Association for
Palliative Medicine
Of Great Britain and Ireland

REPORT AND OVERVIEW OF THE PALLIATIVE MEDICINE WORKFORCE IN THE UNITED KINGDOM

Produced by Workforce Committee of APM

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1. OVERVIEW OF THE PALLIATIVE MEDICINE WORKFORCE

1.1 INTRODUCTION

The Association for Palliative Medicine (APM) of Great Britain and Ireland represents nearly 1,200 doctors and medical students working in palliative medicine in the four nations of the United Kingdom (UK) and the Republic of Ireland. A separate palliative medicine workforce plan has been developed for the Republic of Ireland (see below). The aim of our report is to inform the UK strategy in maintaining and developing the medical workforce with regard to our specialty within the context of the evolving healthcare needs of each of the 4 countries. We have very little data regarding the paediatric palliative medicine workforce. This report will therefore focus on palliative medicine for adult patients, but we also acknowledge the palliative care needs of patients transitioning into adult care provisions.

In December 2017, Health Education England (HEE) published a draft health and care workforce strategy for England to 2027, titled *"Facing the Facts, Shaping the Future"* [1]. Production of this document was led and co-ordinated by HEE, but it was a product of the whole national system including NHS (National Health Service) England, NHS Improvement, Public Health England, and the Department of Health. HEE exists for one reason only: to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place. The consultation on this document concluded in March 2018, with production of the strategy expected in July 2018 for the 70th anniversary of the NHS, but it is still currently awaited.

Scotland, Wales and Northern Ireland commission healthcare differently to England, but the issues that they are facing are very similar as they are also part of the NHS.

It seems timely, therefore, to produce a report that looks at the current palliative medicine workforce, estimates the current undersupply of doctors, and looks at trends for the future workforce. We are taking into account the changes brought by Shape of Training, particularly the dual accreditation of consultants in palliative medicine with Internal Medicine, and the anticipated increased demand in healthcare by the aging population, new illness patterns, and the general improvement of disease management.

1.2 BACKGROUND TO SPECIALTY-SPECIFIC REVIEWS

In December 2012, "Commissioning Guidance for Specialist Palliative Care (SPC): Helping to Deliver Commissioning Objectives" was published collaboratively with the APM, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK. In this guidance document, recommendations were made regarding minimum requirements for different professional staff working in SPC. It highlighted the need to consider workforce requirements in teams rather than medical staff in isolation. It also suggested specific requirements for the size of hospital independently of the population served.

The 2017 Review of the Palliative Medicine Workforce in Ireland [2] was compiled by the National Doctors Training and Planning Unit, to inform training and workforce planning in Ireland. This review has informed our report however the data gathered is not replicated here.

1.3 DATA USED AND LIMITATIONS

The data utilised in this analysis of the medical workforce in palliative medicine is derived from three sources:

1. Focus on physicians: 2017-2018 census[3] (consultants and higher specialty trainees) Royal College of Physicians (RCP)
2. 2018 annual collection of data as of 1 September 2018 by Training Programme Directors (TPDs) for the Specialty Advisory Committee (SAC) in palliative medicine
3. 2018 Workforce survey sent to all APM members to collect their views and opinions on workforce matters

Variations between datasets are not unexpected and therefore the results from the different sources in the reviews are not identical. The limitations of the datasets are due to variations in the time-point of data collection, differences in the variables collected (i.e. whole-time equivalents (WTE) versus headcounts), differences in the definitions of some variables (e.g. less than full-time (LTFT) versus part-time), absence of variable values (i.e. missing data) in datasets, and varying quality of data between sources.

The weaknesses of benchmarking domestic data against international data are known and include:
(i) a lack of contextual consideration;
(ii) assumptions that the international standard is best practice; and
(iii) potential complacency should the domestic value equal that of the international value.
There is merit however, in this kind of comparison, as these ratios are interesting in terms of contextualising the demand for consultants across international healthcare systems with similar training and healthcare delivery infrastructures to those in the UK. Furthermore, it provides an international baseline for comparison and can help identify areas for improvement. Many British and Irish doctors traditionally migrate to countries like Australia and New Zealand. Benchmarking against these countries is a useful exercise.

