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

September 2015

Summary of RCPCH position

The RCPCH responded to part 1 of the MAC call for evidence on minimum salary thresholds for tier 2. Our response can be found here: http://www.rcpch.ac.uk/sites/default/files/consultation/RCPCH%20-%20MAC%20min%20salary%20thresholds%20for%20T2%20July%202015.pdf. This document updates and builds on our response to part 1.

The RCPCH believes that the current workforce shortages and difficulties recruiting to paediatric posts – in particular to tier 2 medical rota posts – warrant the inclusion of paediatric training posts and non-consultant non-training grade posts to the national shortage occupation list (NSOL).

The RCPCH Rota Compliance and Vacancies Survey[i] indicates that 19.5% of tier 2 paediatric rotas are vacant or have gaps due to out of programme activities. Only 51% of those vacancies or gaps are filled by a locum. Tier 1 paediatric rotas are also experiencing vacancies/gaps (6.9%) and fewer vacancies/gaps are filled by a locum (39.7%) at this level.

The survey showed that 14.4% of tier 2 paediatric rotas are not compliant with Working Time Regulations (WTR) in practice. 4.1% of tier 1 paediatric rotas are not compliant with WTR in practice.

Paediatric service leads were asked how concerned they were that their service would not be cope with the demands placed on it within the next 6 months. 78% were either very or moderately concerned that their service would not be able to cope.

The RCPCH has recently completed its annual paediatric recruitment round for 2015. Table 1 shows the fill rates and posts for the 2014 and 2105 rounds for paediatric ST4 trainees. Only 67.9% of vacancies were filled, compared to 77% in 2014.

Table 1: Fill rates and posts for ST4 2014 and 2015

Deanery/LETB	2015 vacancies	2015 posts filled	% filled	2014 vacancies	2014 filled (% fill)	+/- 2015 vs 2014 posts filled
HE East Midlands	3	2	66.7%	5	5 (100%)	-3
HE East of England	1	1	100.0%	3	3 (100%)	-2
London Shared Services	6	6	100.0%	3	3 (100%)	+3
HE North East	8	5	62.5%	7	7 (100%)	-1
HE North West (North Western)	10	10	100.0%	7	7 (100%)	+3
Northern Ireland	1	1	100.0%	2	2 (100%)	-1
Scotland	3	3	100.0%	11	10 (91%)	-7
HE South West (Severn)	4	3	75.0%	4	1 (25%)	+3
HE Thames Valley	8	8	100.0%	6	6 (100%)	+2
Wales	2	0	0.0%	1	1 (100%)	+1
HE Wessex	1	1	100.0%	2	2 (100%)	-1
HE West Midlands	1	1	100.0%	10	10 (100%)	-9
HE Yorkshire & Humber	30	10	33.3%	36	15 (42%)	+5
HE Kent, Surrey, Sussex	6	6	100.0%	0	0 (N/A)	+6
Total	**84**	**57**	**67.9%**	**97**	**75 (77%)**	**-18**

Table 2 shows the fill rates and posts for paediatric St3 trainees in 2014 and 2015. 50% of posts were filled in 2015 – compared to 100% in 2014.

Table 2: Fill rates and posts for ST3 2014 and 2015

Deanery/LETB	2015 vacancies	2015 posts filled	% filled	2014 vacancies	2014 filled (% fill)	+/- 2015 vs 2014 posts filled
HE East Midlands	2	0	0.00%	4	4 (100%)	-4
HE East of England	1	1	100.0%	1	1 (100%)	-
HE West Midlands	1	1	100.0%	1	1 (100%)	-
HE Wessex	0	0	N/A	1	1 (100%)	-
HE Yorkshire & Humber	12	5	41.7%	7	7 (100%)	-2
London Shared Services	1	1	100.0%	1	1 (100%)	-
Scotland	1	1	100.0%	1	1 (100%)	-
Total	**18**	**9**	**50.0%**	**16**	**16 (100%)**	**-7**

Table 3 shows that 17 posts at ST4 were originally offered to resident labour market test applicants, however due to late submission of certificates of sponsorship in 6 LETBs, posts were withdrawn from 16 applicants. This reduced the ST4 fill rate for 2015 to 48.8%.

