement. If it is clear there is much more to be done to clarify how PAs can deliver care for children.

3.7 Models of care

Models which are being developed for paediatric and neonatal critical care, particularly operational delivery networks must be a benchmark for the respective workforce models. HEE must work closely with NHSE to deliver these models through the recommendations of the PCC and NCL service reviews.

3.8 The Paediatric Clinical Academic Workforce

We are particularly concerned about the decline in the senior clinical academic workforce over recent years. In 2015 this represented 4.2% of the total paediatric consultant level workforce in paediatrics compared to 9.6% in 2001[8]. There needs to be action from HEE to work with NIHR, Universities and professional bodies to halt this decline.

3.9 Working together with primary care

It is pleasing that HEE believes it should further evaluate the case for an extra training year for GPs (page 61). We strongly believe this should include paediatrics as children make up around 30% of all general practice workloads and an estimated fewer than 40% of GPs are trained in paediatrics. It is important that this is progressed with more detail in the next iteration of the strategy.

3.10 Integration of health and social care

Integrated models for ICYP are different to models for adults and the elderly. These models must also involve collaborative working with other sectors such as education, youth justice and the voluntary sector to deliver patient-focussed, joined-up care.

3.11 Public Health

There is a welcome focus on public health, particularly that specialist public health nurses for children will be required in sufficient numbers (page 113), and it would be good to have more detail on numbers expected.

4. Responses to the 8 consultation questions

Question 1. Do you support the six principles proposed to support better workforce planning? Will the principles lead to better alignment of financial, policy, and service planning and represent best practice in the future?

RCPCH response

Workforce planning by budget has been shown to lead to an undersupply of workforce and has resulted in the crisis the health service now faces. It is crucial that there should be a focus on the needs of the population and use of a life course approach, not just addressing adulthood and the elderly years. There should be an emphasis on creating a workforce which effectively delivers prevention and early intervention strategies. Intervening early in life can lead to long term health and wellbeing benefits in adult life through to old age (vaccination, health visiting, school nurses etc.). A principle around health promotion and healthy living would be welcome.

The State of Child Health reports produced by the RCPCH[9] highlight the importance of early life interventions, in mental health, obesity, and the impact of relatively poor uptake of breastfeeding in the UK. Workforce planning must also align with commissioning intentions. Furthermore, national workforce planning must address the workforce gaps in public health as well as in primary, secondary and tertiary care. The introduction to the principles (page 18) implies finance and service redesign are main drivers for workforce planning and patient needs and expectations confounding factors adding to uncertainty. We should be progressing to a system where patient need should determine the finance needed and service design.

RCPCH disagrees that there is greater clarity on future service models. Two out of 50 Vanguards are taking a strategic approach to addressing the health care needs of infants, children and young people (ICYP). STPs, Integrated Care Systems (ICS) are all in their infancy and future functions are not clear. Very few STPs have strategic approaches to improving child health and wellbeing[10]. This lack of focus on children is stark when considering the population of children in a typical ICS area's population which covers perhaps 4-5 CCG areas. Within this the equivalent of at least one CCG would be children. Effective integrated models of care for ICYP must have collaborative working between health and other sectors such as education, social care, youth justice and the voluntary sector. Further, at the time of writing, funding and resourcing for New Care Models is uncertain and they do not form a part of a coherent national plan.

The six principles in isolation are all important but RCPCH believe some principles need adding and some are less important in terms of underpinning future decisions than others.

We strongly support principles 5 (modern model employers), and 6 (service, financial and workforce planning) intertwined but the step before this is service commissioning based on population need.

We support principles 2 and 3.

Securing the supply (page 18) is extremely important, but maximising self-supply should not be the only policy option. RCPCH agree with the ethical arguments that we should not necessarily be taking qualified staff from countries with greater health needs, but even accounting for recently announced increased nursing and medical graduate places, it would take decades to reach anywhere near self-supply and we would question the desirability of such a policy. Overseas doctors both from the EU and non-EU countries, particularly in sub-specialties and research can add considerable benefit to the NHS. the NHS has historically relied on a 'trade' of staff both coming from and going to other healthcare systems and this has contributed greatly to the richness of the NHS.

Widening participation is important as an objective and should be embedded (if not already) as part of the NHS constitution, but is it a crucial part of workforce strategy i.e. in planning for the correct numbers and competencies of staff?