1.4 OVERVIEW OF THE PALLIATIVE MEDICINE WORKFORCE IN UK

1.4.1 The Context of palliative medicine in the UK Health Service

Palliative medicine is the branch of medicine involved in the treatment of patients with life-limiting disease for whom the focus of care is optimising quality of life. Palliative care is a multidisciplinary approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. This is achieved through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems; physical, psychosocial and spiritual (WHO, 2017). The management of patients with cancer is a key part of palliative care, however, the role of palliative medicine in caring for patients with non-malignant conditions is well recognised, and expanding rapidly.

Palliative care has a 50 year history in the UK and continues to influence the delivery of services. Services originated in the voluntary sector with the establishment of St Christopher Hospice in 1967 by Dame Cicely Saunders, followed in the subsequent 20 years by many new independent hospices in major cities and rural areas of the UK. In 1987, palliative medicine was established as a medical specialty and affiliated to the RCPs (London). The Republic of Ireland followed in 1995. No other European country has since then established palliative medicine as a distinct medical specialty, but significant numbers of medical practitioners work in Palliative Care teams across Europe.

The voluntary sector (local and national charities) contributes significantly to palliative care in the UK in integrating inpatient and community care, the latter under a variety of modalities; home visits, day therapy, outpatient clinics and hospice at home services. The NHS provides some inpatient units, many community teams, and as a rule all hospital palliative care services.

1.4.2 Model of service delivery

"Specialist palliative care" (SPC) is the active, total care of patients with progressive, advanced disease and their families. Care is provided by a multi-professional team who have undergone recognised specialist palliative care training. The aim of the care is to provide physical, psychological, social and spiritual support.

"*Supportive Care"*, usually but not exclusively, for patients in cancer centres, is emerging as a distinct terminology from SPC but practiced by palliative medicine specialists. Supportive care as a concept is aimed at patients throughout their illness journey from diagnosis and through treatment to potential remission/cure and survivorship whilst also incorporating care of patients with incurable disease, end of life care and bereavement. The terminology of supportive care may reassure patients, families and clinicians by overcoming existing associations with end of treatment and end of life, facilitating referral and uptake of services. Some independent units are also abandoning the term hospice for the same reasons.

"End of life care" is an important part of Specialist Palliative Care but not exclusively linked to SPC or admission to hospice inpatient units. End of life care services are also provided by generalist clinicians in primary and secondary care and the responsibility for these services lies with hospital trusts and clinical commissioning groups. Physicians working in palliative medicine do however play a role in supporting good quality generalist care end of life care in their locality. This ranges from education and providing specialist support to advocacy and leadership roles

2. CURRENT WORKFORCE

2.1 INTRODUCTION

This section of the report will provide a breakdown of the data currently available on the number of doctors working in SPC services.

Specialists in palliative medicine may work in a hospital setting, in the community, and in SPC units. The population of doctors working in palliative medicine in the UK is made up of consultants, specialty trainee doctors, and SAS (Specialty and Associate Specialist) doctors.

2.2 DATA ANALYSIS

Examination of the available data has allowed for a breakdown of the palliative medicine workforce by grade. It has allowed for further detailed analysis of those doctors actively participating in the medical workforce across the UK by gender, working patterns, contract type and the age profile of doctors.

The first section outlines the consultant workforce in palliative medicine, followed by an analysis of doctors in specialty training, and thirdly an analysis of associate specialists and staff grade doctors.

2.3 PARTICIPATION OF CONSULTANTS IN PALLIATIVE MEDICINE IN THE UK HEALTHCARE SYSTEM

2.3.1 Number of consultant posts

In 2017, there were 622 consultant posts in palliative medicine recorded by the RCP's census. (This is 3.95% of the 15727 medical consultants and ranks 12th when listed by main medical specialty).

