Royal College of Paediatrics and Child Health Scotland
Leading the way in Children's Health

Scottish Government:
Consultation from Scottish Labour on Social Care Workforce Commission

Response to Consultation from the
Royal College of Paediatrics and Child Health

April 2018

About the RCPCH

The Royal College of Paediatrics and Child Health (RCPCH) is responsible for training and examining paediatricians. The College has over 17,000 members in the UK and internationally and sets standards for professional and postgraduate education. We work to transform child health through knowledge, research and expertise, to improve the health and wellbeing of infants, children and young people across the world.

RCPCH response to the Scottish Labour NHS and Social Care Workforce Commission
from Anas Sarwar MSP, Shadow Cabinet Secretary for Health and Sport

Comments

1. **It became clear from the earliest discussions among Commissioners that consideration on how best to decide the appropriate number of training places for health and social care workers was a crucial issue.**

We would, therefore, welcome your views, among other issues, on training place numbers and, particularly, how you believe the number of training places should be decided.

Specifically:

- Considering your own sector or area of expertise, what do you consider to be the adequate level of education training places for individual health and social care workers?

  Undergraduate medical school places and postgraduate specialty training places need to be at a level that will at least provide and maintain paediatric and neonatal consultant numbers at a level which enables RCPCH, BAPM and other safety standards to be met. In our briefing document[1] *https://www.rcpch.ac.uk/news/scottish-workforce-report-finds-1-4-paediatric-units-closed-new-admissions-due-staffing-concern*

  RCPCH estimate that given the current configuration of services an extra 84-110 WTE consultants are required to meet those standards in Scotland, an increase of 27-35% above the 309.5 WTE consultants recorded in our 2015 Workforce Census.

  We understand that whilst 90% of Scottish medical students continue to work in Scotland as doctors, only two thirds of non-Scottish medical students at Scottish medical schools remain in Scotland. Approximately half of places at medical schools in Scotland are taken by non-Scottish domiciled students so any attempt to increase the number of doctors in Scotland by increasing medical student places in Scottish medical schools needs to consider that many graduates will not actually work in Scotland after graduation.

- What analysis and evidence did you use to come to this conclusion?

  NHS workforce documents, GMC reports on consultant, doctor and medical student numbers[2], national documents of nursing workforce. Behavioural trends amongst students and qualified staff. Changes in the population health complexity. College documents including:

  - *Facing the Future (FtF) acute standards[3], FtF Together for Child Health and FtF Workforce Implications [4,5]*
  - *RCPCH Workforce Census 2015[6] (We are in the middle of data collection for 2017 – results due late summer 2018)*
  - *State of Child Health: The paediatric workforce[7]*
  - *State of Child Health: Short report series: Paediatric workforce data and policy briefing[8]*
  - *State of Child Health: The Community Paediatric Workforce[9]*

  Also:

  - *BAPM standards[10]*
  - *Clinical Guidance – Paediatric Intensive Care[11]*
  - *PIC Network – annual report[12]*
  - *Improving the standard of care of children with kidney disease through paediatric nephrology networks[13]*
  - *Defining staffing levels for children's and young people's services: RCN standards for clinical professionals and service managers[14]*

- How do you expect this trend to change over the coming years, thinking over the next decade and beyond?

  We anticipate needing more staff to provide a safe, high quality and convenient child health service in Scotland. Reasons for this increase include a reorientation of primary care towards management of chronic/non-communicable disease (mostly in adults), increasingly complex management options for children and young people[15] and an increasing birth rate.

- For which professions and roles do you believe the Scottish Government should have direct control on the number of training places?

  Undergraduate and postgraduate training places for doctors, nurses and allied health professionals including dieticians, physiotherapists and speech and language therapists.

- What additional data do you believe the Scottish Government should collect to better inform them of training places needs?

  If you limit training places you will always under produce the numbers of health care workers you need. Otherwise they will need data on:

  - *Trends in A&E attendances, emergency admissions and outpatient attendances for children and neonates.*
  - *Data on growth of co-morbidities and complex conditions*
  - *Ward closures due to lack of staff*
  - *Actual (elapsed) length of training*
  - *Growth in less than full time and flexible working amongst medical staff.*
  - *Attrition from training and reasons why*
  - *Retirements and returners*

- *Immigration from EU and non-EU trends*
- *How are the Integration Joint Boards actually going to work in partnership with NHS and local authorities?*

- What agreements do you believe the Scottish Government should have with further and higher educational institutions in relation to (a) direct commissioning (b) funding?

  We do not know what the current arrangement are so cannot comment on this.

