Academy of Medical Royal Colleges
and Faculties in Scotland

CfWI Shape of the Medical Workforce:

Starting the debate on the future consultant workforce

Response of the Scottish Academy Trainee Doctors’ Group
The Academy of Medical Colleges and Faculties in Scotland would like to thank the Department of Health for the opportunity to be involved in this consultation. Many of our member colleges have responded individually therefore we are not submitting a collated response but we would like to highlight the response below from the Scottish Academy Trainee Doctor’s Group which spells beautifully the issues pertinent to the consultation.

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Whilst we recognise that this is a DoH paper, and that individual Colleges and Faculties will be providing detailed responses to this consultation, the SATDG believe that the issues raised within are as pertinent in Scotland as in England, and that any changes in England that occur as a result of this will undoubtedly have a considerable impact north of the border. We also believe that our profession needs to fully engage in this consultation process or risk an extensive reform being “done unto us” that could potentially dwarf the negative impact of MMC and MTAS. We have considered the implications and general concepts of the paper, and the seven suggested scenarios therein, and call on Scottish Academy to include these considerations in the final response document.

**Key principles**
(i) Mixed references to the terms “consultant” and “trained doctor”. We believe that the two should be synonymous, and that the term “consultant” should be consistently used. We are concerned that the creep of the phrase “trained doctor” suggests the conscious or unconscious creep of the subconsultant or junior consultant grade, which we strongly resist.
(ii) The primary goal must be to develop a workforce that is fit for purpose and meets the needs of the UK patient population. Secondary goals should be to ensure that medicine remains an attractive career that attracts and retains capable, motivated individuals, and to appropriately manage the career paths and expectations of undergraduate and postgraduate trainees.
(iii) With the inevitability of change in the structure of the medical workforce comes the likelihood of expanding SAS doctor numbers. We believe that urgent review and reform of the SAS grade is necessary, to improve how it is internally and externally perceived, to improve career development opportunities for those who wish to pursue them, and to improve opportunities for education and support, and call upon Scottish Academy to promote such discussions.

**The 7 Scenarios**

*Scenario 1 – Business as usual. No changes are made to current patterns of recruitment and deployment of trainees and doctors. Trends continue as at present.*
In the current economic climate this option is non-viable and should be refuted. Continuing the status quo risks large-scale medical unemployment and waste, and as such is unacceptable.

*Scenario 2 – Shift to General Practice. There is a shift from hospital specialty training posts to General Practice to achieve a target 50:50 ratio.*
The split of numbers of hospital consultants and general practitioners should be based upon projected needs of the UK population i.e. service needs, rather than current trainee supply. If a significant increase in general practitioners and a reduced need for hospital consultants is needed, then such a shift may need to occur, although it would be essential to recognise that trainees at present provide a considerable proportion of service delivery, and thus alternative methods of delivering service within hospitals would still need to be devised (i.e. scenario 2 is not a stand-alone option, and will only work in combination with an expansion of non-training hospital posts or a consultant-delivered service). Furthermore, it would be important to manage medical students
and Foundation doctors’ expectations about career opportunities in hospital medicine with appropriate careers guidance.

**Scenario 3 – Change in retirement age. Retirement is fixed at 60 years of age.**
This is entirely at odds with the current pensions reforms and the national political agenda for later retirement in an aging population, so we consider this option redundant.

**Scenario 4 – Set level of demand. The size of the consultant workforce is set using the Royal Colleges demand criteria.**
The projected level of demand needs to be set and targeted but to do so there needs to be examination of what the service will look like, including whether it will be a consultant-delivered or consultant-present service. Once necessary output has been agreed, intake numbers should match (allowing for attrition, changes to working patterns and the increasing feminisation of the workforce). This may result in gaps in service provision if numbers of trainees diminish further, and so concurrent discussions about how to fill these must occur to ensure an appropriately trained and ready workforce.

