The Association for Palliative Medicine Workforce Commentary 2015

APM Workforce Committee 2015

Chair of APM Workforce Committee Stephanie Gomm
Representatives for:

England	Benoit Ritzenthaler
Scotland	Kathleen Sherry
Wales	Caroline Usborne
Northern Ireland	Julie Doyle
Ireland	Feargal Twomey
Registrars	Mary McGregor
SSAS	Alison Talbot
SAC	Polly Edmonds

A new addition to the membership is Laura Norris who is representing the APM Junior Members Committee.

The APM workforce committee links closely with the RCP Workforce Unit and our specialty report for 2013-14 was presented at the College meetings in London in November 2014 and 2015.
In addition, we have the invaluable support of the training programme directors on the SAC Palliative Medicine who do a sterling job in providing up-to-date workforce data each October in regard to the numbers of trainees and consultants in their Deaneries/LETBs.

In 2015, the most significant challenge to all medical workforces remains the current financial climate in the public sector and its impact on the voluntary sector. As predicted there has been a significant slowing of consultant expansion.
As well as '"crunching" workforce numbers it is vitally important as a specialty we define the purpose of our medical workforce especially in the context of 4 significant publications in 2013 and their subsequent implementation: Future Hospital Commission Caring for Medical Patients - RCP; The Shape of Medical Training - Academy of Medical Colleges; The 2022 GP Provision for General Practice in the Future - RCGP; and the Hospice Commission - Help the Hospices 2013.

APM Workforce Report 2014

The APM Workforce survey has been in electronic format since 2010 and the 2015 APM workforce report contains a commentary on the APM 2014 data with the full analysis in appendix 1; workforce data from RCP Census of consultant physicians and higher specialty trainees 2013-14, and the 2014 workforce data provided by the SAC Palliative medicine.

RCP workforce meeting 12th November 2014:
For the APM, Benoit Ritzenthaler, Caroline Usborne attended jointly with Idris Baker for the SAC Palliative Medicine, to present the palliative medicine report of the RCP 2013-14 workforce census, along with other medical specialties. Discussions for each specialty focused on current consultant numbers, expansion, recruitment and unfilled posts; current trainee numbers, recruitment, with an opportunity to raise issues for our specialty and to make predictions for workforce planning over the next 5 years.
Harriet Gordon RCP workforce Lead highlighted the following from the RCP census 2013-4:

- Palliative medicine Consultants had not expanded from the 2012 Census (see below).

- Expressed concern about the decision that LAT posts could disappear at the next recruitment round which will lead to difficulty in relation to cover for 'out of programme experience' (OOPE), sickness and maternity leave and for the smaller specialties reduce opportunities for 'taster' experience. Note subsequently confirmed for 2016 recruitment.

RCP Census of Consultant physicians and higher specialty trainees 2013-14: reported an overall UK Consultant Physician expansion rate of 4% compared to 3.5% in 2012 .The major concern remains the shortage of recruitment into acute medicine and geriatric medicine and the impact of dealing with the influx of acute medical admissions and the frail elderly.
Academy of Royal Colleges publications the 'Commission of the Future Hospital' and the 'Shape of Medical Training' in 2013 and their indicative impact on the format of 7-day access to services in palliative medicine, length of training, continuity of care, our relationships with the wider hospital and community healthcare provision, and the promotion of (general) internal medicine skills across the medical workforce.

APM Workforce Commentary.

Country representatives:

England:

- 50% (137/274) of Consultant responders work full-time (49% in the UK; APM 2014). SAC data 2014 indicated a total of 454 (43% FT) consultants .
- 67% (145/215) of Registrars (SAC 2014) are in full-time posts compared with UK-wide, 68% (SAC) and 66% (APM 2014) respectively.
- 44 of 583 respondents (7.5%) of respondents, held academic positions vs. 8% across the UK. (APM 2014).
- For lead employer, 73% of consultants who responded hold NHS contracts, 23% a voluntary hospice contract and with an academic institution 3.6% (APM 2014).
- 203/268 (76%) of consultant posts that responded receive funding from the NHS, 45 (17%) from a charity, 107 (40%) from a voluntary hospice and 17 (6%) from an academic institution. (Table 54 and Fig.15. Appendix 1).

HEE published for 2014/15 underestimates of numbers of training posts and consultants for the specialty despite extensive information from the APM and Palliative Medicine SAC. In 2014/15 there has been no reduction in training numbers and recommendation to maintain CCTs at 40-45/year. For 2015/16, HEE has published: Investing in people: *Developing people for health and healthcare. Proposed Education and Training Commissions for 2015/16:Workforce Plan 2015/16*, similarly, we have provided information to HEE on workforce numbers and planning for England. LETBs will send their workforce plans to HEE by 31st October 2015 and HEE publish their workforce recommendations including training numbers in January 2016. It remains challenging to interface with LETBs re palliative medicine workforce needs but vitally important we do so for 2016/17, and submit information to HEE on workforce numbers and planning for England.

Wales

- 53% (8/15) of Consultant respondents work full-time (49% in the UK; APM 2014). SAC data 2014 reported 35 consultants (52.8% FT).
- 92% (12/13) of Registrars (SAC 2014) are in full-time posts compared with UK-wide, 68% (SAC) and 66% respectively (APM 2014).

- 3 of 35 respondents (8.6%) of Consultant respondents, held academic positions vs. 8% in the UK. (APM 2014).
- 100% of Consultant responders hold an NHS contract (APM 2014).
- 15/16 of consultant posts that responded indicated that funding was received from the statutory sector, 2 posts from a voluntary hospice and 1 from an academic institution. (Table 54 and Fig.18 Appendix 1.)

It is not anticipated that there will be a significant further expansion in medical workforce in Wales. These calculations are based on the existing models of service delivery and workforce. There remains uncertainty, depending on the outcome on the current consultation on the 'Shape of Medical Training' about what the impact of this will have making future projections difficult for the Welsh medical workforce at this juncture.

Scotland

- 52% of Consultant responders work full-time (49% in the UK; APM 2014). SAC data 2014 reported 46 consultants (39% FT).
- 54% (8/13) of Registrars (SAC 2014) are in full-time posts compared with UK-wide, 68% (SAC) and 66% (APM 2014).
- 5/51 (9.8%) of Consultant respondents, held academic positions vs. 8% in the UK. (APM 2014).
- 55% of respondents are employed by NHS, 33% by voluntary hospices and 13% by Academic /Research Institution. (APM 2014).
- 13/20 (65%) of consultant posts that responded receive funding from the statutory sector, 6 from a charity, 6 from a voluntary hospice and 3 from an academic institution. (Table 54 and Fig.17 Appendix 1.)

Following the decision approved by the Reshaping Medical Workforce Project Board that NES should work with whole time equivalent (wte) numbers rather than trainee establishment numbers. The Scottish training Programme has been given one additional trainee, which increases the number of trainees on the Programme from 13 to 14 and included in National Recruitment from April 2015.

Northern Ireland

- 14 consultants responded to APM survey 2014 (6 full-time and 8 < full-time) and 4 registrars. SAC data 2014 reported 20 consultants (45% FT) and 7 registrars (57% FT) compared with FT UK-wide, 68% (SAC 2014) and 66% (APM 2014).
- For the 12 Consultant respondents all receive NHS funding, of these 1 receives funding from a charity,1 from an university and 6 from voluntary sector hospices. (Table 54 and Fig.16 Appendix 1.)
- Most Consultants participate in on-call for Hospice units, including those who work primarily in hospitals. In one Specialist Palliative Care Unit, Consultants participate in a first on-call Rota. There is currently no commissioned out-of-hours cover for hospitals in Northern Ireland. There is variable out-of-hours Consultant cover for Community Teams.