Country	Number of consultants
England	517
Northern Ireland	20
Scotland	49
Wales	36
TOTAL	**622**

The 2018 SAC data collection identified 628 substantive consultant posts in palliative medicine across the UK, 2/3 of them working less than full time. There were 25 more substantive consultants than in 2016 (603).

2.3.2 Workforce planning analysis and informatics

RCP data shows that there is large regional variation for population per WTE consultant (see details in 3.1 section). The range (regionally) is from 44,600 population per WTE to 343,470; the UK average being 126,976 population per WTE palliative medicine consultant.

Country	Number of consultants	Number of consultants (WTE)	Population per WTE
England	517	436.1	127 538
Northern Ireland	20	16.3	114 822
Scotland	49	39.7	136 645
Wales	36	28	111 613

According to data from the 2017/18 RCP census, the proportion of the workforce per employer (percentage) demonstrates that most consultants in palliative medicine have a contract which is not exclusively NHS. Only England and Scotland have some pure non-NHS contracts.

Country	n	Pure NHS	Academic (+/-NHS contract)	Joint NHS-Other	Other
England	517	38	6	41	15
Northern Ireland	20	57	0	43	0
Scotland	49	36	21	21	21
Wales	36	31	25	44	0
TOTAL	**622**	**38**	**8**	**40**	**14**

2.3.3 Gender and working patterns

Of the 622 consultants in palliative medicine considered in the RCP census, 147 were male and 475 were female.

	Number of Consultants	Female (%)	Male (%)	LTFT (%)
England	517	399 (77)	118 (23)	264 (51)
Northern Ireland	20	13 (65)	7 (35)	14 (71)
Scotland	49	35 (71)	14 (29)	34 (69)
Wales	36	28 (78)	8 (22)	20 (56)
TOTAL	**622**	**475 (76)**	**147 (24)**	**332 (53)**

The APM workforce survey received returns from 196 individuals. (47.8% were full time employees, 48.4% were LTFT employees and 3.8% were retired/partially retired). It is significant that palliative medicine exhibits a different profile to most of other medical specialties. Looking at the RCP census data for 2017 for all consultants (n=15727), 36% are female and 64% male. There are 3549 consultants (23%) working LTFT.

2.3.4 Permanent locum and temporary locum status of consultant contracts

The RCP census does not account for locum posts, but the SAC data recognises the existence of locum posts held by individuals who are not on the Specialist Register and the frequent need of post to cover parental leaves. In 2018 there were 39 locum consultants in post. Of those 17 (44%) were working fulltime and the remaining 22 (56%) were LTFT. The 39 locums represent 6% of the Consultant workforce (Total 667).

2.3.5 Age profile and projected retirement

	34 or younger	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 65	Older than 65	Unknown
England	24	100	121	113	84	58	16	0	1
Northern Ireland	1	2	5	2	3	6	1	0	0
Scotland	0	9	13	11	8	4	3	1	0
Wales	3	7	7	7	8	2	0	2	0
TOTAL	28 (4.5%)	118 (19.0%)	146 (23.5%)	133 (21.4%)	103 (16.6%)	70 (11.3%)	20 (3.2%)	3 (0.5%)	1 (0.2%)

Of the consultants actively working in palliative medicine, according to 2017 RCP census, 4.5% were under the age of 35, 42.5% were between the ages of 35 and 44, 38% were between the ages of 45 and 54 and 15.2% were over the age of 55 years.

The “mean intended age of retirement”, for palliative care consultants, is 61.2 years (2017 RCP census). The data indicates that over the next 10 years approximately 207 consultants in palliative medicine, representing 33% of the workforce, are likely to exit the workforce due to retirement. The SAC data indicate that 68 consultants expect to retire over the next 5 years from Sept 2018. The APM workforce survey had responses from 174 consultants; 71 indicated that they were planning to retire within the next 10 years (40.8%). So, regardless of data source, this will have a notable impact on the existing workforce and require careful consideration for workforce planning.