Table 3: ST4 2015 - resident labour market test (RLMT) applicants and offer withdrawals

Deanery/LETB	2015 vacancies	2015 posts filled	% filled	RLMT	Offers withdrawn	2015 % filled after withdrawals
HE East Midlands	3	2	66.7%	1	1	50.0%
HE East of England	1	1	100.0%	0	N/A	N/A
London Shared Services	6	6	100.0%	0	N/A	N/A
HE North East	8	5	62.5%	4	4	12.5%
HE North West (North Western)	10	10	100.0%	3	3	70.0%
Northern Ireland	1	1	100.0%	0	N/A	N/A
Scotland	3	3	100.0%	0	N/A	N/A
HE South West (Severn)	4	3	75.0%	1	1	25.0%
HE Thames Valley	8	8	100.0%	1	0	N/A
Wales	2	0	0.0%	0	N/A	N/A
HE Wessex	1	1	100.0%	0	N/A	N/A
HE West Midlands	1	1	100.0%	0	N/A	N/A
HE Yorkshire & Humber	30	10	33.3%	6	6	13.3%
HE Kent, Surrey, Sussex	6	6	100.0%	1	1	83.3%
Total	**84**	**57**	**67.9%**	**17**	**16**	**48.8%**

Table 4 shows that both posts offered to resident labour market test applicants at ST3 were withdrawn, reducing the fill rate for 2015 to 38.9%.

Table 4: ST3 2015 - resident labour market test (RLMT) applicants and offer withdrawals

Deanery/LETB	2015 vacancies	2015 posts filled	% filled	RLMT	Offers withdrawn	2015 % filled after withdrawals
HE East Midlands	2	0	0.0%	0	N/A	N/A
HE East of England	1	1	100.0%	0	N/A	N/A
HE West Midlands	1	1	100.0%	0	N/A	N/A
HE Wessex	0	0	N/A	0	N/A	N/A
HE Yorkshire & Humber	12	5	41.7%	2	2	25.0%
London Shared Services	1	1	100.0%	0	N/A	N/A
Scotland	1	1	100.0%	0	N/A	N/A
Total	**18**	**9**	**50.0%**	**2**	**2**	**38.9%**

In order to allow those applicants whose offers were withdrawn to reapply, an extraordinary local round of interviews had to be run in July 2015[1].

In summary, the RCPCH believes that paediatric posts of ST3 and above and non-consultant non-training grades should be included on the shortage occupation list, and be exempt from the resident labour market test.

[1] The additional round of local interviews resulted in 24 posts being offered and accepted by applicants. Out of this number, 13 of the 16 applicants whose posts were withdrawn from the original recruitment round were able to take up posts in the affected deaneries.

Regular advice should be sought from the RCPCH and employers to monitor recruitment issues in other grades of the paediatric workforce (i.e ST1-ST2 and paediatric consultants).

Call for evidence questions

1. ***What impact, if any, will reducing the level of Tier 2 migration have on the economy? What are the reasons for your answer?***

The population is expected to continue to grow and the percentage of children and young people is higher than many other European countries. Service provision to these families is already stretched; one of the reasons is unfilled middle grade rotas across the country. When children are ill, parents are likely to be off work for longer. The burden of diseases in childhood also has a long term exponential effect on adult health, which leads to poor productivity.

2. ***How well does the Resident Labour Market Test provide evidence that no domestic labour is available? How could the test be improved?***

Many doctors chose location over vocation when it comes to taking a post, so certain areas in the UK find it much harder to recruit to than others.