Limited workforce planning has commenced in Northern Ireland and the Training Committee is requesting that Palliative Medicine be considered for review within this system.

UK on-call data

Total number of UK Consultants providing on-call was 293/351 representing 83.4% of respondents. 5% (13) were 1st on call, 58% (169) second on call and 37% (107) fist and second on call.(Figs20 & 21, Appendix 1).

- 80% of on-call Consultants cover out of hour's emergency admissions.
- % of Consultants receiving contracted PAs: range from 51-53% for telephone advice, 49-53% for face to face contact across the services; 80% hospital and community and 45% for hospices for emergency recall.
- On-call more frequent than 1 in 4 ranges for second on-call 27 to 33%; first and second on call from 15 to 30% and for first on call only (Appendix 1.Tables 55 -57).

Republic of Ireland (RoI)

This year's response rate for those doctors working in the Republic of Ireland to whom the survey was circulated (27/30 = 90%) was encouraging. Twenty-one of these were in consultant posts. The small number of trainee and SSAS data makes any valid comparison/commentary for these groups not possible.

Notable findings within ROI data included:

- 95% of Consultant responders work full-time (49% in the UK)
- UK-wide, 66% of trainees are in full-time posts compared with 93% of ROI Specialist Registrars.
- Nine of twenty-one (43%) of Consultant respondents, in the ROI held academic positions vs. 8% in the UK.
- 100% of consultants who responded indicated that 15 posts received funding came from the statutory sector and 1 of these also had charitable funding. (Table 54 and Fig.19. Appendix 1.).
- No Consultant in the RoI provided first on call only, while 64% provided second on call only and 36% undertook first and second on call.

An exercise is underway to outline the future needs of the palliative medicine workforce required to deliver palliative medicine input to palliative care services across Ireland. It is anticipated that considerable expansion of the consultant workforce will be required to meet the palliative care needs of an ageing population who will present with a significant increase in diagnoses of cancer and complex non-malignant disease. The reliance of many specialist palliative care services on stand-alone non-training post holders for service provision adds a further layer of complexity. It is unlikely that the current number of training posts will be sufficient to supply the required consultant workload despite the low numbers of consultant retirements anticipated in the next decade. National strategic publications are expected as follows: the National Palliative Care Framework 2016-2019 and the third National Cancer Strategy 2016-2025.

SSAS Doctors

SSAS doctors were defined for the purpose of the survey as Associate specialist, Staff grade, Clinical assistants, Medical officers, GPwSI, Specialty Doctors and other non-training grades. Total numbers who responded were 153. 78% were female and 20% male. Overall 38% were >50years of age. In total, 47 % were working less than full-time.

For SSAS doctors, the number of respondents is small, one of the issues highlighted by the APM data and the SSAS survey 2014 is that for SSAS doctors we have been able to contact, many of them are

still on old contracts. Trying to identify SSAS doctors working in palliative care who are not members of APM is difficult, and can be designated as a 'lost tribe' in that we have no information about them or from them.

SAC representative

A significant interface occurs between the SAC Palliative and the APM workforce committee, the major challenges for the specialty are: - the implementation of the Shape of Medical Training Review and the impact on Palliative Medicine; of the discontinuation of LAT posts in 2016 and the effect of changes to the national tariff for training in England.

Implementation of the Shape of Medical Training Review
In February 2015 the Shape of Training Steering Group highlighted the need for further work to describe how doctors' training could be more generic to better meet the current and future needs of patients. In April the Royal Colleges were invited to begin an internal scoping exercise to look at the extent to which generic components of the curricula could be developed.

In May 2015 a briefing paper from SAC palliative medicine about the Shape of Training Review and the potential impact on Palliative Medicine was circulated to all APM members along with an invitation to complete a questionnaire.http://apmonline.org/wp-content/uploads/2015/05/Shape-of-Training-and-Impact-for-Palliative-Medicine-APM-Review-Paper-pdf

Results from the APM Survey:
There was a 41% response rate from the membership, which included 37% of all consultants 33% of SSAS doctors and 63% of trainees.
The key findings were as follows:

- 56% of respondents did not feel that the changes suggested in Shape of Training would have a positive impact on the training of doctors in Palliative Medicine. 25% were neutral
- 59% of respondents did not feel that a 12 month placement in General Internal Medicine would help trainees to meet specialty curriculum competencies. 18% were neutral
- If trainees are required to complete placements in GIM then 88% of respondents felt that the length of training should be increased
- The purpose and role of credentialing caused the most confusion. 27% felt they were unable to give a view on whether there were any areas in the curriculum which would be suitable for credentialing. 43% felt that there would be no suitable areas but 30% felt that this could be further explored with suggested suitable topics including interventional pain techniques, research and hospice management
- 66% felt that the creation of opportunities for dual accreditation with other medical specialties would be a positive development for Palliative Medicine. 20% were neutral
- 82% said they had concerns about the impact that the changes suggested in the Shape of Training review would have on service delivery in Palliative Medicine
- 81% felt that Palliative Medicine training should be increasing the experience in the community setting rather than just increasing the experience in the acute hospital
- 68% felt the current curriculum is effective in producing doctors who are equipped to meet the changing needs of the patient population
- 58% felt that the current undergraduate and foundation programmes do not prepare doctors well for entry into Palliative Medicine

- 50% felt that Palliative Medicine as a specialty should not support the changes to training outlined in the Review. 19% felt that the changes should be supported and 30% were neutral .

All of the medical specialties have submitted a response to the JRCPTB. The response from the Palliative Medicine Specialty Advisory Committee (SAC) has been based on SAC discussions and the results from the APM survey. The information obtained from the specialties will be used to formulate the Federated response to the 'Training Doctors for Patients' Shape of Training Mapping exercise, led by the Academy of Medical Royal Colleges. Further news on next steps is expected sometime in the autumn.

National tariffs for training:
Since April 2014 the change by HEE to MADEL funding of basic salaries for FY2 and Registrar trainees in reducing funding from 100% to 50% and a £11,400 placement fee which could adversely affect training programmes across England. The APM, SAC and Hospice UK made strong representations of the impact of this funding reduction for training placements. Currently those provided by hospices remain outside of the national tariff and LETBs should now be receiving guidance to maintain the status quo for funding in 2015/16.

LAT posts
HEE have notified that LAT posts will no longer exist at the next recruitment round in England in 2016, the SAC has made strong representations for the specialty as this will lead to difficulty in relation to cover for 'out of programme experience' (OOPE), sickness and maternity leave and reduce opportunities for 'taster' experience.

Trainees

The APM 2014 survey echoed the trend in previous surveys confirming a female majority (84%) trainee workforce with a third in the UK working part time. This contrasts with the consultant workforce, which is currently 49:51 full-time: < full-time. If this trend continues it suggests that trainees reduce their working hours during their consultant post or could imply the need to for trainees to reduce their hours when < full-time posts are reappointed to.
47 people hoped to take up new consultant posts in the next 12 months, but only 7 retirements predicted in the same period. This highlights the need/expectation for on-going expansion in consultant numbers across the UK & ROI. It also makes it more likely that trainees in areas that have already seen consultant expansion are going to have to move location to find a consultant post.
The impact of the Shape of training review and the new junior doctor contract are difficult to predict but both may affect the numbers entering training and on the length of time it takes them to become a consultant.

