1. The Association of UK University Hospitals (AUKUH) is the key representative body for university hospitals, with major teaching and research interests, across the UK.

2. AUKUH promotes the policy interests of its 44 members who between them employ a significant proportion of the NHS workforce.

3. AUKUH is pleased to provide comments on the Centre for Workforce Intelligence (CfWI) report, *Starting the debate on the future consultant workforce*.

**General Comments**

4. The challenges and opportunities highlighted in this report are of profound significance to AUKUH members. This study is welcomed as it recognises that the medical workforce is a vital but expensive resource that needs to be used optimally.

**Engagement with the debate**

5. There is a danger that those who need to engage in this important debate could be distracted by the unprecedented and immediate financial challenge they face. Every available mechanism needs to be used to promote this debate with full, active participation of clinical leaders and Executive Directors of hospitals.

6. The relatively short time scale for contributing comments to this report is noted, though we recognise that there will be future opportunities to engage. Notably, AUKUH is holding a meeting of Affiliate Group members (Directors of Finance, Directors of Nursing, HR Directors and Medical Directors) on 28 September 2012 which will focus on ‘the future of the university hospital workforce’. We look forward to discussing these issues with CfWI at this event.
Over supply and robustness of data

7. The excess in trainee numbers is not uniform across all specialties or localities. Further consideration of disparities between specialties and localities needs to occur before accurate predictions of excess numbers can be made. We welcome plans outlined in the report to look in more detail at specialty level modelling. Regional modelling over a 5-10 year period could be a useful output of the emerging Local Education and Training Boards to assist with national work.

8. We note that the report “does not specifically review the variable impact of the feminisation of the workforce in particular specialties”. However, we believe that the proportion of women entering the medical workforce will have an effect on the ratio of jobs to the number trained and should be considered. The gender spread is not uniform across specialties.

Service reconfiguration

9. Service models should influence workforce planning, as without consideration of this it will be difficult to align the healthcare workforce with demand. The scenarios presented do not take account of the effect of changes to service delivery. We note that the report is presented as a starting point in considering this and states that further analysis is required. However, we feel strongly that the high level changes of service reconfiguration and the increasing shift of services to the community are important to consider. We appreciate that this is difficult to model, though international comparisons may be a helpful source of information.

The Role of the Doctor

10. We believe that the Role of the Doctor Consensus Statement provides useful context for CfWI’s work.

http://www.medschools.ac.uk/AboutUs/Projects/Documents/Role%20of%20Doctor%20Consensus%20Statement.pdf

Productivity

11. Detailed consideration of productivity, what it means and how it will influence workforce planning is necessary. While the report states that this is ‘out of scope’, the complexities of this issue are important and will require further exploration to make effective workforce plans. There is recent evidence that assertions of declines in productivity are mythical1.

Consideration of UK context

12. While the report focuses on England, many of these issues are pertinent for all four nations in the UK. Cross-border flows should not be overlooked and it is important that this work connects with other efforts in this area in the devolved administrations.

Scenarios

Scenario 1 – Business as usual

13. Without proactive medical workforce planning this scenario is likely to prevail. However, it is assumed that the NHS cannot afford this option both in terms of actual and lost opportunity costs. Indeed, the projected increase in consultant salaries outlined in the report is likely to be unaffordable on the current models of service delivery and tariff funding for hospitals, particularly in the current financial context. Therefore, it is important that the connected benefits of resourcing an increased consultant pay-bill to patient flow, productivity and efficiency within hospitals are explored. In addition we feel that additional forecasting is required to look at how changing ways of working may affect projections.

Scenario 2 – Shift to General Practice

14. Scenario 2 appears to be consistent with service planning though we believe that a) understanding the interactions between primary and secondary care based doctors and b) considering the outcome of additional GP training places will be important to ascertain whether the reported 50:50 ratio is desirable. With the change of GP training likely to increase to 4 years\(^2\), and the pressure to shift care to the community, it would appear that increasing the number of GP trainees may be sensible. However, the consequent impact on secondary care service delivery would need to be considered.

15. The scenario currently suggests a model where primary and secondary care is ‘segregated’. Alternative models, such as vertical integration of primary and secondary care and the potential impact this could have on consultant and GP roles should be modelled.

Scenario 3 – Change in retirement age

16. The assumption of a retirement age of 60 is unrealistic. Retirement at the age of 60 could not be enforced due to UK age discrimination laws and the end of the default retirement age. As the average retirement age for the NHS workforce and consultants in particular, is more than 60, it is unlikely that this would occur in the absence of legislative change. The planned increased in the

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\(^2\) RCGP (2012) ‘RCGP successful in bid for extended and enhanced GP training’
state retirement age and the normal retirement age of 65 in the NHS Pension Scheme\(^3\) also damage the case for this scenario.