There should be a principle about the service being demand led and the importance of demand analysis and modelling. Workforce decisions should be subject to horizon scanning.

There needs to be a principle which recognises that improving population health or increasing productivity can only be achieved by a workforce which can thrive and is properly resourced. Constant pressure and growing individual workloads work against this.

Question 2. 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?

RCPCH response:

NHS/HEE must be more explicit as to what the future model of care for children will be, and acknowledge and embed the expected standards to deliver the care, for example, if we are to have a 7-day service delivered by senior career grade clinicians, then this will have a significant impact on the undergraduate and postgraduate training requirements.

NHS/HEE needs to make clear whether the expansion of medical undergraduate numbers translate into more postgraduate training places in future or will it merely cover an expected decline in applications from non-UK graduates for postgraduate training due to Brexit and future immigration policy. There needs to be transparency and clarity about future training numbers. Furthermore, NHS/HEE need to make it clear whether, as well as the expansion of nursing undergraduate numbers, there will be increased funding for post registration education for ANPs to develop advanced skills and competences and for specialist nursing roles, or to support return to practice in a rapidly changing NHS.

There needs to be a consensus, led by HEE on staff numbers and recognition of the impact of staff shortages and heavy workloads on retention and morale. A focus on careers (page 45) is a step forward, as is the commitment to reduce attrition from EM training (page 62) but these need commitment / acknowledgement to look at the reasons for heavy workload and for attrition. While we agree that different generations have different motivations (page 14), all generations will be de-motivated by stress and pressure caused by not enough staff and high workload.

An increase in children's nurses, school nurses and health visitors for the reasons also articulated in the response to question 1.

The system needs to consider the rationale of capping undergraduate training in nursing, medicine and allied healthcare professionals, recognising that we operate in a global health market.

Question 3. How can we ensure the system more effectively trains, educates and invests in the new and current workforce?

RCPCH response:

Health Education England should initiate the children's workstream which was announced when HEE was set up 4 years ago. There is currently no lead for children at HEE, but there needs to be a responsible person for this role at national and local level.

There should be detailed analysis of demand in order that medical training numbers can provide the qualified workforce. In this respect, closer liaison needed with Royal Colleges and other professional bodies to understand dynamics of the whole workforce.

HEE and employers need to ensure their postgraduate trainees can access all the necessary training and education. Developing other professional groups such as advanced nurse practitioners (over and above existing nursing numbers) to reduce rota gaps would aid this. Currently the strategy does not address the role of advanced nurses as a workforce solution or recognise that they already play an important role e.g. in neonatology.

HEE should construct a model so that training for all in leadership, public health and quality improvement science are vital components. It is also essential that all professionals have training in mental health and that all working with children and young people have received appropriate education and training e.g. GPs, Practice Nurses, A and E staff.

CPD for all is essential in such a rapidly changing NHS and should be supported as part of revalidation requirements.

Question 4. 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?

RCPCH response:

Wider entry gates into health professional careers is essential which includes considering how to financially encourage mature students to enter a health service professional training.

There needs to be opportunities for multi professional and modular training, so that staff can divert with relative flexibility into different career paths during their career, relatively easily.

If post-qualification and credentialing are to be developed (which would give the opportunity for a more flexible workforce), funding for this must be found from central sources rather than rely on individual employers. Schemes should be developed in liaison with the relevant professional bodies and Royal Colleges.

Flexible and less than full time working should be seen as a solution to the changing job aspirations of modern graduates.

There should be more workplace experience schemes to foster good relationships between schools and the NHS to encourage children and young people to consider the breadth of opportunities available in the NHS.

There needs to be a greater emphasis on retention of staff and for this to happen we need to improve the quality of NHS staff lives, for instance wrap-around care for children and elderly relatives. Imaginative thinking to consider for example, the availability of a support worker to visit elderly relatives' homes which may allow a more senior health care worker be at their place of work.

There is a need to unify employers across local areas and increase training numbers and consultant numbers.

Question 5. How can we better ensure the health system meets the needs and aspirations of all communities in England?

RCPCH response

The government, the NHS and HEE need to invest in children. A much greater focus on patient need is required particularly where need is greatest - population groups who need most help and remote and rural areas in particular. This would be a shift from the direction of the strategy document which states on page 3 that it uses "a focus on professions to analyse need and set out actions".