Changes in Consultant Workforce

Table 1. Comparison of APM Consultant headcount 2014 with RCP 2013-4 and SAC 2014 data.

Consultants	England	N Ireland	Scotland	Wales	UK	ROI
APM 2014	296	14	25	20	351	20
SAC 2014	454	20	46	35	555	-
RCP 2013/14	414	15	48	25	502	35*

* RCPI 2014 data.

The RCP Census 2013/14

The Federation of Royal Colleges of Physicians of the UK 2013-14 census of consultant physicians https://www.rcplondon.ac.uk/sites/default/files/palliative_medicine_2013-14_census_spec_report.pdf identified 502 palliative medicine consultants working in the UK: 414 in England, 25 in Wales, 48 in Scotland and 15 in Northern Ireland. There was no overall expansion of UK Palliative Medicine Consultant posts compared to 4% for all specialties Overall 52.3% of consultants in palliative medicine work less than full -time (LTFT). Women comprise a higher proportion of the consultant workforce (73.3 %) than most other medical specialties, with 63.6% of women working fewer than 10 PAs per week. The average rate of retirement (due to consultants reaching 65 years of age) is anticipated at 4.5 per year during the period 2014–18, and 11 per year over the following five years. However, intended average retirement ages reported in the census in the UK is 60.7 yrs and ranges from 59.8 years (Northern Ireland) to 61.7 years (Scotland)

Fig.1

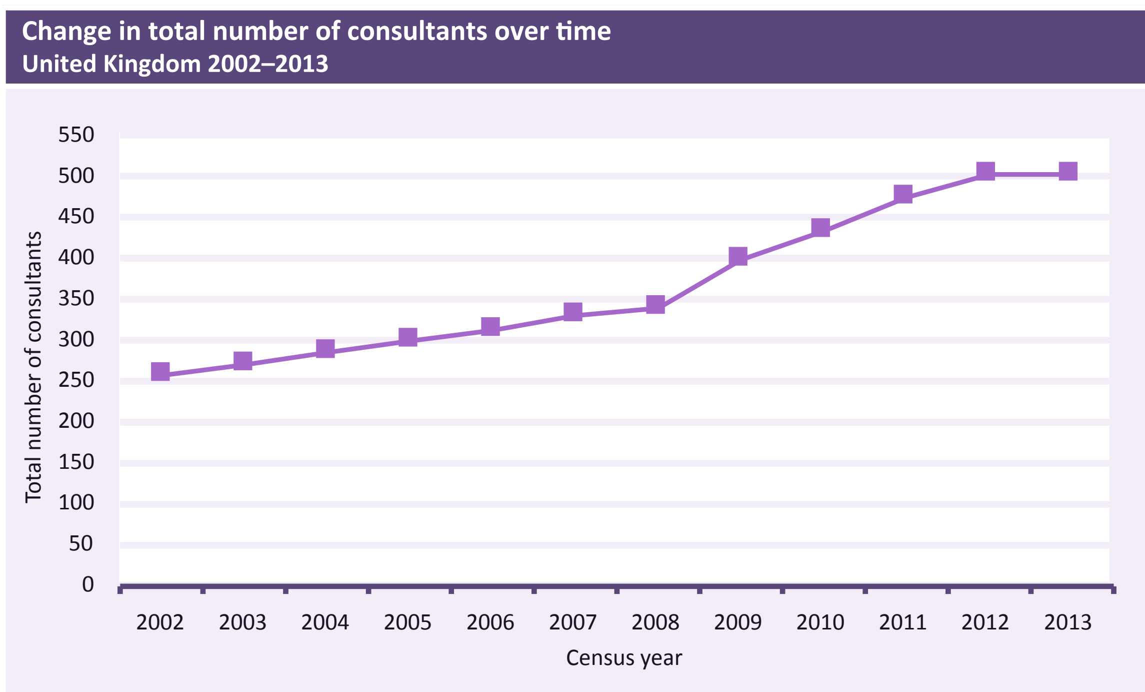
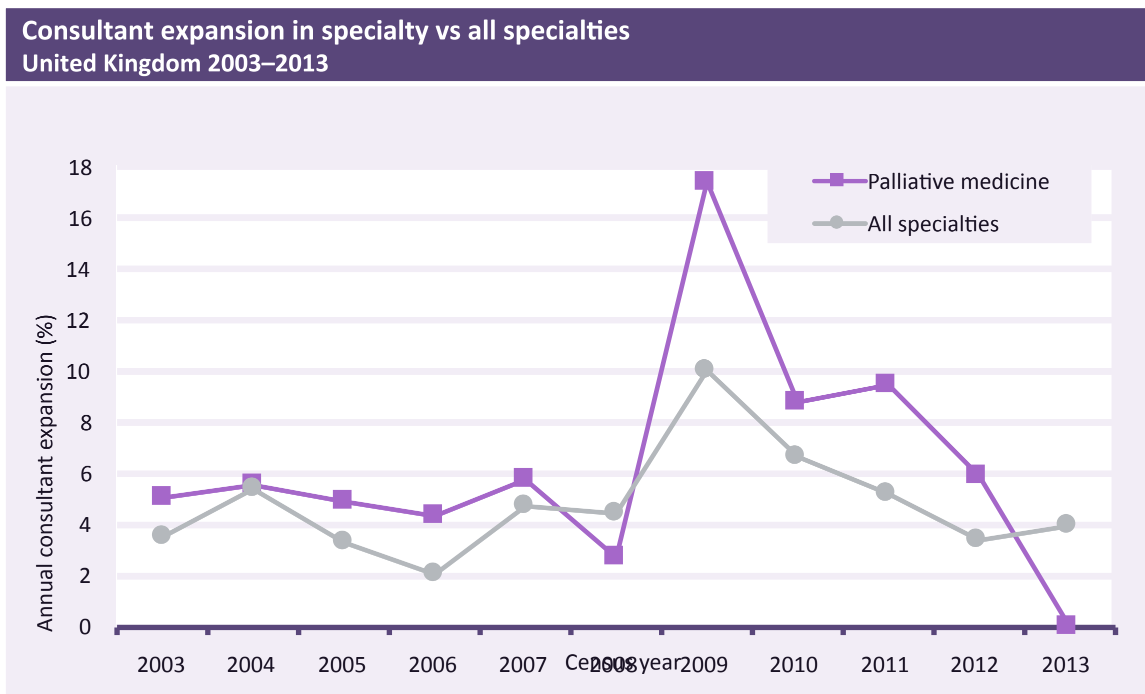


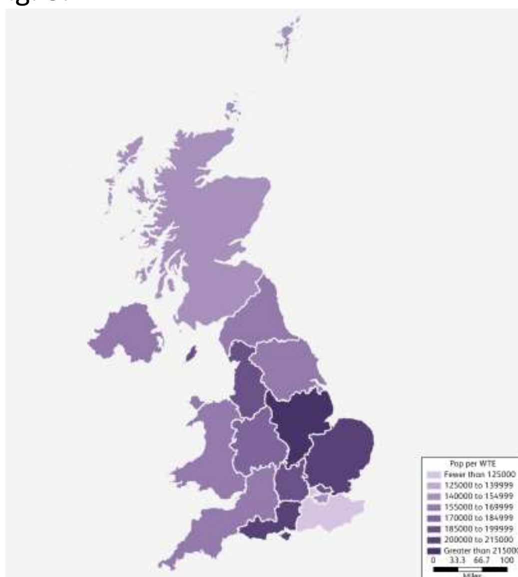
Fig 2.