2.4 PARTICIPATION OF PALLIATIVE MEDICINE SPECIALTY TRAINEES IN THE UK HEALTHCARE SYSTEM

2.4.1 Training programme

At time of writing, applicants for specialty training in palliative medicine must have successfully completed a core training programme in medicine, acute care, anaesthetics, surgery or general practice, or hold an Alternative Certificate of Core Competence[4] (specifically for PM applicants), with sufficient time spent working in general and acute medicine. Applicants also need to have successfully completed the college membership exams for one of medicine, general practice, surgery or anaesthetics. This will be restricted to MRCP from 2022 with the advent of mandatory dual accreditation (PM and IM) with the implementation of shape of training.

Specialty Training in palliative medicine is currently a minimum of four years in duration and will remain so following Shape of Training but this will include the equivalent of 12 months training in IM effectively reducing the time in PM placements

to 3 years. However with 32% of trainees woking LTFT and time taken out of programme for research, training opportunities and parental leave, the trend is for a longer duration of training. Trainees can also apply to reduce the duration of their training programme by evidencing the attainment of all required competentcies.
Currently training requirements include hospice, community and hospital experience. After gaining their Certificate of Completion of Training (CCT), candidates are eligible for inclusion on the Specialist Register and are eligible to apply for substantive consultant posts in palliative medicine.

2.4.2 Number of palliative medicine Specialty Trainees

In 2017, there were 212 palliative medicine specialty registrars (STR) recorded by the RCP's census which equates to 185.1 WTE. (This is 2.92% of all STRs, and ranks 14th when listed by main medical specialty)

	Number of STRs
England	179
Northern Ireland	7
Scotland	15
Wales	11
TOTAL	**212 (185.1 WTE)**

The SAC data collection identified 225 STRs in palliative medicine across the UK out of which 139 (62%) working fulltime. 6 of these are working in Academic training posts and another 5 were Academic Clinical Lecturers. 18 trainees were Out of Programme (OOP) including 4 in education posts and 9 in research posts. There were 26 (20.6 WTE) on parental leave. There has been a drop of 4 training posts across the UK compared to the 2016 data. There were only 34 posts offered in August 2018 and 2 in February 2019. All posts offered were filled demonstrating a high level of suitable candidates.

2.4.3 Workforce planning analysis and informatics

Overall there exists 1 WTE STR per 356,847 of the population.

	Number of STRs	Number of STRs WTE	Population per WTE
England	179	156	356,535
Northern Ireland	7	7	279,229
Scotland	15	14	387,486
Wales	11	9	354,629

RCP data shows that there is large sub-regional variation for population per WTE STR ranging from a ratio population per number of STR of 228,934:1 in London to 520,712:1 in the East of England.
This has potential implications for consultant workforce planning as The RCP census data found geography was the most common factor in choosing a consultant post (reported by 62% of STRs). The APM Workforce survey found 54% of STRs want to apply for posts in their training area, but 75% would consider moving out of area.

2.4.4 Gender and working patterns

Of the 212 palliative medicine STRs considered in the RCP census, 85% were female and 15% male. This compares to 51% female in all medical specialties combined; 32% of STRs worked LTFT (compared to 13% in all medical specialties combined). 48% of STRs completing the APM Workforce survey intended to work LTFT as a consultant.

2.4.5 Age profile and projected CCT

From the RCP data 56% of STRs are in the 31-35 year age range, with an even split above and below this. 23% of STRs are in their 4th year of training, with 34% of existing STRs expected to CCT in 2018, 20.8% in 2019, 21.7% in 2020, and 13.7% in 2021. These proportions may change due to STRs moving in or out of LTFT training, and periods spent out of programme.

From SAC data, approximately 30 trainees have completed training and gained their CCT each year for the last two years. 91% of STRs completing the APM Workforce survey intended to apply for a substantive consultant post in the UK post CCT.