- How can employers and other stakeholders in the health and social care sector work together to better identify and resolve recruitment and retention issues?

  Stop workforce planning by budget. Workforce plan according to demand and co-produce workforce plans with stakeholders such as the Royal Colleges, GMC, BMA and patient groups.

  Robust and evidence based analysis of demand. Build in modern ways of working – Less than full time (LTFT) etc. to the model.

  Share and get consensus on data affecting workforce numbers, attrition from training, retirements etc.

  Use GMC survey trainees or undertake new surveys and take note of findings?

- How would you promote and give value to care staff across the social care setting?

  This is outside RCPCH's expertise.

- Do you have any further proposals which you believe the Commission should give consideration to?

  No.

2. We believe there are a number of barriers in the way of attracting and retaining health and social care staff. These include pay, in light of the pay cap, and a lack of clear career pathways.

We would therefore welcome your views on what you consider are the barriers to a successful recruitment and retention strategy.

- What barriers do you think currently exist for individuals considering applying (a) to study a course relating to health or social care (b) to work in health and social care in Scotland?

  (a) and (b) fees could be waived for the non-Scottish (RUK) student who then works in NHS Scotland for the first 5 years after graduation.

  International students who might wish to study here are then subject to visa restrictions which limit their potential to take up post study work opportunities. We anticipate that this limitation is likely to extend to EU students after Brexit arrangements have been finalised.

  A form of Clinical Excellence Awards could be reintroduced in Scotland to retain and also to attract clinicians. Clinical excellence awards are not available in Scotland and holders of these awards in England will be highly unlikely to take a job in Scotland.

- What impact do you believe that 7 years of pay restraint has had on attracting and retaining the NHS workforce?

  We have no evidence to objectively answer this question. Our best guess is possibly not as much as one would expect. The biggest problem has been the fall in the number of training places and lack of production of nurses and doctors in the UK as a whole. There is a need to increase the pipeline.

- Outside the NHS, what impact do you consider pay restraint has had on staff recruitment and retention in health and social care and those who work in the sectors?

  Paediatrics is not practiced extensively outside of the NHS so an impact on staff outwith the NHS is likely to be minimal.

- What additional incentives, excluding pay, could be introduced to encourage more individuals to apply for a health or social care role. Would that also help to address the challenges around retention? If not what else could be done to increase staff retention?

  Flexible training pathways, rather than full time undergraduate or postgraduate study.

- What impact could Brexit and International recruitment restrictions have on the health and social care workforce?

  Key issues facing health and social care provision in Scotland include staffing recruitment/retention and austerity. Brexit has the potential to make both of these issues more acute. The implications of Brexit for children in Scotland are the same as those facing children across the UK. We have set out our concerns about the potential impact of Brexit and how to mitigate it below.

  How could the potential risks of Brexit for health and social care in Scotland be mitigated?

  1. Staffing

  (i) Clarifying as a priority the post-Brexit status of EU citizens living in the UK. This would benefit both current and future EU citizens who live in the UK. At present, EU citizens are not applying for jobs in the UK due to this uncertainty. At present, EU clinicians living in the UK are very uneasy about their future and that of their families.

  (ii) Increasing the number of specialties and roles which are on the Home Office Shortage Occupation List. Paediatrics in Scotland is already on the list but this may help other medical specialties whose members work predominantly in child health, e.g. paediatric anaesthetists are categorised as anaesthetists.

  (iii) Expansion of the Medical Training Initiative to provide a sustainable number of newly qualified doctors, physician assistants and advanced nurse practitioners. While the increases in medical undergraduate places is welcome as is reassurance in the autumn by the government of the status of EU nationals in the UK, more is needed to remove uncertainty for this group which is reflected in declining numbers of applicants for training (doctors and nurses) from EU.

  (iv) Novel approaches to attract staff from EU and non-EU overseas nations could be designed and delivered.

2. European Working Time Directive (EWTD)

This has transformed working practice for doctors since it was introduced in 2004. The working time regulations (1998) are a UK statutory instrument implementing the EWTD and RCPCH would oppose the repeal of the S.I.

- What do you consider are the barriers to creating and/or retaining posts to meet needs in health and social care?

  These have been previously discussed and are therefore summarised here; ensuring enough staff are trained, financial commitment and service planning (including anticipating changes to the population and workforce).

- What support needs to be available to promote health and well-being of staff?

  Caring management, visionary leadership with effective political support. In our response[17] to Health Education England's workforce strategy, we set out what it means to be a modern employer:

  - *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.*

- What do we need to do to support the retention of expertise across health and social care roles, including improved career pathways?