Data for advisory appointments committees in England, Wales and N Ireland from January - December 2013 show that 43 out of 59 (73%) were successful, six were not made and 10 were cancelled. The average number of consultant appointments during 2008–2011 was 30 per year. The UK consultant vacancy rate is 7.5%[1] (or 40 posts). The projected average number of CCTs per year over next three years is 50.[2]

The geographical distribution of UK consultant posts presented in the map shows that the East Midlands, East of England and Wessex LETBs have the lowest number of full- time equivalent (fte) consultants (i.e. 1 fte: greater than 215,000 population).

Fig. 3.



[1] SAC data 2014 (unpublished)
[2] JRCPTB data 2014 (unpublished)

SAC Palliative Medicine data September 2014

A decrease in expansion rate from 5.3 % to 3.2% in UK Consultant numbers from 538 (436 fte) in 2013 to 555 (454 fte). Number of vacant posts and vacancy rates has fallen in all countries except Northern Ireland.

Table 2. SAC Workforce data 2014 compared to 2013.

Consultants SAC 2014 SAC 2013	UK	England	Scotland	Wales	N Ireland
Number 2014 2013 Fte 2014 2013	 555 538 454.2 407.4	 454 438 367.2 321.95	 46 45 39.2 39.65	 35 36 30.2 29.2	 20 19 17.4 16.6
Participation ratio 2014 2013	 0.82 0.76	 0.79 0.74	 0.85 0.88	 0.86 0.81	 0.87 0.87
Vacant posts 2014 2013 fte 2014 2013	 40 39 30 36.4	 30 33 24.8 30.6	 3 2 3 2	 4 1 3.2 1	 3 3 3 2.8
% Vacancy rate 2014 2013	 7.5% ↓7.2%	 ↓6.6% ↓7.5%	 ↑ 6.5% ↓ 4.4%	 ↑11.4% ↓ 2.7%	 ↓13% ↑15.8%

APM Workforce Survey 2014

This was undertaken from 1st July 2014 to 31st January 2015 obtaining information for UK and ROI on numbers and grade of post-holders, age, gender, ethnicity and full-time and less than full -time working. Overall response rate was 67.0 % hence under-reports workforce numbers.
For the APM 2014 survey we issued 1091 questionnaires with a return rate of 727 (67%).
Full data analysis is reported in Appendix 1.

Table 3. APM data 2014: Consultant number of posts by country

CONSULTANT POSTS	ENGLAND	NORTHERN IRELAND	SCOTLAND	WALES	UK TOTAL	ROI
Consultant	296	14	23	18	**351**	20
Locum Consultant	20	-	2	2	**24**	1
Total Consultant Posts	**316**	**14**	**25**	**20**	**375**	**21**

Table 4. APM data 2014: Consultants by gender UK and RoI

CONSULTANT POSTS	UK		ROI	
	FEMALE	MALE	FEMALE	MALE
Consultant	259 (69%)	92 (95%)	9 (90%)	11 (100%)
Locum Consultant	19 (7%)	5 (5%)	1 (10%)	-
Total Consultant Posts	278 (74%)	97 (26%)	10 (48%)	11 (52%)
Total Consultant Posts by Country	375		21	

Age

In UK and ROI 30% of respondents and in contrast 5% in ROI as under 40 years and 34% and 35% of Consultants were > 50yrs of age (see Figs 9 & 10 in full analysis Appendix 1).

Working Hours

The RCP 2013 -14 Census reported working hours are higher at 10.16 PAs than contracted 9.01 PAs, but are overall lower compared to most specialties reflecting the higher proportion of less than full time working. Table 5 compares contracted and actual working hours (PAs) for FT and < FT Consultants.

Table 5. Contracted and Worked Hours UK RCP 2013-4

Contracted hours	TOTAL PAs	DCC	SPAs	Academic PAs	Other PAs
All	9.01	6.33	2.12	0.27	0.3
FT	10.61	7.25	2.44	0.45	0.47
<FT	7.53	5.48	1.82	0.09	0.14
Worked hours	TOTAL PAs	DCC	SPAs	Academic PAs	Other PAs
All	10.16	6.84	2.65	0.27	0.40
FT	11.79	7.7	3.18	0.46	0.45
<FT	8.67	6.05	2.16	0.11	0.35

APM survey 2014 reported Consultants FT = 49% and < FT 51%

SAC 2014 FT = 43% and < FT = 57%

RCP 2013/14 = 48% and < FT = 52%

Table 6a APM survey 2014 breakdown of contracted Mean PAs by full time and less than full time (consultant posts) – United Kingdom. This data was similar to RCP census except for higher mean contracted academic PAs for FT consultants.

Table 6a. Breakdown of contracted Mean PAs by full time and < full time (UK consultant posts)

Full time or less than full time	Mean Contracted Programmed Activities				
	Clinical	***Supporting***	***Academic***	***Other***	***Total***
Full Time	7.5	2.6	2.2	1.4	10.5
Less than full time	5.2	1.9	0.9	0.9	7.4

Note the Total, Clinical and SPAs are comparable to RCP data in Table 5. Academic and Other PAs appear higher than expected in comparison and may reflect interpretation of the question. **Table 6b. Breakdown of Contracted Mean Hours By Full Time And Less Than Full Time (Consultant Posts) – Republic of Ireland**

Full Time Or Less Than Full Time	Mean Contracted Hours				
	Clinical	**Supporting**	**Academic**	**Other**	**Total**
Full Time	29.0	10.3	4.0	6.0	39.5

Type of Clinical Services:

Table 7. Type of Clinical service led by number of Consultant Posts - UK

Place of work of work	**England**	**Northern Ireland**	**Scotland**	**Wales**	**Total**
Hospice Inpatient Beds	184	12	19	9	224
Hospice Day Care	108	5	5	8	126
Hospice Outpatient Clinic	129	5	9	10	153
Hospital Specialist Palliative Care Team	181	14	12	12	219
Hospital Specialist Palliative Care Inpatient Beds	59	4	2	7	72
Hospital Day Centre	54	3	2	5	64
Hospital Outpatient Clinic	98	11	4	7	120
Community Specialist Palliative Care Team	176	11	13	13	213
Community Outpatient Clinic	76	3	2	9	90
Total Consultants	317	14	25	20	376

Table 8a. Mean PAs delivered for Type of Clinical Service (Consultant Posts) - UK

UK Consultants Place of work	Full-Time consultants		Less Than Full-Time		All Consultants	
	Mean PAs	Consultants	Mean PAs	Consultants	Mean PAs	Consultants
Consultants (UK)						
Hospice Inpatient Beds	3.2	101	2.7	94	3.0	195
Hospice Day Care	0.9	37	1.5	28	1.1	65
Hospice Outpatient Clinic	1.3	54	1.0	50	1.2	104
Hospital Specialist Palliative Care Team	4.2	111	2.8	90	3.6	201
Hospital Specialist Palliative Care Inpatient Beds	3.1	7	2.4	6	2.8	13
Hospital Day Centre	1.5	2	1.5	1	1.5	3
Hospital Outpatient Clinic	1.2	58	1.0	27	1.1	85
Community Specialist Palliative Care Team	2.1	87	2.2	94	2.1	181
Community Outpatient Clinic	1.3	18	1.0	22	1.1	40
Total Consultants UK	376					

See Tables 45 -50 for each country data Appendix 1.