2.5 PARTICIPATION OF SAS DOCTORS IN THE UK HEALTHCARE SYSTEM

2.5.1 Number of SAS doctors

2018 SAC data showed that there were 529 (482 in 2016) SAS doctors working within palliative medicine in the UK. This represents of 297.4 WTE, a number equating to 60% of the total consultant workforce (~500 WTE), highlighting the considerable proportion of the UK palliative medicine workforce that falls within this grade.

The recent 2018 APM Workforce survey captured data from a significantly smaller proportion of the total SAS workforce, but the data does suggest that over 50% are employed as Specialty Doctors, with 20% continuing to hold the title Associate Specialist. A smaller proportion, 7%, are working as Medical Directors. Approximately 75% are employed at least partially within the voluntary/independent sector.

2.5.2 Working patterns

The SAC data suggests that 450 (85%) of these doctors are working part time. The more recent APM Workforce survey covering the UK broadly supports that this trend continues with 70% of those answering the survey were working LTFT.

2.5.3 Workforce planning analysis and informatics

SAC data shows that 2 doctors successfully achieved specialty registration via the CESR route in 2016, with a further 4 achieving the same in 2017 and 3 in 2018. The 2018 APM survey suggests that a further 11 of those who responded are currently pursuing this route, whilst 3 are intending to apply for palliative medicine specialist training. 67% intend to remain in their current grade.

At some point after 2022, once the current single accreditation palliative medicine curriculum is no longer in use, it is highly likely that existing SAS doctors will no longer be able to meet the criteria to apply for CESR via the dual accreditation curriculum and the numbers achieving specialty registration via this route will fall significantly, if not stop all together. Anecdotally there is some suggestion that some of the SAS doctors affected by this change are likely to consider the new Associate Specialist role when this becomes available.

The 2018 APM survey regarding retirement plans of SAS doctors had a poor response rate. However, of those that did respond, 7 are intending to retire within the next 3 years and a further 6 within the next two. In total, 21 intend to retire in the next 10 years. Clearly it is not possible to accurately extrapolate from this data, but it does point towards a potentially worryingly number of SAS doctors that could be lost from the workforce.

2.6 PARTICIPATION OF NON-SPECIALTY TRAINING GRADE POSTS

Palliative medicine posts are also included in rotations for junior doctors during foundation year training, core medical training and general practice training.

- **Foundation doctors**

SAC 2018 data found 21 FY1 and 52 FY2 doctors working in palliative medicine.

- **CMT**

SAC 2018 data found 27 doctors working in palliative medicine.