In paediatrics, 34% of the non-training grade workforce (consultants and other non-consultant, non-training grade doctors) graduated with their primary medical qualification outside the EEA[ii]. In a sector so reliant on non-EEA workers, we feel that there is clear evidence that there is not a supply of resident labour and therefore we recommend that paediatrics should be exempt from the resident labour market test.

3. ***Does the points mechanism operating in respect of the limit on Tier 2 certificates of sponsorship prioritise those migrants of greatest benefit to the UK? How could its efficiency at doing this be improved?***

It does not for paediatric doctors, who should be exempt from the resident labour market test.

4. ***What criteria should be used to select jobs and occupations that are genuine skills shortages and people that are highly specialist experts? What use should be made of selection criteria such as salaries, points for particular attributes, economic need, number and length of vacancies and skills level? What other criteria should be considered?***

The opinion and expertise of the RCPCH and the hospitals should be used to determine the requirements for the paediatric workforce. Recruitment round figures can be used to indicate the ability to fill vacant posts and reliance on resident labour market test applicants, as can vacancy rates in the paediatric workforce as a whole (i.e. not just training grades).

The current proportion of non-EU staff in the paediatric workforce indicates the traditional reliance on those doctors to provide the service, and given no large changes in the number of medical undergraduate places or paediatric training posts, we do not expect this to change.

5. ***What will be the impact of restricting Tier 2 (General) to genuine skills shortages and highly specialist experts?***

If paediatric services are unable to recruit non-EEA doctors to fill vacancies, the safety and sustainability of those services will continue to be at risk. As highlighted in our recent survey[i], the result could be that hospitals have to close their door to admissions, and children and young people and their families will have to travel further for emergency care. Remote and rural areas are likely to be disproportionately affected, as it can be more difficult to recruit to these areas and travelling distances to the next hospital are already long. The strain on the workforce and breakdown of services could cause real harm, and we could see more of the type of high profile patient safety cases we have seen in recent years.

This further supports the case for paediatric posts to be added to the shortage occupation list and exempt from the resident labour market test.

6. How could a restricted Tier 2 (General) route maintain flexibility to include: a) high value roles; b) key public service workers?

We believe that paediatric posts of ST3 and above and non-consultant non-training grades should be included on the shortage occupation list and exempt from the resident labour market test.

Regular advice should be sought from the RCPCH and employers to monitor recruitment issues in other grades of the paediatric workforce (i.e ST1-ST2 and paediatric consultants).

7. What evidence is there of significant regional differences in skills shortages?

Table 5 indicates compliance on paper and in practice by the working time regulations by country[i].

Table 5: Compliance with WTR on paper and in practice by country

	No. of rotas	Compliance on paper	No. of rotas	Compliance in practice
Tier 1				
England	168	100.0%	164	95.7%
Northern Ireland	6	100.0%	6	100.0%
Scotland	12	100.0%	12	100.0%
Wales	11	100.0%	11	90.9%
United Kingdom	**197**	**100.0%**	**193**	**95.9%**
Tier 2				
England	153	96.7%	148	86.5%
Northern Ireland	4	75.0%	4	25.0%
Scotland	11	100.0%	11	100.0%
Wales	11	90.9%	11	81.8%
United Kingdom	**179**	**96.1%**	**174**	**85.6%**

Table 6 indicates the total number of vacancies and gaps, the proportion of rota posts that are vacant, and the locum fill rate[i].

Table 6: Vacancies, gaps and locum cover by country

	Total vacancies and gaps	Vacancies and gaps %	Number of locums	Filled by locum %
Tier 1				
England	58.75	6.8%	25.2	42.9%
Northern Ireland	3	13.6%	2	66.7%
Scotland	6	7.6%	1	16.7%
Wales	3.2	5.0%	0	0.0%
United Kingdom	71.0	6.9%	28.2	39.7%
Tier 2				
England	117.25	18.9%	65.2	55.6%
Northern Ireland	7.75	35.6%	3.5	45.2%
Scotland	4	10.8%	1.5	37.5%
Wales	12.5	27.5%	2	16.0%
United Kingdom	141.5	19.5%	72.2	51.0%

See Table 1, Table 2, Table 3, and Table 4 for a breakdown of recruitment to ST3 and ST4 by UK region.

