ASSOCIATION OF PALLIATIVE MEDICINE

WORKFORCE REPORT JUNE 2016

Executive Summary

Workforce Report and Commentary

Key messages:

- As a medical specialty we have the highest % of female trainees 88% and similarly 74% for Consultants.
- Overall 61% of Consultants are LTFT rising each year and for trainees LTFT = 35.3%.
- Current rate of expansion is falling for UK Consultants is 471 FTE compared to 454 FTE in 2014 an increase of 3.6 % compared to 10% increase by head count with the need to focus on this message to deaneries/LETBs.
- 31% of the Consultant workforce is aged >50years of age (RCP Census 2014-15) and APM (2015).
- Vacancy rate is 7.6% of Consultant workforce and increase in anticipated retirement rate of 10/year for 2015-19.
- Expansion of NTNs: Current estimate of need for the UK is 646 FTE (838 headcount) based on 2.5 FTE per 250,000 population i.e. there is currently a shortfall of 175 FTE for a 5-day service and an additional FTE for 7-day service.
- Impact of loss of LATs in 2016 for hospices re funding LAS posts for maternity leave and OOP experience and the reductions in tariff could result in the potential withdrawal of training posts if hospices are disadvantaged. Major risk of not meeting the curriculum if hospices financially become less willing to train.
- No current recruitment problems all ST3 posts filled in 2015 and no vacant NTNs.There are insufficient NTNs given the existing Consultant vacancies of 46 posts (7.5%), the overall unmet need and major geographical variation. RCP data for 2013/14 – East Midlands has the lowest number of Consultants at 1FTE > 215,000 population followed closely by Eastern and Wessex. Consideration needs to be given to recruiting additional funded NTNs in these geographical areas, and specifically in LETB areas where Consultant recruitment is difficult and a greater increase in both training numbers and capacity are required.
- Despite detailed data from APM and SAC, HEE and LETBs use information from Trusts that underestimates both the headcount and FTEs for Palliative Medicine trainees/Consultants and their required expansion e.g. 272 FTE Consultants for England. The SAC data reports 385 FTE. Across England engagement with LETBs has been difficult, in many places there is either disinterest or lack of understanding about NHS and voluntary sector workforce.

- It remains challenging to interface with deaneries and LETBs re Palliative Medicine workforce needs but vitally important we do so for 2016/17 e.g. submission of information to HEE on workforce numbers and planning.

- Just over half (51%) of the SSAS doctors who responded to the SSAS 2015 survey are on the new 2008 contract and only 90% have a regular appraisal.

- Need to determine the impact of implementation of Shape of Medical Training. Whilst we have agreed to deliver training and future hospital services as part of acute medical care with other physician colleagues, there must be clear recognition of the need to not only maintain, but also to expand both training and service delivery in the community and for hospices. This will change the distribution of our medical workforce undertaking Palliative Medicine and those who will also practice acute medicine.

- The current pay structure for non-resident on call within the junior doctors contract in England is set to significantly change. Combined with the changes to pay progression this may affect the choices juniors make about entering the specialty, and the choices made about taking time out of programme for research etc.

The APM workforce committee links closely with the RCP Workforce Unit and our RCP specialty report for 2014-15 was presented at the College meeting in London in November 4th 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 that 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.

RCP Consultant Census 2014-15

The overall UK Consultant Physician expansion rate is decreasing – 3.2% in 2014-15 compared to 4 % in 2012-13.The major concerns remain 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. The overall expansion of medical HST is decreasing over last 4 years and declined to 2.3 % over last 12 months.

Academy of Royal Colleges publications the 'Commission of the Future Hospital' and the 'Shape of Medical Training' continue to be debated see www.jrcptb.org.uk and their indicative impact on the

format of 7-day 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.

APM Workforce Commentary

For England: HEE published investing in people: Developing people for health and healthcare. Proposed Education and Training Commissions for 2015/16: Workforce Plan 2015/16 which despite extensive information from the APM and Palliative Medicine SAC published underestimates of numbers of training posts and consultants. As a specialty there has been no reduction in training numbers in 2015 and 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.

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 2016/17.

For Scotland: 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.

For Wales: 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' in making future projections difficult for the medical workforce.

For Northern Ireland: Workforce issues are under discussion with the Medical Workforce Planning Lead at the Public Health Agency, currently no proposed changes in trainee numbers.