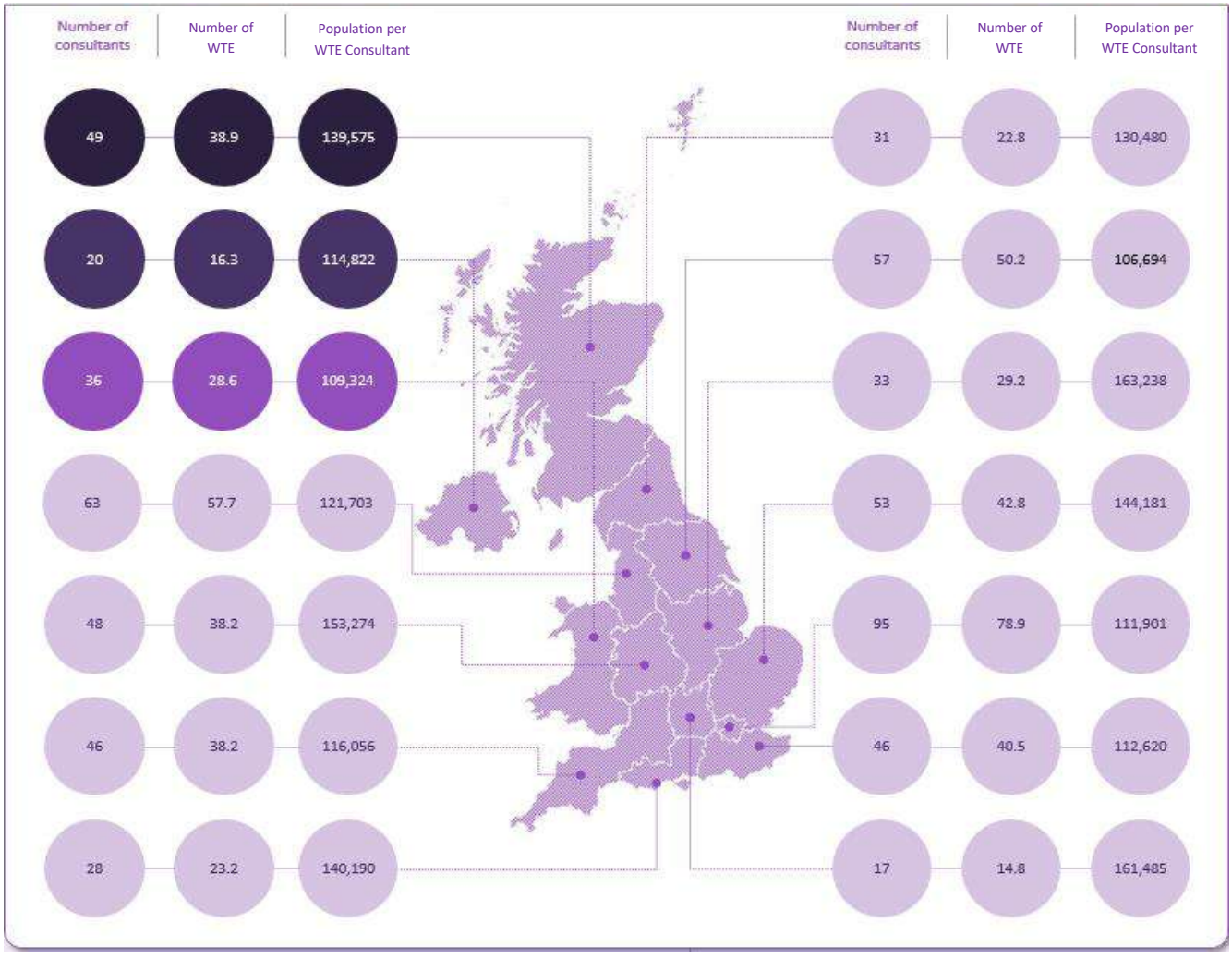
- **GP VTS trainees**

SAC 2018 data found 169 doctors working in palliative medicine.

These numbers are likely to evolve over time and a new category of Specialty Trainees from other medical specialties is likely to emerge out of Shape of Training. The majority of Foundation doctors working in palliative medicine express that this opportunity has equipped them with important skills that enhance their understanding of the breadth of the role of a doctor in supporting and advising patients and families. It seems that the earlier junior doctors are exposed to palliative medicine the more they are likely to be impacted for the rest of their career. There may of course be a bias in as much as many of them have made this placement a personal choice.

3 ESTIMATION OF THE CURRENT UNDERSUPPLY OF DOCTORS IN THE PALLIATIVE MEDICINE WORKFORCE

3.1 GEOGRAPHICAL DIFFERENCES ACROSS UK



Geographical location of substantive consultants in palliative medicine (2017–18 consultant census RCP data tool) [5]