8. What evidence is there of the need to recruit highly specialist experts?

See above and summary section.

9. What would be the impact on business and the economy of restricting recruitment to genuine skills shortages and highly specialised experts for:
I. migrants switching from the Tier 4 student route;
II. all other in-country applications?

No response.

10. How could the methodology to set the Shortage Occupation List be expanded to develop a revised Tier 2 (General) which restricts the route to genuine skills shortages and highly specialised experts only?

No response.

11. What occupations would you expect to see on an expanded shortage occupation list? How does the occupation or job title you are suggesting satisfy each of our criteria in relation to "skilled", "shortage" and "sensible"? Alternatively, what other criteria does the occupation or job title satisfy that meets the requirement of being in a genuine skills shortage or for highly specialised experts?

As above, we believe that paediatric posts of ST3 and above and non-consultant non-training grades should be included on the shortage occupation list and exempt from the resident labour market test and have demonstrated that this need satisfies the criteria "skilled", "shortage" and "sensible".

12. What would be the impact of an expanded Shortage Occupation List on business and the economy?

No response.

13. How far in advance can your organisation, sector or local area anticipate a potential shortage in skilled labour?

In paediatrics, we see the shortage continuing for the foreseeable future. It takes a minimum of 8 years to train a doctor to the point of entering specialist training. It then takes a further 8 years to train a paediatric consultant. Changes to medical student places now would not affect the supply of doctors available for paediatric specialist training for at least 8 years.

14. Alternatively, is it sensible to leave the present Tier 2 (General) route intact and achieve any reduction in economic migration by raising the pay thresholds only?

No.

15. The MAC has been asked how to limit the length of time occupations can be classed as having shortages:
a. How long should any maximum duration be?
b. What, if any, exceptions should there be to this and why? Please provide evidence to support your answer.

As demonstrated above, there is a long time lag before changes in input to training native doctors will have any effect on the supply of paediatricians at ST3 and above. The time lag and changes to the number of undergraduate medical places and paediatric training posts should be taken into account when considering the duration of inclusion on the shortage occupation list.

In terms of length of stay for individuals, the revalidation period (every 5 years) and time taken for training should also be considered for doctors. For those who have a national training number (NTN), length of stay should reflect the time taken to achieve certificate of completion of training (CCT).

We believe that a visa of 2 years is not attractive for a doctor coming to work in the UK, particularly for a doctor in training to have a meaningful training experience.

16. ***The Tier 2 (Intra-Company Transfer) category is the most used route under Tier 2. The Government has asked that the MAC consider the scope for action to tighten the intra-company transfer provisions:***

The tier 2 (Intra-Company Transfer) category does not apply to the paediatric medical workforce.

17. ***The Government has asked that the MAC consider to which businesses a skills levy should apply and the impact this may have, balancing the need to maximise the incentive for employers to recruit and train UK workers with the ability of businesses to access the skilled migrants they need. The proceeds of the levy would fund apprenticeships in the UK.***
    a. ***What would be the impact of different levels of levy on your occupation or sector? Would a skills levy affect the way you recruit?***

    A skills levy would increase the burden on an already financially strained NHS, and would not have the desired effect as individual NHS employers are not responsible for recruiting and training medical undergraduates.

    b. ***Should a skills levy apply to all businesses recruiting from outside the EEA? If not, to which businesses should a skills levy apply and why? Why should other businesses be exempt from the levy?***

    No, a skills levy should exempt public sector organisations.

    c. ***Should a skills levy be a one-off payment at the point of recruitment of a Tier 2 migrant or should it be on an annual basis for the duration of the migrant's stay under their initial Tier 2 visa?***

    No response.

    d. ***Would a skills levy have specific regional impacts?***

    No response.

