Royal College of Paediatrics and Child Health response to the Migration Advisory Committee call for evidence: Minimum salary thresholds for Tier 2

July 2015

The RCPCH believes that the proposed changes to the minimum salary thresholds for tier 2 will have a negative effect on the ability to recruit to medical, nursing and allied health professional posts, and subsequently may impact the effectiveness and safety of the NHS. The RCPCH therefore opposes the proposed changes. This documents sets out the evidence and rationale for this position.

Evidence

In February 2015, based on evidence submitted by RCPCH, MAC included non-consultant non-trainee grade paediatricians (SAS doctors and other non-consultant non-training grade) in its recommendations for the shortage occupation list for the UK. It also included paediatricians of all grades on the recommendations for the shortage occupation list for Scotland[i].

The evidence submitted by the RCPCH is included in Appendix 1.

The difficulties in recruiting paediatric staff continue to be of great concern to the College membership. In a recent survey (January-April 2015) of clinical directors conducted by the RCPCH to look at rota compliance with working time regulations and rota vacancies, 78% of respondents were either very or moderately concerned that their service would not be able to cope with demands placed upon it within the next 6 months (unpublished data). Preliminary results from the survey also indicate that vacancy rates on tier 2 (middle grade) general paediatric and neonatal rotas have increased over the past 2 years.

In the RCPCH biennial workforce census 2013, clinical directors of child health services were asked to state the workforce pressures that they felt posed significant risk to the service or to children, young people and their families. 50% cited difficult recruiting paediatric staff[ii].

The pay scales for doctors in training and SAS doctors in England, Wales, Northern Ireland and Scotland for 2014-2015 are available here: http://bma.org.uk/practical-support-at-work/pay-fees-allowances/pay-scales.

The proposed changes would affect the following groups:

- Trainee paediatricians in all UK countries on scales 1 to 5.
- Specialty doctors on the 2008 contract in all UK countries on minimum and scale 1.
- Associate specialist doctors on the pre-2008 contract in all UK countries on the minimum.
- Specialty doctors on the pre-2008 contract in all UK countries on minimum to scale 2.

Response to call for evidence questions

1. *How do the existing salary thresholds for Tier 2 compare to, and impact on, the overall wage distribution for each occupation?*

   Addressed above.

2. *What types of jobs and occupations are done by highly-specialised and/or highly-skilled experts, and is pay a good proxy for this high level of specialisation or skill?*

   All paediatricians, whether in training or trained, are highly specialised and highly skilled experts, however some of the salary scales fall below the proposed threshold. In this case, pay is not a good proxy for high levels of specialisation and skill.

3. *What would be the impact of increasing the thresholds to a level that better aligns with the salaries of highly-specialised and/or highly-skilled experts?*

   Increasing the threshold would exacerbate what are already major issues and major concerns to the paediatric community – difficultly recruiting to, and vacancies on, tier 1 and tier 2 medical rotas. These rotas are traditionally staffed by paediatric trainees and SAS grade doctors – the group who would be affected by the proposed change.

   These recruitment issues have a greater impact on remote and rural areas, where there is often a very small population to recruit from locally, and it is very difficult to attract workers to move into the area from other UK regions. We have received reports from our membership that the challenges recruiting to middle grade rotas have reached crisis point in some parts of the UK.

   The proposed changes are likely to have a more significant impact on nursing and other allied health professionals. The paediatric community is keen to explore alternative staffing models for child health services in order to address recruitment difficulties, for example, increased recruitment of advanced nurse practitioners; however the supply is not available to make this a viable option at present.

   This is likely to impact the effectiveness and safety as the system as a whole.

4. *What would be the impact of increasing the thresholds to a level that restricts the route to occupations which are experiencing skills shortages skilled to NQF level 6 or higher?*

   No comment.

5. *What would be the impact of increasing the Tier 2 minimum thresholds from the 10th to the 25th percentile for each occupation for new entrant workers?*

   Not relevant due to fixed NHS pay scales.

6. *What would be the impact of increasing the Tier 2 minimum thresholds from the 25th to the 50th or 75th percentiles for each occupation for experienced workers?*

   Not relevant due to fixed NHS pay scales.

7. *As an employer, what would be the impact of increasing the Tier 2 minimum thresholds on: a) hiring migrant workers from outside the EU; b) hiring migrant workers from within the EU; c) hiring natives.*

   a) The proposed changes have the potential to increase the difficultly of filling posts with migrant workers from outside the EU. They will potentially make it less attractive for these workers to take a post within the NHS.

   b) Paediatrics does not heavily rely on migrant workers from within the EU to fill posts (see Table 3, Appendix 1). It is unlikely that the proposed changes would have an impact.

c) It is unlikely that the proposed changes will impact hiring natives.

8. *Are there additional national pay scales or sources of salary data that should be used to set the thresholds?*

   See: http://bma.org.uk/practical-support-at-work/pay-fees-allowances/pay-scales.

9. *What other appropriate measures would you like to see for determining the minimum salary thresholds?*

   No comment.