Nation	NHS region	Sub-region	Female	Male	Total headcount	Total WTEs	Population	Population per WTE
England	London	North East and Central London	27	9	36	30.4	3,463,676	114,325
		North West London	15	3	18	12.8	2,075,696	163,602
		South London	35	6	41	35.7	3,285,629	92,488
		Total			95	78.9	8,825,001	112,620
	Midlands and East	East Midlands	20	13	33	29.2	4,771,666	163,238
		East of England	42	11	53	42.8	6,168,432	144,181
		West Midlands	41	7	48	38.2	5,860,706	153,274
		Total			134	110.2	16,800,804	152,457
	North	North West	46	17	63	57.7	7,022,390	121,703
		Northern	25	6	31	22.8	2,971,682	130,480
		Yorkshire and the Humber	39	18	57	50.2	5,359,412	106,694
		Total			151	130.7	15,353,484	117,471
	South	Kent, Surrey and Sussex	34	12	46	40.5	4,562,563	112,620
		South West	38	8	46	38.2	4,431,584	116,056
		Thames Valley	14	3	17	14.8	2,391,696	161,485
		Wessex	23	5	28	23.2	3,254,298	140,190
		Total			137	116.7	14,640,141	125,451
Northern Ireland		Northern Ireland	13	7	20	16.3	1,870,834	114,822
Scotland		Scotland (East)	3	1	4	4	1,373,880	343,470
		Scotland (North)	5	3	8	6.2	307,210	44,685
		Scotland (South)	15	2	17	13.2	1,126,410	85,822
		Scotland (West)	12	8	20	15.5	2,617,300	167,062
		Total			49	38.9	5,424,800	139,575
Wales		Wales (North)	5	1	6	5.8	696,284	124,708
		Wales (South)	23	7	30	22.8	2,428,881	108,601
		Total			36	28.6	3,125,165	109,324

Location of substantive consultants in palliative medicine (2017–18 consultant census RCP data tool) [4]

3.2 CONSULTANT VACANCIES and OUTPUT OF CCT HOLDERS

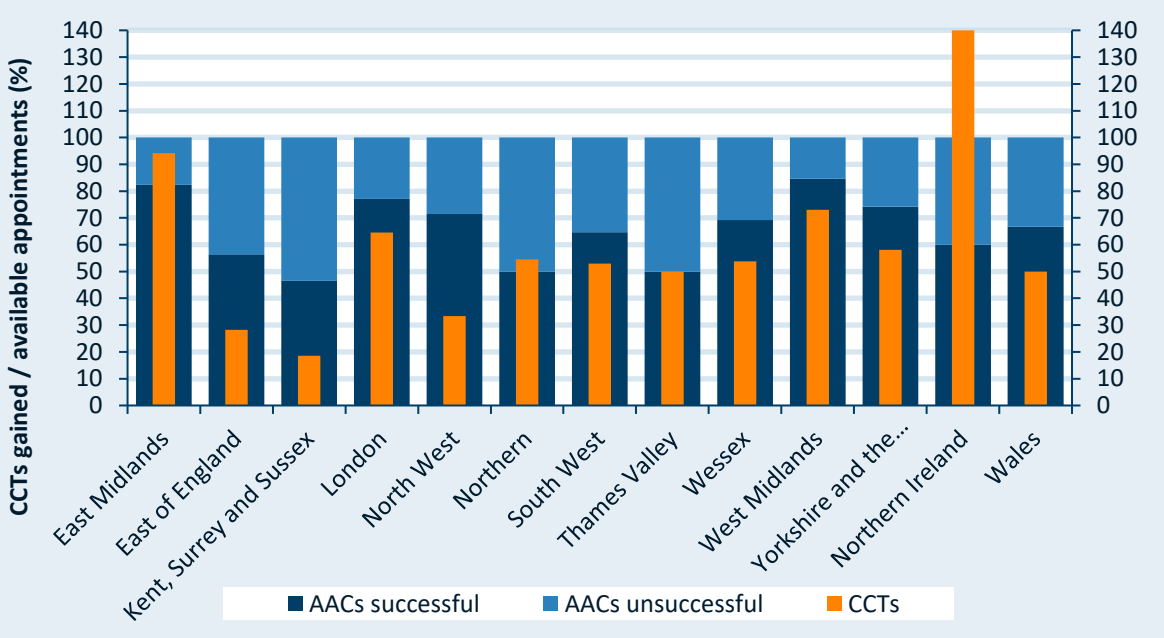


Figure: 2012–2016 statistics of Appointment Advisory Committees[6]

In 2016, 2017 and 2018 the SAC data collection identified respectively 61,54 and 56 consultant posts vacancies whilst the anticipated CCTs were between 30 and 35.