18. ***Dependants of Tier 2 migrants, such as partners, spouses and adult minors, presently have the unrestricted right to work in the UK. The MAC is asked to consider the impact of removing this automatic right:***

    a. ***How would removing the automatic right of dependants to work affect main applicants' decision of whether to come to work in the UK?***

    Removing the automatic right of dependants to work in the UK would have a strongly negative effect on the paediatric medical workforce, where it is common for families to make family focused choices – given the nature of the people who chose to work in paediatrics. We believe that this may prevent some doctors from taking positions in the UK.

    b. ***How many of your Tier 2 employees bring dependants? If so, do they work whilst in the UK? Are they qualified to degree level? What occupations do they work in? If possible, please specify occupations or job titles according to the SOC 2010 classification.***

    We are unable to provide data on this, however anecdotally we feel that it is common for non-EU paediatricians to have highly skilled dependants, who may be doctors themselves.

c. How would removing the automatic right of dependants to work impact on:
i. the economy;
ii. public finances?

No response.

d. Would removing the automatic right of dependants to work have social impacts?

No response.

e. Would removing the automatic right of dependants to work have specific regional impacts?

No response.

19. To what extent do the existing Tier 2 mechanisms and framework work optimally to enable business to bring in the skilled workers that they require?

It does not work well for paediatrics.

20. What changes would you make to the design of the route that would address the issues identified and are not reflected in the changes discussed elsewhere in this call for evidence?

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

They do not have an effect.

22. 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?

Pay is not a good proxy for high level of specialisation or skill among the paediatric medical workforce given the standardised pay rates and high skill level.

23. 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?

See RCPCH response to Part 1: http://www.rcpch.ac.uk/sites/default/files/consultation/RCPCH%20-%20MAC%20min%20salary%20thresholds%20for%20T2%20July%202015.pdf

24. 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?

Doctors hold qualifications that exceed NQF level 6, so this would have no effect on the paediatric medical workforce.

25. 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?

See RCPCH response to Part 1: http://www.rcpch.ac.uk/sites/default/files/consultation/RCPCH%20-%20MAC%20min%20salary%20thresholds%20for%20T2%20July%202015.pdf

26. 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?

See RCPCH response to Part 1: http://www.rcpch.ac.uk/sites/default/files/consultation/RCPCH%20-%20MAC%20min%20salary%20thresholds%20for%20T2%20July%202015.pdf

27. As an employer, what would be the impact of increasing the Tier 2 minimum thresholds on: a) hiring migrant workers from outside the EU;

Increasing Tier 2 minimum thresholds would reduce the number of doctors that we are able to recruit from non-EU countries at a time when there are shortages in the paediatric medical workforce.

b) hiring migrant workers from within the EU;
c) hiring natives.

We still have unfilled ST 4-5 posts, even with a national recruitment system. In addition most trusts have unfilled clinical fellow posts, meaning that native trainees are filling rota gaps, diluting the quality of their training time. 34% of the non-training grade paediatric workforce obtained their primary medical qualification outside the EEA. This indicates a long standing reliance on non-EEA doctors to support paediatric services in the UK.

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

http://www.nhscareers.nhs.uk/working-in-the-nhs/pay-and-benefits/agenda-for-change-pay-rates/

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

Not applicable.

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

Not applicable.

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[i] RCPCH. *Rota compliance and vacancies survey, Winter 2014/2015*. http://www.rcpch.ac.uk/improving-child-health/better-nhs-children/workforce-planning/rota-compliance-and-vacancies/rota-com accessed 11 September 2015.
[ii] RCPCH. *RCPCH Medical Workforce Census 2013.* www.rcpch.ac.uk/census accessed 10 September 2015.