Table 8b. Mean PAs for Type of Clinical Service (Consultant Posts) - ROI

Consultants **Place of work**	**Full-Time consultants**		**Less Than Full-Time**	
	Mean Hours	Consultants n= 17	Mean Hours	Consultants n= 0
Hospice Inpatient Beds	14.6	13	-	-
Hospice Day Care	1.5	2	-	-
Hospice Outpatient Clinic	2.0	6	-	-
Hospital Specialist Palliative Care Team	11.1	16	-	-
Hospital Specialist Palliative Care Inpatient Beds	-	-	-	-
Hospital Day Centre	4.0	2	-	-

Hospital Outpatient Clinic	3.8	10	-	-
Community Specialist Palliative Care Team	4.0	11	-	-
Community Outpatient Clinic	8.0	1	-	-
Total Consultants – Republic of Ireland =21				

Table 8c. Actual workload: Supporting/Non-Clinical work

Actual supporting/non-clinical work per week	United Kingdom		Republic of Ireland	
	Mean PA's	Consultants n = 351	Actual Hours	Consultants n = 20
Trust/hospital management	3.2	145	7.5	10
Hospice management	1.2	180	3.8	11
Supervision of trainees	0.5	211	1.3	13
Undergraduate teaching	0.6	161	1.5	11
Postgraduate teaching	0.5	175	0.8	11
Academic/research	1.1	101	1.3	12
CPD	0.6	235	1.4	13
Appraisal/revalidation	1.1	178	0.4	8
Clinical audit	0.4	188	0.7	11
Strategic planning	1.4	190	1.1	10
Other	0.9	93	5.7	6
Answered the question	298 Consultants		14 Consultants	

Contracts of Employment

In all countries NHS/HSE is the majority employer: - 100% held in Wales, 92% in N Ireland and 86.6% in RoI compared to 73% in England and 49% in Scotland, with the highest for those holding a hospice contract is 33% in Scotland.

Table 9. Consultant posts by Employer and country

Employer	England	Northern Ireland	Scotland	Wales	UK KTotals	Republic Of Ireland
HSE Ireland	-	-	-	-		13 (86.6%)
NHS Employer	199 (73%)	11 (92%)	10 (49%)	16 (100%)	**236** (73%)	-
Academic / Research Institution	10 (3.5%)	-	3 (13%)	-	**13** (4%)	-
Hospice	63 (23%)	1 (8%)	7 (33%)	-	**71** (22%)	2 (13.3%)
Other	2 (0.5%)	-	1 (5%)	-	**3** (1%)	-
Total Consultant Posts	**274**	**12**	**21**	**16**	**323**	**15**

Source of funding

15/15 of consultants in Republic of Ireland who responded indicated that the statutory sector contributed mean % funding of 100% of their posts. This is comparable with the statutory sector contributing to consultant posts in Northern Ireland (mean % funding - 92%) and Wales (mean % funding - 94%), but different to England (mean % funding - 76%) and Scotland (mean % funding - 65%). (Figs 14-20 Appendix 1.)

Table 10. APM Survey 2014

Funding Source	England	Northern Ireland	Scotland	Wales	Republic Of Ireland
University / Grant	17	1	3	1	-
Charity (Marie Curie / Macmillan / Sue Ryder)	23	1	3	-	-
Charity (Other)	22	-	3	-	1
Voluntary / Hospice	107	6	6	2	-
Statutory / NHS / HSE	203	12	13	15	15
Any other source not listed above	13	-	1	-	-
Number of responses	268	12	20	16	15
Total Consultant by country	296	14	23	18	20

On call

Total number of UK Consultants providing on-call was 293/351 representing 83.4% of respondents.

Table 11. On-call UK Consultants

	on-call	%
First on-call	13	5%
Second on-call	169	58%
Both first and second on-call	107	37%

80% of on-call Consultants cover out of hour's emergency admissions. % of Consultants receiving contracted PAs: range from 51-53% for telephone advice, 49-53% for face to face contact across the services;

80% of on-call Consultants for hospital and community and 45% for hospices receive contracted PAs for emergency recall.

On-call more frequent than 1 in 4 ranges for second on-call 27 to 33%; first and second on call from 15 to 30% and 100% of consultants for first on call only. (Appendix 1. Tables 55-57).

In RoI 70% (14/20) Consultant respondents provide on call. No Consultants provided first on call only, while 64% provided second on call only and 36% first and second on call. 87% covered out of hour's emergency admissions.
% of Consultants with contracted hours for telephone advice ranged from 31% -50% across the services (Appendix 1.Fig 39). Contracted hours for face to face contact across the services was 46% hospices, 29% hospital and 8% for community (Appendix 1.Fig 43); emergency recall hospice and hospital 62-64% and community 31%. (Appendix 1.fig 47).
On-call frequency for all types of on-call was 1 in 4 or greater.

Full data see Appendix 1 Tables 55-59 and Figs 20-22).

Professional leave

Less than 10% of UK and RoI Consultants found it fairly or very difficult to take professional leave

Ethnicity

Consultants UK: Ethnic groupings were 13.6% unknown, BAME 7% and White 79.4% of 375 respondents. For BAME grouping the majority of these were declared in England.

Table 12. Ethnicity By Grade – UK

ETHNIC GROUPING	CONSULTANT POSTS	SSAS AND OTHER NON TRAINING GRADE POSTS	TRAINING GRADE POSTS	UK TOTALS
Arabic	1	2	-	**3**
Asian or Asian British – Bangladeshi	1	1	-	**2**
Asian or Asian British - Indian	11	4	6	**21**
Asian or Asian British - Malay	-	-	-	**-**
Asian or Asian British - Pakistani	2	-	1	**3**
Asian or Asian British - Other	2	-	2	**4**
Black or Black British - African	-	1	2	**3**
Black or Black British - Caribbean	-	-	-	**-**
Black or Black British - Other	-	-	-	**-**
Chinese	4	-	2	**6**
Middle Eastern	-	1	-	**1**
Mixed – Asian and White	3	-	4	**7**
Mixed – Black African and White	1	-	-	**1**
Mixed – Black Caribbean and White	-	-	-	**-**
Mixed - Other	1	-	1	**2**
White - British	272	94	120	**486**
White - Irish	13	4	12	**29**
White - Other	13	5	5	**23**
Ethnicity not stated	51	27	6	**84**
Total Respondents	**375**	**139**	**161**	**675**

Table 13. Ethnicity By Grade – Republic of Ireland

ETHNIC GROUPING	CONSULTANT POSTS	SSAS AND OTHER NON TRAINING GRADE POSTS	TRAINING GRADE POSTS	ROI TOTALS
Mixed – Black Caribbean and White	-	-	1	**1**
White - Irish	15	1	2	**18**
White - Other	1	-	-	**1**
Ethnicity not stated	5	1	-	**6**
Total Respondents	**21**	**2**	**3**	**26**

Academic Post-holders

Table 14. APM 2014 Academic posts by country

ACADEMIC POSTS	ENGLAND	NORTHERN IRELAND	SCOTLAND	WALES	UK TOTAL S	ÉIRE
Clinical Lecturer	10	1	2	-	**13**	5
Lecturer	4	1	-	1	**6**	1
Professor	5	-	1	-	**6**	1
Reader	3	-	-	1	**4**	-
Research Fellow	8	-	2	1	**11**	-
Senior Lecturer	14	-	-	-	**14**	2
Total Academic posts	**44**	**2**	**5**	**3**	**54**	**9**
Total Respondents by country	**583**	**27**	**51**	**35**	**696**	**27**

For UK and ROI 55% and 44% are female. 70% and 65% in UK and ROI respectively < 50 years of age (Appendix1.Table 20 and Figs.7 & 8.)