  Development of careers that mean staff are not in very high pressurised situations for prolonged periods of time, with the ability to move to roles that are more about strategy and wisdom with seniority, where appropriate.

  In addition, concerns have been raised by the Third Sector that they face similar issues when it comes to the recruitment and retention of staff. This problem can be magnified due to the nature of Scottish and Local Government funding cycles, particularly yearly funding awards.

- What evidence do you have to support the concern that current funding models are making it difficult to recruit and retain staff?

  This is outside RCPCH expertise

- How would changing the funding cycle make a difference to your organisation and the services it can deliver

  This is outside RCPCH expertise

3. **Supporting students entering a career in the Health or Social Care is, we believe, important to the recruitment of students. We would welcome your views on funding models, for example, what can be done to better support students to ensure that they are able to finish their studies.**

   - Do you believe the current levels of student support are adequate to encourage individuals to apply for health care related places?

     This is outside RCPCH expertise

   - Are there any gaps in current student financial support? If so – what are they?

     The removal of bursaries for nursing students in England is likely to have an impact of the numbers of individuals available to apply for health care related places across the entire UK.

   - If you support further incentives, what form do you believe they should take?

     We are not aware of any further incentives for students but would support any strategy which encourages Scottish students to take up places at Scottish medical schools.

4. **Recent figures reveal an increase in the public sector's reliance on agency staff. There is clear evidence of significant financial payments being made to private agency staff, well in excess of what an equivalent NHS worker would receive. We do not believe this is best use of limited resources.**

We are seeking your view on this issue and what reform, if any, is needed to reduce costs going to private agencies.

Specifically:

- Are there gaps in the bank system and if so what are they?

  Our rota gaps and vacancies survey of 2017[19] showed many gaps on training rotas and that half of these gaps could not be filled by locums. This is less than other specialties. These gaps have

already led to ward closures in Livingstone and Elgin and constantly threaten smaller units in Scotland.

- Do you think any reforms could be made to the bank system that could further reduce the need to use private agencies?

  This is outside RCPCH expertise

- Are there areas of the health and social care workforce where bank arrangements for supplementary staff could be usefully instituted?

  This is outside RCPCH expertise

- Do you believe that the amount that agencies are allowed to charge should be capped? If no, please give reasons for your response. If yes, how would you envisage this working?

  If you cap the employment agencies, you should do the same to the suppliers of hospital equipment etc. It would be inconsistent to do otherwise and create an "internal market" with boards competing for individuals by increasing agency wages. Capping agencies in England has not worked.

- How could the Scottish Government better use its procurement processes to secure value for money when using agency and to assist in changing the culture by promoting best practice?

  This is outside RCPCH expertise

5. **Demographic changes are going to have an impact on future workforce requirements. We are seeking your views on this issue and whether the current workforce planning arrangements take this sufficiently into account and what more could be done to plan for this.**

   - Do you believe the current workforce planning frameworks are fit for purpose?

     No

   - How would you change them?

     This has previously been raised. Changes to the population size and characteristics need to be predicted and the number of healthcare workers modelled on this. We accept that there has to be some estimation in this. There has been a 40% rise in acute medical paediatric admissions between 2000 and 2013 but the workforce has not risen by this much and this leads to an obvious increase in per capita workload.

   - What demographic data on both workforce and population need should be collected to better inform decision making on future workforce requirements to ensure that Scotland assesses and plans the workforce against the needs of Scotland's communities?

     Please see our response in section one.

6. **We are keen to understand what you consider could be additional frameworks, regulations or legislation that would best support the health and social care workforce.**

Specifically:

- Do you believe that more health care worker roles should be included on the Shortage Occupancy List for immigration purposes?

Yes, and additionally Tier 2 visa rules need to be amended so that quotas and pay limits are not arbitrary restrictions on health boards being able to appoint to hard to fill vacancies.

- Given that the Scottish Government, Health Boards and Local Authorities have a role in workforce planning, how can this be better aligned?

  As previously, the key aspects are training, support and planning

- What should the Safe Staffing legislation contain to ensure it has an impact on safe effective care?

  This should focus on systems and must not criminalise those working in a massively overstretched service.

- Is there any other regulatory or legislative action which Government could take, which you consider would have a positive impact on the recruitment and retention of the Health and Social care workforce?

  Government should consider recent regulatory decisions which may have had a negative impact on recruitment and retention e.g. immigration visas.

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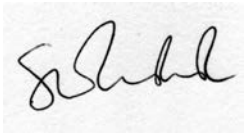
For further information about any aspect of this consultation response, please contact Professor Steve Turner, Officer for Scotland at: s.w.turner@abdn.ac.uk



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