17. Even if there were to be a change in retirement age, this would not necessarily result in a retirement profile that is identical to the current profile. The way in which people approaching retirement prefer to work may change significantly and could have unintended consequences. As the population continues to age and remain generally fit and well as they reach the age of 60, it is unrealistic to expect that a significant proportion of consultants will not want to continue to work.

**Scenario 4 – Set level of demand**

18. We agree that there is a clear need, as identified, to define the supply that is required for the future and the impact on future training numbers. However, we feel there is a risk that asking the profession to design its own future may lead to plans that retain traditional career paths and service models, which may not be achievable or desirable. Indeed, the spread of conditions/diseases across different royal colleges would make it difficult to establish a cohesive service pathway.

**Scenario 5 – Training consolidation period**

19. This scenario may provide employers with an opportunity to reconsider how services are delivered and enable trainees to embed their learning. To deliver this, a consolidation period would need to be well structured and supervised. Significant modelling work would need to be undertaken to consider the impact on the wider workforce and the costs and benefits. We would suggest that this scenario may not provide sufficient impact on numbers and may simply ‘store’ issues for later in the pipeline.

20. Additionally, it may be helpful to consider a phased increase of service commitment as trainees near completion of training, rather than a set period of consolidation. There may be a case for a semi-independent grade at the end of a training programme before achieving a substantial consultant position as outlined as band C in scenario 7.

**Scenario 6 – Consultant-present Service**

21. There needs to be clarity of what is meant by consultant ‘present’ service in comparison with consultant ‘resident’, ‘delivered’ and ‘led’. If there is a desire for consultants to deliver what registrars are currently doing, it is important that this is explicit so that people enter medicine with realistic expectations. The benefit of a consultant present or delivered service will not be uniform across all specialties. Factors such as level of training of supporting staff, patient turnover out of hours and ability to support consultant rotas will influence whether consultant resident, present, delivered or led service is appropriate.

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22. The risks of removing the thread of continuity of care and increased ‘burn out’ of consultants are important considerations in assessing this model. Additionally, the ability of consultants to deliver the often physically demanding tasks of junior medical staff as they grow older needs to be factored into analysis of this model.

23. The potential cost saving of this model is to reduce the junior doctor paybill as they become more supernumerary. It is important to consider that driving down salaries at trainee level would compromise the recruitment and retention of doctors in the UK. Therefore, careful consideration of the other potential efficiencies (such as potential reduced litigation bill from the current £863 million paid in connection with clinical negligence claims4) would be valuable in exploring the costs and benefits of this model. In addition, we would note that the contribution of other healthcare professionals should not be overlooked. Additional modelling of how a consultant ‘led’ (as opposed to ‘present’) service would deliver costs and benefits would be welcome.

24. We feel that assumptions regarding the average number of PAs allocated in this scenario are unrealistic. Assuming 10 PAs does not mirror the current situation, and we believe that this is unlikely to change in the near future. Furthermore, from a value for money perspective, payments to individual consultants above 10 PAs for additional clinical work done is a more cost effective way of paying for such activity than recruiting a new consultant on 10 PAs, a proportion of which are Supporting Professional Activities not Direct Clinical Care. Remodelling may be required, particularly due to the importance of innovation, research and education activities which need to be allocated sufficient time.

**Scenario 7 – Graded career structure**

25. The principles of this scenario are welcome, though we feel that considerable further modelling is required to understand the full implication of a graded career structure. Having different grading for consultants could work, though it is unclear how this would be applied to those consultants with long service and who are very experienced and expert. For example, would this exceed the ratio of 10% in the highest band? Building in flexibility into career structures will be increasingly important and will need consideration in modelling.

26. Renegotiating the current consultant contract to deliver this model is unlikely to be feasible in the time frame required. However, consideration does need to be given to the career grade structure below the consultant grade, to determine whether the proposed changes (if desirable) could be delivered in this way. We feel that phasing out the senior 2 levels as the respective consultants retire, leaving only a junior level of consultant should not be pursued.

4 NHS Litigation Authority figure for 2010/11 [http://www.nhsla.com/home.htm](http://www.nhsla.com/home.htm)
Risks

27. We concur with the majority of risks identified and would highlight the following issues as particularly important:

- The accuracy of workforce planning’s underpinning assumptions together with the validity of the data
- The importance of considering the impact of alternative models of service delivery
- The risk of potential cohorts of doctors unemployed in the future
- The danger of significant increases in cost attached to some scenarios
- The risk of trainees having reduced experience under a model of heavier consultant involvement, making them less able to act independently at later career stages

Recommendations

28. We support the recommendations of the report and would also suggest:

- The flexibility of deaneries will be important if employers are to succeed in maximising the benefit of trainees currently in the training pipeline.
- The need for full engagement with all stakeholders in what is a complex process with a short window to agree change.