For the Republic of Ireland: Expansion in consultant posts remains slow and impacts significantly on the availability of consultant posts for qualified trainees. Workforce information has been submitted by RCPI to HSE as part of a workforce review. The National Clinical Programme for Palliative Medicine is seeking to develop a model of care for palliative care delivery in Ireland. A workforce planning exercise across all disciplines including Palliative Medicine will be required to inform and develop this model of care. The National Clinical Lead and Dr Feargal Twomey are working up the Palliative Medicine Workforce component of this which will include sense-testing existing national policy (2003) and the 2012 UK Commissioning Guidance for use in the Irish setting. Our colleagues in

Ireland keen to learn from the experiences of colleagues in Northern Ireland, England, Scotland and Wales.

Trainees

Registrars

Specialist Advisory Committee (SAC): In October 2015, the SAC reported 236 (204 FTE) palliative medicine registrars in the UK. Overall, 35% of registrars were working LTFT. The breakdown for these posts was: 202 (174.7 FTE) in England, 14 (10.4 FTE) in Scotland, 13 (12.5 FTE) in Wales and 7 (6.4 FTE) in Northern Ireland, 15 (14.5 FTE) registrars in Republic of Ireland. The number of OOP trainees in UK was 25 post-holders and 20 on maternity leave. In England there were 7 academic fellows and 4 academic clinical lecturer posts occupied. ST3 recruitment for August 2015 was 35 posts.

43 CCTs were achieved in 2015. There are 37 CCTs expected in 2016. The projected average number of CCTs per year over next 3 years is 45 to 50.

Table 1 Comparisons of Trainee Numbers RCP and SAC data

Registrars	RCP 2014-15	SAC 2015
UK	219	236
England	192	202
Northern Ireland	6	7
Scotland	12	14
Wales	9	13
Ireland * RCPI	15	

RCP Census reported 88% of trainees were female the highest medical specialty.

SSAS Doctors APM Survey 2015

Clinical assistant, Medical Officer, GPwSI, Specialty Doctors and other non-training grades: The total number who responded was 128. 81% were female. Overall 38% were >50 years of age. In total, 73% were working less than full-time.

Of 163 SSAS doctors responding to the SASS 2015 survey just over half (51%) are now on the new 2008 contract and only 90% having a regular appraisal. Trying to identify SSAS doctors working in palliative care who are not members of the APM is difficult, and they could be designated as a 'lost tribe' in that we have no information about them or from them.

Consultant Workforce

- SAC 2015 Consultant numbers UK 609 (471 FTE) compared to 555 (454 FTE) in 2014 due to more accurate data collection. Consultant expansion of 3.4% compared to 5.3% in 2012.
- RCPI expansion rate of 0 % no change in 35 Consultant posts.
- UK Consultant % vacancy rate slightly lower 7.6%, 46 posts (31.45 FTE).
- AACs 2014 for England, Wales and N Ireland: - 68% appointed compared to last year 67%. Note this applies only to those with a RCP representative. Average AAC appointments 2010-

2014 = 44/year.

- 50 Expected retirements for 2016 -20 = average 10 per year increasing over last 5 years from 4-5/yr

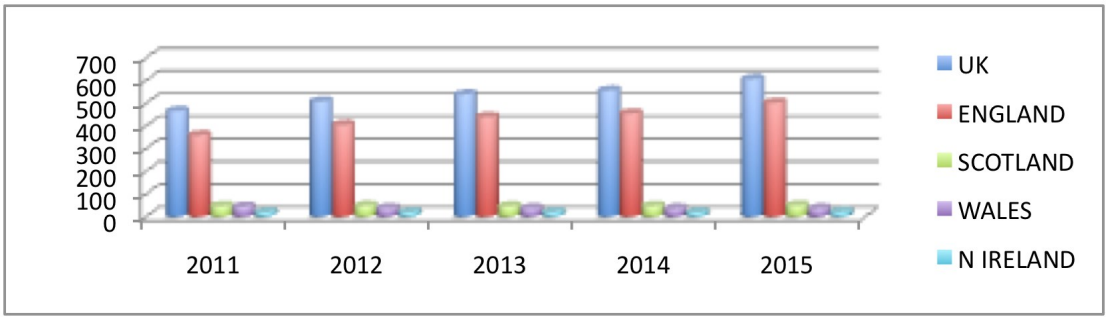
Table 2. Comparisons of APM Consultant headcount 2015 with RCP 2014 and SAC 2014-15 data.

Consultants	England	N Ireland	Scotland	Wales	UK	Eire
APM 2014	296	14	25	20	351	20
APM 2015	282	10	18	20	330	16
SAC 2014	454	20	46	35	555	-
SAC 2015 *	505	20	49	35	609	
RCP 2013-14	414	15	48	25	502	-
RCP 2014-15	427	15	51	26	519	-
RCPI 2015						35

Note * SAC data 2014 compared to 2015 under-reporting of consultant numbers hence 10% expansion compared to RCP increase of 3.4%.