SSAS Doctors APM Survey 2014.

SSAS doctors were defined for the purpose of the survey as Associate specialist, Staff grade, Clinical assistants, Medical officers, GPwSI, Specialty Doctors and other non-training grades. Total numbers who responded were 153. 78% were female and 20% male. Overall 38% were >50years of age. In total, 47 % were working less than full-time. Table 15 shows their distribution by country.

Table 15. Grade of SSAS Doctor by country.

SSAS And Other Non-Training Posts	England	Northern Ireland	Scotland	Wales	Uk Totals	Roi
Associate Specialist	19	1	2	-	**22**	-
Clinical Assistant	1	-	-	-	**1**	-
GP with Special Interest (GPwSI)	4	1	1	-	**6**	2
Macmillan GP Facilitator	1	2	-	-	**3**	-
Medical Director ONLY	9	1	-	-	**10**	-
Medical Officer	5	3	-	-	**8**	1
Specialty Doctor	65	4	8	2	**79**	-
Staff Grade	7	-	-	-	**7**	-
Other non-training post	13	-	2	2	**17**	-
Total SSAS and other non-training posts	**124**	**12**	**13**	**4**	**153**	**3**

Working Hours – SSAS and Other Non-Training Posts (UK)

Table 16. Breakdown of mean contracted PAs by full time and less than full time (SSAS and other non-training posts) – UK

Full time or less than full time	**Contracted Programmed Activities (PAs) - Mean**				
	Clinical	Supporting	Academic	Other	Total
Full Time	9.4	3.2	2.0	1.3	13.0
Less than full time	5.2	2.0	1.0	0.9	7.4

Note the Academic and Other PAs appear higher than expected in comparison and may reflect interpretation of the question.

Table 17. Gender by Full Time and Less than full time (SSAS and other non-training posts) – UK

Gender	**Full-Time**	**Less Than Full-Time**	**Totals**
Female Posts	26 (24%)	81 (76%)	107
Male Posts	11 (34%)	21 (66%)	32
Total Posts	37	102	139

Employer

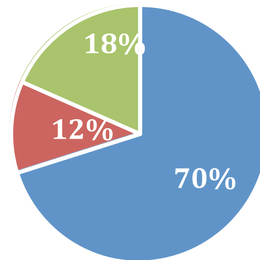
2014 data for SSAS doctors in UK: 34.5% employed by NHS and 66.5% by a hospice.

Ethnicity

SSAS UK Ethnic groupings shown in Table 12 were 19.5% unknown, BME 6.5% and White 74% of 183 respondents.

On-call

Total SSAS and other non training grades providing on-call United Kingdom
62.5% of SSAS and Other Non-Training Grades (UK) undertake on-call with % On-call Frequency across all locations as follows:



62% of SAS doctors cover out of hour's emergency admissions. % of SAS receiving contracted PAs for out of hours across services range from 41-49% for telephone advice, 46-53% for face to face contact; 62% for hospices and < 15% for hospital and community emergency recall .
23 -33% undertake across services for first on-call more frequent than 1 in 4.

Full data see Tables 60-62, & Figs 50-52 Appendix 1.

Trainees

Specialist Advisory Committee (SAC) 2014.

In September 2014, the SAC reported 248 (202.8 fte) palliative medicine registrars in the UK (Table 7) with 84.4% female. Overall, 31.8% of registrars were working < FT. The breakdown for these posts was: 215 (173.3 fte) in England, 13 (11.6 fte) in Scotland, 13 (12.5 fte) in Wales and 7 (5.8 fte) in Northern Ireland. The number of OOP trainees in UK was 18 post-holders and 28 on maternity leave. In England there were 10 academic fellows at registrar grade and 4 academic clinical lecturer posts. Annual expansion rate of registrar posts JRCPTB has fallen in 2013 and 2014 compared to 2012 (Table 8) and to the overall expansion rate of 54.1% between 2001 and 2010.

In ROI there were in Sept 2014:16 registrar posts (14 Female) 1 on long-term leave of absence; 1 at Locum Consultant level.

Table 18. UK Trainee Registrar SAC Data September 2014

Sept 2014 SAC	UK	ENGLAND	SCOTLAND	WALES	N IRELAND
TOTAL REG FTE	248 (202.8)	215 (173.3)	13 (11.2)	13 (12.5)	7 (5.8)
REG FT	169 68.1%	145 67.5%	7 53.8%	12 92.3%	5 71.4%
REG <FT	79 31.9%	70 32.5%	6 46.2%	1 7.7%	2 28.6%
LAT	11	10	1	0	0
OOP	18	17	1	0	0
Education	0	0	0	0	0
Research	8	7	0	1	0
Clinical	6	6	0	0	0
Other	4	4	0	0	0
Mat leave	28	22	4	1	1
ACF	10	10	-	-	-
CMT	29	24	3	1	1

Table 19. Expansion of Registrar posts (JRCPTB database)

No. UK Registrars	Year	% Expansion
135	2001	
179	2005	32.6%
208	2010	16.2%
220	2011	5.8%
243	2012	10.5%
240	2013	- 1.2%
248	2014	3.3%

CCTs and Outcome of achieved CCT holders:

Overall, it takes on average 5 years to train a Palliative Care Physician (Note: this figure modified from 4 years full-time training because of the number of less than full-time trainees). For the period 1st August 2014 to 31st July 2015 expected CCTs are 37.

For the period 1st August 2013 to 31st July 2014 33 certificates of completion of training (CCTs) in palliative medicine were awarded 10 recipients in substantive posts, 4 in locum consultant posts, 14 in their periods of grace, 1 abroad and 4 other.

Projected numbers of CCTs for the next 5 years are taken from JRCTB data for UK between 2014 and 2018. (Table 9) and for RoI (Table 10). These projected numbers will vary year on year affected by changes to less than full-time working, periods out of programme etc .The average number of CCTs estimated per year between 2014-2018 is 50/year.

Table 20. JRCPTB Projected CCT data September 2014.

Year	England	Northern Ireland	Scotland	Wales	UK
2014	54	0	4	6	64
2015	57	1	8	2	68
2016	39	2	1	0	42
2017	25	1	0	0	26
2018	5	0	0	1	6
Totals	180	4	13	9	206

Table 21. Projected CCSTs for Eire (APM data 2014)

Year CCST due	2014	2015	2016	2017	2018
Number	1	2	6	2	3

APM Survey 2014 Trainees

157 registrars completed the survey for UK and 3 for ROI compared to SAC data of 248 and 16 registrars respectively. Age and gender split however were similar to SAC data see Appendix 1 Table 26 and Fig 13). 33% UK registrars were < full time and all full-time in ROI.