Review of commissioning and funding to ensure funds meet the needs of the whole population. This will include a massive injection of funds into social care.

The strategy argues that new medical school places target areas with most need. It is difficult to see how this would work given that most medical schools are in large cities or university towns, without radically changing how undergraduate training is organised.

There could be more placements in undergraduate and postgraduate training in remote and rural, poorer/deprived areas. More mandatory rotations need to be considered to give wider experience.

Given evidence that more deprived communities have greater morbidity, lower life expectancies and greater demands on the health[9], there could be the development of special interests / credentialing in inequality medicine / medicine for deprived communities.

RCPCH set out in 2017 key recommendations for the future role of STPs and ICS[10] including ensuring "that all ACS/ACO and/or STP, develop, implement and evaluate a strategic plan which meets the needs of infants, children and young people within their respective geographical footprints"

Carers are the major workforce in caring for children with disability and long-term conditions and their commitment should not be taken for granted but support offered to provide respite for families.

Learn lessons from paediatrics: Open visiting and encouraging the involvement of families in the care of adult patients in hospital e.g. allowing visiting over meal times to support patients to eat.

Question 6. What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?

RCPCH response

A modern model employer should have the following characteristics:

- Commitment to leadership development for health professionals and all staff.
- Commitment to training, research and CPD
- For medical staff, providing contracts that allow recommended SPAs for supervision, CPD, research, audit etc.
- Supporting the principle of team job planning to enhance the safety and sustainability of services
- Protected training time and adequate systems for restitution if cannot be taken.
- Developing schemes to involve medical trainees in the management of the organisation such as executive shadowing and listening to the trainee voice. This will increase buy-in and resilience and reduce stress.
- Support for less than full time (LTFT) working, flexible working, family friendly environments and portfolio careers. Build it into workforce planning culture. Younger generations of doctors expect their careers to develop in ways that were very different from the traditional model; greater flexibility, more part time working, and stepping on and off the training ladder. This support must not be tokenistic.
- Needs to be sustainable and adaptable for the older generation. We can't afford to have people leave the workforce through burnout, so adaptability and flexibility need to be developed. Further disincentives such as people retiring and not being able to return to the workforce need to be reviewed, as well as maximum pension pot regulations which encourage early retirement.
- Consistency across employers, reduction of variation in terms and conditions according to geography.
- Work with other employers in networks to provide the best care for patients. Potentially have more network provider employer models.
- Foster multi-disciplinary working for the benefit of patients. It is not a solution to supply problem as mentioned on page 90, but for better, more co-ordinated patient care.
- Accountability for the management of staff and supportive visibility of managers.
- Recognition of the impact of stress and workload pressures on workforce with effective strategies to early warn, reduce and help staff in need
- Positive recognition and reward schemes.

Question 7. Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?

RCPCH response:

Clarity that responsibility for excellent care rests with the government through one single employer, the NHS, to ensure that the variation and decline in services that we have seen through fragmentation is halted. The accountability framework must be explicit.

Development of service standards and guidance to deliver quality and efficiency, help productivity and widen staff engagement. (page 84-85)

Use existing national standards and recommendations for staffing levels, rota cover etc. and actively pursue their implementation. Use audits to improve the workforce model.

Adhere to working time regulations, time allowed (protected time) for education and training.

Ensure that "Every Contact Counts"[11] is embedded in training for all staff and given greater priority

Monitor and embed good practice, guidance and regulations regarding shift working, unsocial hours – ensure national consistency in application of rules.

Valuing and engaging staff, a modern flexible education etc. (page 77) should not be an option but a must.

Increased public health focus, with emphasis on healthy living and prevention e.g. through vaccination, increase in health visitors and school nurses. Ensure clinicians are equipped to speak about public health issues, sexual health issues. Healthier children become healthier adults.

Question 8. What policy options could most effectively address the current and future challenges for the adult social care workforce?

RCPCH response:

It is a serious omission and unconscious bias that this document does not address the issue of the social care workforce for children.

Integration of health and social care – unify funding and ensure that this applies to children as well as adults

Mandated skills across employers – development of mandatory competency framework for social care professionals; similar models and guidance to medicine and nursing needs to be developed.

Increasing living standards through better housing, education, wages.