**Scenario 5 – Training consolidation period. A consolidation period is introduced during Certificate of Completion of Training.**
We presume here they mean during Higher Specialty Training rather than “during CCT”. Prolongation of the period between graduation and CCT may help fill rota gaps for a time, but ultimately will not change the output i.e. number of CCTs, only deferring the problem. This is therefore not a solution, as it still leaves us with the ultimate problem of excessive production of consultants, unless the number of consultant posts expands. This scenario suggests that “50% of trainees accept the opportunity to work for a year at ST4, before returning to where they left to complete their training. There is no attrition during the consolidation year”. We are concerned that “opportunity” may become a “mandate” during which career progression is stalled, which may lead to increased trainee dissatisfaction, and the idea that there would be no attrition during this year is entirely unrealistic. We would highlight that doctors at this stage have only recently commenced Higher Specialty Training so will be functioning at a junior clinical decision making level – it is therefore unclear how this will help service in an era of “trained doctor” delivered service.
This scenario does not appear to have any real impact upon the main issues, which are essentially (i) input > output (or funding for output), and (ii) how we attain consultant-led (delivered or present) service when money is tight.
The SATDG does not support this scenario, or other enforced consolidation or plateau periods in an era of competency-based training.

**Scenario 6 – Consultant-present service. Employers move to a service where a consultant is in the vicinity at all times (or able to return to the hospital within a short timescale) with accountability and responsibility for patient outcomes.**
There is an increasing evidence base that consultant-delivered and consultant-present care improves patient care and safety, which is therefore a model we should be working towards, particularly in acute specialties. Increasing consultant presence should also result in improved trainee supervision and increasing consultant numbers should, provided appropriate time is allocated and protected to do so, improve undergraduate and postgraduate medical training. There would need to be restructuring of support services, particularly in diagnostic specialties, to translate this to further efficiency benefits.
The SATDG believe that this is the only acceptable and achievable suggestion of the seven scenarios.

**Scenario 7 – Graded career structure. A multi-level career structure is introduced which recognises different levels of expertise, competence and intensity of work.**
This option discusses a multi-level consultant career structure with pay banding that seeks to gradually ‘breed out’ higher pay bands as these consultants retire, leaving newer/younger
consultants on lower (cheaper) pay bands throughout their career. The cumulative effect of this and many other recent reforms, from pension changes, dissemination of the 9:1 contract, and award freezes, makes a career as a hospital consultant increasingly less appealing, disenfranchising trainees and new consultants and encouraging higher attrition rates and a demotivated workforce. Appointing new consultants to lower bands introduces a differential akin to the junior or sub-consultant, to which we are strongly opposed. For all these reasons, those advocating or supporting these views may be seen as “pulling up the bridge behind them”. Furthermore, the suggestion of working up a banding structure with “the doctor continuing to then develop more specialist skills on the job, while working as a fully trained doctor” devalues the CCT as a marker of completion of training.
We thus view scenario 7 as an entirely unacceptable option.

Other generic concerns
(i) Many of these projections are based on a number of data inaccuracies and assumptions (by the CfWI’s own admission); much data is >3 years out of date, others based largely on guesswork. Sound data collection and expedient interpretation is required to provide solid foundations on which to base workforce projections.
(ii) The use of terminology such as “during CCT training” and “staff grade” suggests a poor or incomplete understanding of the structure of medical training and staffing and thus fails to gain our full confidence. A sound and up-to-date understanding of current structures is essential upon which to understand the projected implications of the proposed scenarios.
(iii) It may be more helpful, in terms of calculating actual clinical service provision, to consider how many overall PAs are needed. In discussing headcount vs FTEs, the CfWI state “we believe that the headcount is a more reasonable figure to focus on, as the actual headcount will more closely reflect the numbers of doctors seeking consultant posts”. We believe this assumption of working forwards from numbers in training, rather than working backwards from numbers of consultants needed, is erroneous. The number of consultant posts in the UK should reflect the number of PAs needed, and the number of doctors we train should ideally reflect that.

In summary, we are pleased that the CfWI is seeking to involve key stakeholders in cohesive workforce planning, but have significant concerns that we have outlined above. We are keen to remain actively engaged and involved with future debate and planning.

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