Table 22. Training posts by country

TRAINING POSTS	ENGLAND	NORTHERN IRELAND	SCOTLAND	WALES	UK TOTALS	REPUBLIC OF IRELAND
F1 Post	-	-	-	-	-	-
F2 Post	-	-	-	-	-	-
CMT 1/2	-	-	-	-	-	1
GP Specialty Trainee	-	-	-	-	-	-
Specialist Registrar	15	1	-	3	19	2
Specialty Registrar (MMC ST3 and above)	121	3	9	5	138	-
Specialty ST1/ST2 Post	-	-	-	-	-	-
Unspecified posts	4	-	-	-	4	-
Total Training Posts	140	4	9	8	161	3

Table 23. Training posts by gender UK and ROI

Training Posts	UK 161 (98%)		Republic Of Ireland 3 (2%)	
Gender	Female	Male	Female	Male
F1 Post	-	-	-	-
F2 Post	-	-	-	-
CMT 1/2	-	-	1 (33%)	-
GP Specialty Trainee	-	-	-	-
Specialist Registrar	14 (10%)	4 (15%)	2 (67%)	-
Specialty Registrar (MMC ST3 and above)	115 (85%)	20 (77%)	-	-
Unspecified Training Post	6 (4%)	2 (8%)	-	-
Total Training Posts	135 (84%)	26 (16%)	3 (100%)	-

Ethnicity

UK Ethnic groupings for trainees APM survey 2014 as shown in Table 12 were 3.7% unknown, BAME 11.2% and White 85% of 161 respondents.

Changes in Consultant workforce

The following factors will influence the numbers and development of the consultant workforce:

Drivers for workforce demand

Future increases in workload are expected as a result of:

- An increase in the number of dying patients as a result of the growing population, with a predicted 20% increase in mortality rates for patients aged over 80 years or older over the next 2 decades.
- The increasing life span of patients with advanced disease requiring longer periods of specialist palliative care
- Increasing workload due to higher prevalence of cancer and patients with long -term conditions.
- The need to ensure equitable access for advanced life-limiting illnesses and the resultant Increase in referral of patients with long-term conditions.
- The increasing complexity of medical treatments in advanced disease and increasing co morbidities
- An increasing role in the supportive care of patients receiving potentially curable therapies for cancer and non-malignant diseases
- The increased patient and carer expectation of medical treatments in advanced disease
- Increases in Palliative Medicine consultant outpatient episodes (CWfI 2011)
- The centrally led focus on increasing and improving delivery of End of Life Care services into the future including a focus on limiting inappropriate admissions to hospital for patients at the end of life
- Implementation of Shape of medical training (2013) on length of training and changes to specialty curricula to meet need for general internal medicine training

Workload capacity factors

Capacity is expected to be affected by :

- The high proportion of women trainees greater than 80%, and overall > 30% of total number of trainees working < FT.
- Changes in the length of training of registrar trainees as a consequence of the impact of the report Shape of Training (2013), if 1 year of general internal medicine is added and increases training time from 4 to 5 years and by definition to on average to 6 years considering the number of less than full time trainees.
- The percentage of consultants working less than full time RCP Census 2013 (52%) and current percentage of <FT trainees SAC Data 2013 and 2014 (32 -38%); APM survey 2014 reported Consultants FT = 49% and < FT 51%.
- The increase in retirement rates from older consultants and the impact of the changes in retirement age for those currently younger than 50 years
- Major factor currently limiting expansion of new posts are the limitations of the current financial climate.

However the number of Consultant posts available may increase due to trainees moving abroad, entering whole-time research or leaving medicine, an increase in the rate of retirement among older consultants, and the impact of the state retirement age for those currently younger than 50 years increasing to the age of 67.
The most important variable, though, is the creation of new posts and their funding (ie expansion in consultant numbers) within the current financial climate.

Consultant Expansion and Retirements.
RCP Census 2013/14:
Consultant expansion rate: The annual UK expansion of our consultant numbers showed a decrease from 9.5% in 2011 to 0 % in 2013-4 (RCP). This compares to an overall fall in expansion rates for medical specialties from 10.2% in 2009 to 4%.
Using SAC data % expansion from 2013 t0 2014 decreased from 6.1% to 3.2%.
Consultant appointments in 2012 advisory appointments committees (AACs) appointed consultants in 70 out of 83 cases (84%), with 13 appointments not made January - December 2013 show that 43/59 (73%) were successful, six were not made and 10 were cancelled. In 2014 = 47/70 appointments were made (67%).

***Consultant retirements*.**
APM data 2014: for UK between 2014 and 2018.estimated 33 retirements on average 6.5/year and from 2019 -2023 = 9.5/yr. In 2013 the average age of retirement is 60.2 years.
Only 2 responses from the Republic of Ireland: 1 intends to retire in 2023 the other intends to retire in 2021.
RCP 2013 -14: The average rate of retirement (due to consultants reaching 65 years of age) is anticipated at 5 per year during the period 2014–18, and 11 per year over the following five years. However, intended average retirement ages reported in the census in the UK is 60.7 yrs and ranges from 59.8 years (Northern Ireland) to 61.7 years (Scotland).
Consultant vacancy rate has fallen to 7.2% of the workforce for 2013 and 7.5% in 2014 (SAC) compared to 8.8 % in 2010 and 12.3 % in 2009.

Workforce issues for the specialty in the UK 2015 -19
The projected average number of CCTs per year = 45- 50 which can be used as a model to match number of Consultants needed. A simplified predictive model (Table 24) with the need ***to interpret***

with caution as it is dependent on historical consultant expansion being maintained tempered by the annual number of retirements and the fluctuation in CCT holders each year.

Table 24.

	Average Per annum 2015-19			Per annum expansion 2010-14	Potential excess CCT holders in 2019 if historical expansion maintained
	New CCT holders/yr	Consultant retirements/yr	Consultant expansion required		
Palliative Medicine	50	7	43	40	35 Average 7/yr

Estimated Consultant workforce requirements:
Palliative medicine has been in a phase of expansion since 2001 but the rate has declined significantly over the last 3 years, and it is important to note that the specialty baseline workforce requirements are some way from being achieved. See tables below based on RCP 2011 5th Ed. Working for Patients.

Table 25 Estimates for each country in UK and ROI <30% FT

Country <30% FT	Population Est.ONS Millions (2013)	RCP estimate[1]		SAC 2014 data		Participation Ratio
		Headcount	FTE	Headcount	FTE	
Wales	3.1	29.0	24.8	35.0	30.0	0.86
N Ireland	1.8	16.5	14.4	20.0	17.40	0.87
Scotland	5.3	52.0	42.4	48.0	39.20	0.82
England	53.9	532.0	431.2	454.0	367.2	0.81
UK	64.1	625.0	513.0	555.0	454.2	0.82
RoI	4.05	34.0	32.4	35.0	33.6	0.95

The above figures are based on 2 full-time equivalent (FTE) per 250,000 population Consultant Physicians working with patients: The duties, responsibilities and practice of Physicians in Medicine. (5th Ed) Royal College of Physicians, 2011. With participation ratio (0.81- 0.95) for FTE and headcount in each country using SAC 2014 data [1]

APM recommends that the population based requirements should be revised to 2.5 FTE consultants per 250,000 or 10 per million. This is a slight upward adjustment from the 2011 RCP recommendation of 2.0 FTE per 250,000 because of the increased numbers of Consultants working less than full time from 30 to > 40 %. This would require 641 FTE based on the UK population of 64 million.
This does not take into account providing 7-day services or increased demographic demand. Currently only 20% (RCP NCDAH 2014) of hospital palliative care teams provide a service at week-ends (9-5 seven days a week) and those that do mainly rely on telephone advice not face-to-face and regular on site consultant input.

Table 26 shows estimated Consultant workforce numbers and FTE for 2014 for each country on the basis of consultant workforce 40% <FT expressed as 2.5 FTE/250,000 in UK compared to current provision (SAC data 2014). With participation ratio of (0.81- 0.95) for FTE and head count in each country.