10. *Should the minimum salary threshold take account of variations in regional pay? If so, how?*

    Variations in regional pay do not affect NHS staff as pay scales are consistent across regions, though there is very slight variation across the 4 nations.

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Appendix 1

National Shortage Occupation List submission to Migration Advisory Committee - RCPCH Evidence on paediatrics

November 2014

Paediatric SAS doctor numbers

Table 1 shows that there has been a continued trend in the reduction of SAS doctor WTE.

Table 1: Trend in paediatric SAS doctor numbers and WTE

Year	Total count	Total WTE	% WTE change since last census
2001	1501	1216	
2003	1435	1163.5	-4.5%
2005	1337	1096.9	-6.1%
2007	1227	986.1	-11.2%
2009	1285	1073.9	8.2%
2011	1067	868.6	-23.6%
2013	923	766.8	-13.3%

SAS doctors work in both acute and community paediatrics, and are part of a wider workforce which includes consultant paediatricians, paediatric trainees, paediatric nurse practitioners and other professionals. In acute paediatrics, they work on both Tier 2 and Tier 3 rotas, and are vital for service provision, particularly where there are not enough trainees to provide tier 2 rotas. Our 2013 census data indicates that the vacancy rate on tier 2 rotas is 11.7% in the UK, see table 2, and this is the most commonly cited workforce pressure by respondents to our census.

Table 2: Rota vacancies by tier

	Tier 3		Tier 2		Tier 1	
	WTE*	% of total WTE	WTE*	% of total WTE	WTE*	% of total WTE
General	22.8	3.3%	67.7	10.5%	40.8	4.5%
General/neonatal	52.5	5.4%	154.0	14.0%	54.9	5.4%
Neonatal	45.1	10.0%	45.6	8.5%	44.4	6.2%
Overall	**120.4**	**5.7%**	**267.3**	**11.7%**	**140.1**	**5.3%**

In community paediatrics, SAS grade doctors make up 45% of the workforce, and many carry out statutory lead roles, such as named doctor for safeguarding, named doctor for looked after children etc.

A higher proportion of SAS and other career grade doctors took their PMQ outside the EEA, indicating a reliance on overseas doctors to fill these posts (see table 3).

Table 3: Place of primary medical qualification by group grade

		United Kingdom	European Economic Area	Other	Total
Consultant	No.	2384	209	1127	3720
	%	64.1%	5.6%	30.3%	
SAS	No.	454	51	418	923
	%	49.2%	5.5%	45.3%	
Other	No.	17	9	70	96
	%	17.7%	9.4%	72.9%	

Table 4 shows overall reported vacancies, indicating 6.2% vacancies for SAS posts and 26.7% for other grades, compared to 2.5% for paediatric consultants.

Table 4: Vacancy rates by job type and grade

	Specialists	Generalists	Community	50/50	Total
Consultant vacancies	25	29	42	0	96
Filled posts	1487	1443	697	91	3718
Vacancy rate	1.7%	2.0%	5.7%	0.0%	2.5%
SAS vacancies	5	31	24	1	61
Filled posts	58	270	575	20	923
Vacancy rate	7.9%	10.3%	4.0%	4.8%	6.2%
Other grade vacancies	0	31	4	0	35
Filled posts	1	84	8	3	96
Vacancy rate	0.0%	27.0%	33.3%	0.0%	26.7%

Paediatric rotas and *Facing the Future*

The College's Facing the Future Standard 8, revised and agreed by Council on 5 November 2014 states that:-

"All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the Working Time Regulations"

Data from our census, table 5, shows that rotas are still considerably short of meeting that standard with an average of 7.6 WTE on general and neonatal middle grade rotas.

Table 5: Average WTE of doctors on rotas by tier and service

	Tier 3 (consultant)	Tier 2 (middle grade)	Tier 1 (junior)
General	8.4	7.8	8.2
General/neonatal	7.1	7.6	7.6
Neonatal	6.2	7.6	7.2
Overall	7.2	7.6	7.6

Reconfiguration

Facing the Future originally envisaged a reduction in paediatric in patient units to 170 in the UK. Our census of 2013 reveals that the trend has been slower; there are now 191 in-patient units. Further, the number of units which provides some form of acute paediatric care (including stand-alone assessment or neonatal units only reduced from 239 to 233 in the UK between 2011 and 2013.

Further the number of paediatric/neonatal training rotas in the UK reduced only by an estimated 27 between 2011 and 2013, representing 4.9%.

SAS doctors age profile

Figure 1 shows the age profile of paediatric SAS doctors compared to consultants indicating modal ages in the 50s compared to the 40s for consultants.