For Ireland Consultant headcount remains at 35 (33.6 FTE) with three working LTFT.There are up to four new full-time consultant posts due to come on stream this calendar year. SpR numbers are 15 (14.5 FTE) at present with no immediate plans to expand the number of higher specialist training posts.

Fig 1 Changes in Consultant headcount 2011-15 (SAC data)



The RCP census 2014-15 (2013) of Consultant physicians identified 519 (502) palliative medicine consultants working in the UK, with 427 (414) in England, 26 (25) in Wales, 51 (48) in Scotland and 15 (15) in Northern Ireland. Expansion rate of 3.4% compared to expansion rate for all specialties of 4%.

The Palliative Medicine workforce has a higher proportion of female consultants (74%) than most other medical specialties. Across the specialty 61% of female and 14% of male Consultants are working less than full time.

The average intended retirement rate (at age 65 yrs) of 10/yr (2015-19) and 11/yr in each of the next 5 years. Between 2014 and 2018 average intended retirement age ranges from 59.8 to 61.7 yrs reflecting the high % of female Consultants.

Geographical distribution of Consultant posts across UK: The East Midlands, Eastern and Wessex LETBs have the lowest FTE Consultants i.e. 1 FTE for > 215,000 population, however across UK the published RCP estimated need is 1 FTE for 160,000 population, however <40% work FT represents a need of 2.5 FTE /250,000 population.

Table 3 shows estimated Consultant workforce numbers and FTE for 2015 for each country on the basis of 2.5 FTE/250,000 in UK compared to current provision (SAC data 2015). With participation ratio of (0.76 - 0.95) for FTE and head count in each country.

Table 3 Estimates for each country in UK and Eire – <40% full time

Country	Population Est.ONS Millions (2014)	RCP estimate[1]		SAC 2015 data		Participation Ratio
		Headcount	FTE	Headcount	FTE	
Wales	3.1	37.0	31.0	35.0	29.2	0.83
N Ireland	1.8	20.7	18.0	20.0	17.3	0.87
Scotland	5.3	66.3	53.0	49.0	39.2	0.80
England	54.3	714.0	543.0	505.0	385.0	0.76
UK	64.6	838.0	646.0	609.0	471.0	0.77
Eire	4.05	42.5	40.5	35.0	33.6	0.95

Overall significant cumulative consultant expansion occurred in the last decade but has declined over the last 5 years. Noting that there has been an increase in the proportion of Consultants working less than FT, and using 2.5 FTE/250,000 populations would represent 646 FTE needed for UK (Table 3). A significant shortfall exists in England with 385 FTE Consultants in 2015 compared with an estimated need of 543 FTE. 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.

Currently there is no problem in recruiting to NTNs but probably insufficient NTNs given the existing Consultant vacancies of 46 posts, overall unmet need and major geographical variation. Consideration needs to be given to the recruitment of additional funded NTNs in these geographical areas, recognizing the effect of the large proportion of female and LTFT trainees who may not be

able to apply outside their training region.

The most important variables in the current financial climate remain the creation and funding of new consultant posts and the continued funding of existing consultant vacancies. Overall there remains a potential risk of a mismatch of CCT holders in regard to available consultant posts although there is a consistent Consultant vacancy rate of >40 posts and no mismatch in trainees obtaining Consultant posts over the last 5 years. One of the consequences could be the facilitation of recruitment of consultants to regions that are currently under supplied.

Main issues confronting workforce planning are extending the current patterns of 7/7 day working and the potential added commitment to acute medicine, in the context of delivering out of hours cross-site working in community, hospice and hospital settings and securing the 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, there is the impact of changes to the Madel funding of basic salaries for FY2 and Registrar trainees, by Health Education England. The 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 Ireland 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 Palliative Care services?

The current proposed changes to medical training may 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. The anticipated changes in service provision and in the Shape of training review will influence the traditional roles of hospices, community and hospital 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, in meeting the needs of the frail elderly and the rising tide of acute medical admissions.

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. There remains uncertainty, depending on the outcome on the implementation of 'Shape of Medical Training' about what the impact of this will have in making future projections more difficult for the medical workforce at this juncture.

Dr Stephanie Gomm

Chair APM Workforce Committee

APM Workforce Committee 2015-16

Chair of APM Workforce Committee Stephanie Gomm

Representatives for:

England	**Benoit Ritzenthaler**
Scotland	**Vacant**
Wales	**Caroline Usborne**
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Republic of Ireland	**Feargal Twomey**
Registrars	**Heidi Mounsey**
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SAC	**Polly Edmonds /Alison Coackley**
Junior Members Committee	**Laura Norris**