Table 26 Estimates for each country in UK and ROI – 40% less than full time

Country	Population Est.ONS Millions (2013)	RCP estimate[1]		SAC 2014 data		Participation Ratio
		Headcount	FTE	Headcount	FTE	
Wales	3.1	36.0	31.0	35.0	30.0	0.86
N Ireland	1.8	20.7	18.0	20.0	17.40	0.87
Scotland	5.3	64.6	53.0	48.0	39.2	0.82
England	53.9	665.0	539.0	454.0	367.2	0.81
UK	64.1	782.0	641.0	555.0	454.2	0.82
RoI	4.05	42.5	40.5	35.0	33.6	0.95

Shortfall of consultants for UK 40% < FT

There are currently 454 FTE consultants, which is lower than head count because of the proportion of 52% (RCP Census 2013-14) that work less than full time.

HC Shortfall = 782 - 555 = 227

The current FTE shortfall is 641 - 454 = 187 FTE

In addition, there is an average annual Consultant retirement rate of 4 FTE5 each year
Palliative Medicine has a predominately female workforce (77% Consultants and 84% registrar trainees) which impacts on the duration of training, a high proportion of < FT trainees 32 - 38% (RCP 2013 and SAC 2014) and consultants who also choose to work less than full time (52%).
On average the current training takes 5 years (taking FT and < FT trainees together) and generates 38 FTE (45 CCT holders with a participation ratio of 0.85) each year.

Table 27 shows that it will take until 2021 to achieve the current shortfall of Consultants at the existing rate assuming no change in training output and no increase to meet expectations of 7-day services or other demands.

Table 27 Reduction of Consultant workforce shortfall 2015-2021

Year	Ave FTE retirement rate	Deficit FTE	New Consultants FTE
2015	4	187	38
2016	4	153	38
2017	4	119	38
2018	4	85	38
2019	4	51	38
2020	7	17	38
2021	7	0	38

Expansion: ***Taking into account an additional requirement to enable 7 day sessions to be on site within a consultant job plan, this assumes the need to increase the 454 baseline FTE by 2/7 = additional 130 FTE.*** This is to meet access to expectation of access to 7-day medical and nursing care from NICE 2004 guidance, and the recommendations of recent national end of life care reviews (2014 & 2015) that highlighted failure to achieve 7-day services. A further 4-5 years would fill all 130 posts i.e. up to beyond 2025 if the present rate of expansion were to continue.

If Shape of Training (Academy of Royal Colleges 2013) is implemented from 2018/19 with length of higher medical training could increase from on average from 5 to 6 years, this will reduce the output of FTE trained doctors by the year 2021 by a sixth i.e. 32 FTE / year instead of 38 FTE.

INCREASED RATE OF EXPANSION OF NTNs NEEDED FOR UK ESTIMATED CONSULTANT DEFICIT OF 187 FTE AND ADDITIONAL 120 FTE FOR 7 DAY SERVICES OVER NEXT FIVE YEARS.

There is a discrepancy between RCP and SAC data for the UK in terms of consultant headcount and fte likely to represent those who do not hold a NHS contract and time frame of data collection. Currently there is no problem in recruiting to NTNs but probably insufficient NTNs given the existing Consultant vacancies of 40 posts, overall unmet need and major geographical variation, consideration needs to be given to recruit additional funded NTNs in these areas, recognizing the effect of the large proportion of female and LTFT trainees who may not be able to apply outside their training region.

Table 28. Geographical distribution of UK Consultants FTE: Palliative Medicine

LETB/Deanery	Popn	FTEs: popn (category)	Consultant Headcount/ FTE
North West London	1,767,904	Fewer than 125,000	25/17.9
Kent, Surrey and Sussex	4,409,592	Fewer than 125,000 -	48/35.7
South London	3,158,043	140,000 - 154,999	28/24.5
Wales Deanery	3,082,412	155,000 - 169,999	25/19.2
Northern Ireland Deanery	1,829,725	155,000 - 169,999	15/12.3
Wessex	3,164,563	200,000 - 214,999	19/14.6
Scotland Deanery	5,327,700	140,000 - 154,999	48/36.7
Yorkshire & Humber	5,247,797	155,000 - 169,999	45/33.6
North West	6,866,390	185,000 - 199,999	48/37
South West	4,279,765	155,000 - 169,999	34/25.6
North East	2,937,264	160,000 - 169,999	24/17.0
Thames Valley LETB	2,316,301	185,000 - 199,999	16/12.6
North Central and East London	3,245,029	185,000 - 199,999	22/16.3
West Midlands	5,674,712	170,000 - 184,999	41/30.8
East of England	5,954,169	200,000 - 214,999	39/29.3
East Midlands	4,598,729	Greater than 215,000	25/20.6

The above table is based on Consultant data from RCP 2013/14 with East Midlands has the lowest number of 1FTE Consultant > 215,000 population followed closely by Eastern and Wessex LETBs of 1

FTE Consultant > 200,000 population. There is a need to increase the number of trainees in LETB areas where it is difficult to recruit to consultant posts and to consider a greater increase in distribution of training numbers and capacity to these specific areas.

In the current financial climate the most important variable remain the creation and funding of new consultant posts and the continued funding of existing consultant vacancies. Overall there remains a potential risk that in the next 5 years that there will be an over production of CCT holders in regard to available consultant posts (although there has been no mismatch in trainees obtaining Consultant posts). One of the consequences of this may be the facilitation of recruitment of consultants to regions that are currently under supplied

The specialty's response to the Academy of Royal Colleges publications the 'Commission of the Future Hospital' and the 'Shape of Medical Training' in 2013 require addressing in regard to their impact on 7-day service access to palliative medicine, continuity of care, our relationships with the wider hospital and community healthcare provision, and the promotion of (general) internal medicine skills across the medical workforce in meeting the needs of the frail, elderly and the increasing number of acute medical admissions.
Main issues confronting workforce planning are extending the current patterns of working for 7 day services and the potential added commitment to acute medicine; in the context of delivering out of hours cross - site working of community, hospice and hospital and recognition that additional consultant numbers will be needed to achieve this.

Challenges

In all countries, the consequences of financial restraints and envisaged changes to education, training and workforce planning are still a major concern; in particular in England the impact of the Learning and Education Training Boards. There is currently no commitment to national workforce planning or standards. In addition, the changes to the Madel funding of basic salaries for FY2 and Registrar trainees, a reduction from 100% to 50% and a £11,500 placement fee by Health Education England. APM made representations to HEE and our current understanding is that hospice placements and less than full time training will not be subject to the changes in national tariff in 2015/16, however, we await clarification from local LETBs as to how future funding arrangements will be implemented.

For all countries in the UK and ROI a major question is do our current and proposed future models of medical care meet the current need and the unmet need for access to Specialist Palliative Care services?

The anticipated changes in service provision and in the Shape of training review will influence the traditional roles of hospices, community and hospital specialist palliative care teams and the type of medical workforce. These proposals will impact on the format of the delivery of 7-day access to palliative medicine, continuity of care, our relationship to the wider hospital and community service provision and the promotion of general internal medicine skills across the medical workforce in hospital and community.

The current proposed changes to medical training would be to shorten the length of specialty training and that more medical specialties will have involvement in acute general medical intake. These are being considered by the specialties and Colleges but will ultimately be determined by the response of the different Departments of Health.

Overall, it is important that although we may know the current numbers of our workforce but we do need to identify the future need and anticipate unmet need so that we train, develop and deliver a workforce that is fit for purpose.

APM Workforce Committee