Figure 1: Age Profile of Paediatric consultants and SAS doctors

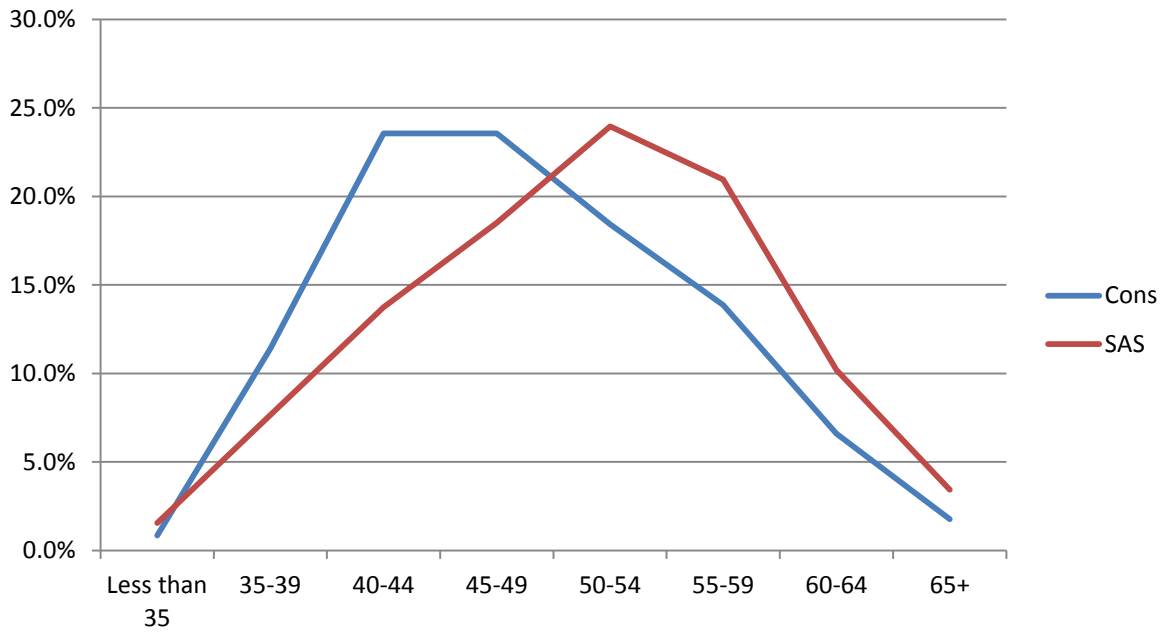

Table 6 reinforces the data in figure 1 by showing the average age of each grade of SAS doctors and the relevant denominators.

Table 6: Average age of SAS Doctors 2013

	Female	Male	Overall	Total drs.	Total providing age
Associate specialist	53.5	55.3	54.4	465	461
Speciality doctor	46.6	46.7	46.6	290	275
Staff grade	49.0	51.2	50.1	166	164
CMO	51.3	NA	51.3	3	3
Overall	**50.6**	**51.6**	**51.1**	**924**	**903**

Possible options for reducing the identified shortage

There is the option to substitute these roles for other child health professionals with equivalent competencies which the College would support, for example nurse practitioners or physician's associates, and it is indeed part of the principles of Facing the Future.

However, there is not currently a surplus supply or regulation in place to allow this to be a short term option. The number of nurses working on paediatric/neonatal tier 2 rotas has in the UK increased from only 48.8 wte in 2011 to 51.6 wte in 2013 while SAS doctors have fallen from 264.9 to 209 over the same time.

Further, only 5% of organisations in our census reported that there were physician associates working in the hospital setting.

Increasing training numbers would alleviate the tier 2 shortages; however there is a risk of producing a surplus of CCT holders, particularly if the consultant growth rate remains steady or declines.

It is also important to consider the feminisation of the paediatric workforce, which has increased length of training time, parental leave gaps and rates of less than full time working. The ratio of new paediatric trainees is approximately 75% female to 25% male, compared to 50% female to 50% male in the consultant workforce, so this effect is likely to continue to change the demographic of the consultant workforce for some time to come.

The is also evidence that trainee doctors in middle grade paediatrics are going on maternity leave earlier and there are higher numbers of doctors working less than full time. Since 2009 in Yorkshire and Humber region, the number of doctors working less than full time at level 1 training has gone from 3% to 16%. While at middle grade (ST4 and over) it has gone from 16% to 30%. This exacerbates the gaps at middle grade and the amount spent on locums. The College feel it would be a useful exercise to compare the cost to the NHS of employing locums against the cost of employing overseas doctors.

Summary

While the College continues to support the widening of child health competencies among other professional groups in the long term, there is no evidence that this is occurring quickly enough to provide the numbers needed to make up the continuing gaps in middle grade provision and that because of the high vacancy rates, the shortfall of provision from standards and the relatively slow pace of reconfiguration, there is a need to allow greater flexibility in the labour market for organisations to recruit experienced doctors to maintain a balance in the workforce and reduce the dependence on trainees to provide service.

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RCPCH

2nd December 2014

[i] Migration Advisory Committee. *Partial review of the shortage occupation lists for the UK and for Scotland.* February 2015. Accessed 22 June 2015. Available at: https://www.gov.uk/government/publications/partial-review-of-the-shortage-occupation-lists

[ii] Royal College of Paediatrics and Child Health. *RCPCH Medical Workforce Census 2013.* December 2014. Accessed 22 June 2015. Available at: www.rcpch.ac.uk/census