5. Identification of areas where greater clarity is needed in the strategy

5.1 Medical school places

It is not clear for how long the additional 1500 medical school places commencing 2018 and 2019 page 36) will continue for. Have NHSE/HEE modelled how many expect to graduate, how many they expect to go onto postgraduate training in medicine (Foundation) and how many go abroad. There must be a plan to ensure there are postgraduate training places to avoid a "brain drain". The strategy does not make this clear.

5.2 Review of the Foundation Programme

It is not clear what form the HEE review of Foundation programme will take (page 101). Any such review should involve key stakeholders such as the Royal Colleges. The foundation destination survey in 2016[12] showed that 7395 doctors completed foundation and only 4268 of those doctors were definitely working as a doctor in the United Kingdom in 2017 – the F3 problem.

5.3 Retention

There is little detail on the NHS Improvement strategy for improving retention (page 44). The Health Foundation's workforce report published towards the end of 2017[13] included some useful analysis in this respect.

5.4 Five-year forward view

We welcome maternity as a Five Year Forward View (FYFV) priority area. However, the other FYFV priority areas: mental health, primary care, urgent and emergency medicine, cancer must explicitly address the needs of children right through from prevention to acute and long-term care. What happens if the STP/ICS plan demonstrates that public health strategies should be an even greater priority? Will the Local Workforce Advisory Boards (LWAB)address this through its workforce strategy?

5.5 Mental Health

Under mental health, it is stated (page 57) that PHE/HEE will improve mental health training, but there is no indication of how this will be done. RCPCH consider that mental health services for children should be an integral part of children's healthcare and should be seen in combination with physical health. Health professionals should therefore be appropriately trained to identify and manage and treat low to medium acute mental health conditions and this should include trainee paediatricians. This is important as mental health issues within children and young people are on the rise [14] [15] [9].

It is stated that there is staff growth required of 47% in areas like CYP services in the mental health workforce plan (page 55) However, without any details, we are concerned about how this level of staff growth (47%) can be achieved within the timescale of the plan.

5.6 Pre-registration attrition

HEE's toolkit (page 38) to help reduce pre-registration attrition sounds interesting, but will it be tested to see if it works.

5.7 Maternity Care

The statement, “We are committed to working with commissioners, providers, women and their families and staff to ensure that we create and develop the right numbers of staff, with the right skills, with the right culture to provide safe and personal maternity care across England.” is laudable but for such an important service, the document is short on the strategic actions to do this. It is helpful that the maternity transformation action plan includes “identify current supply and future demand requirements.”

5.8 Locums

The problem of doctors leaving substantive NHS roles to return as locums is noted but there seems to be no solution offered here or plan to address the issue. A suggestion may be consideration of stopping all locum pay being pensionable thus encouraging individuals to seek substantive appointments.

5.9 Four nations

The document is concerned purely with NHS England, so what level of buy-in was there from the devolved nations? It is important that there is consistency across all four nations, training and standards are developed by UK bodies and there is free movement of staff across all four nations.

5.10 Non-training doctors

On page 100, it is stated that HEE will provide more support to non-training doctors but it is not clear how this will be achieved. Work with GMC and Royal Colleges – liaison important – we can focus views of those doctors.

5.11 Service while providing training

It is welcome that the document recognises the impact of service gaps and would be good to know the outcome of exploration of meeting service while providing good training (page 101). The RCPCH is more than happy to engage and work with HEE on these issues to find solutions to staff shortages and the increased use of locums. In this respect, it is also welcome that HEE say they “will continue to work with royal colleges, ALBs and others, using local intelligence, to determine the numbers required for medical specialty training to produce the consultants and GPs of the future.” This working relationship needs to be formalised, possibly through a memorandum of understanding, to avoid it falling into abeyance.

There appears to be a misunderstanding perpetuated in this document that service is an adjunct to training i.e. “Whilst doctors in training provide an important service to the National Health Service, the primary reason for the placement is to gain education and training leading towards there certificate of completion of training (CCT)”. This is a misconception for paediatrics and many other subspecialties where doctors in training programmes are a hugely important part of the workforce, the prime reason for their pay is to work in a hospital and treat patients. Nearly all of trainees’ time is spent on service. They are key to the care delivery in the National Health Service and this must be recognised to workforce plan effectively.

If you have any questions or need more information, please contact Martin McColgan, Workforce Information Manager, 020 7092 6162 or martin.mccolgan@rcpch.ac.uk.

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