3.3 KEY DRIVERS OF CHANGE TO THE FUTURE OF THE PALLIATIVE MEDICINE WORKFORCE

The major drivers of change to the future palliative medicine workforce are the changes in population health care needs, the changes to palliative medicine training of future consultants in our specialty and in other medical specialties, and the new patterns of working including seven day working.

3.3.1 Changes in population health care needs

A population that is both increasing and ageing means that the numbers requiring end-of-life and palliative care are set to rise in the coming years. People are also surviving longer with life-limiting conditions and with multiple morbidities. Inpatient hospice/SPC services traditionally evolved largely around the needs of people with cancer, but there is a growing demand for these services for other life-limiting conditions Neurological conditions such as motor neurone disease and other degenerative diseases including dementia, heart failure, respiratory disease and renal failure, especially those associated with severe symptom burden and complex clinical and ethical decision process are increasingly referred to palliative medicine clinicians for advice and holistic support. Those complex situations are often difficult to address within hospitals and require community or outpatient follow up.

According to Cancer Research UK[7] there are more than 360,000 new cancer cases diagnosed in the UK every year(2013-2015). In males there were around 183,000 and in females around 177,000 new cancer cases in 2015 in the UK. Since the early 1990s, incidence rates for all cancers combined have increased by 13% in the UK. Rates in males have increased by 3%, and in females by 16%. Almost half of cancers are diagnosed at a late stage in England (2014) and Northern Ireland (2010-2014).
Incidence rates for all cancers combined are projected to rise by 2% in the UK between 2014 and 2035, to 742 cases per 100,000 people by 2035. An estimated 2,273,200 people who had previously been diagnosed with cancer were alive in the UK at the end of 2013. UK incidence is ranked higher than two-thirds of Europe. UK incidence is ranked higher than 90% of the world. While some cancers are being cured, the reality is that most cancer treatments prolong life rather than cure. As advances in new treatments for cancer reduce mortality, these will extend the period during which palliative care will be required, while a rising population over the age of 65 is likely to also increase demand. Therefore, it is expected that there will be a concurrent increase in the demand for SPC services.

3.3.2 Shape of Training

Speciality training in palliative medicine in the UK is evolving with the introduction of Shape of Training. From August 2019, the two-year core medical training will be replaced by three-year internal medicine training. From 2022 specialty registrars will start to dual accredit in palliative medicine and internal medicine (IM). During 4 years of training they will complete 3 years specialty training and 12 months in Internal Medicine. From 2022 entry criteria to specialty training will only include MRCP. Currently other postgraduate qualifications are accepted e.g. General Practice, Surgery and Anaesthetics. However, the number of applicants applying for specialty training with these qualifications is now less than 5%. Some APM members have expressed their concern about the loss of this entry route as these clinicians bring a different skill set to the specialty.

Palliative medicine requires a set of core skills and competencies that are relevant to both internal medicine and general practice. Palliative and end of life care skills have been included as mandatory elements of the new IM Stage 1 curriculum. Palliative medicine doctors should be involved in training both future general practitioners and specialty physicians in these essential skills and competencies. In practice, unless our workforce grows sufficiently we will be unable to deliver on this demanding task.

The mandatory training in internal medicine for PM STRs and conversely the inclusion of palliative and end of life care skills in IM curriculum represent opportunities for palliative medicine to be integrated with other medical specialties in the delivery of acute take and potentially influence the delivery of this care towards enhancing community involvement. Moreover, the growing demands on Emergency Department by patients approaching the end of life should be managed by consultants in palliative medicine who have the appropriate skill set to care for patients with multi morbidities either at home or in the charitable sector settings.

During the winter of 2018 there was a short pause in development of new curricula whilst the Curriculum Oversight Group (COG), led by the GMC and incorporating JRCPTB, HEE and others, reviewed the impact of the planned changes including funding. This pause affected all specialties which were due to commence dual accreditation in 2022. It has now been lifted. The palliative medicine SAC which is the national body responsible for specialty training is now able to continue developing the new specialty curriculum.

The SAC alongside the APM recognise the many challenges of PM trainees undertaking 12 months of IM training and the need to ensure that the specialty has enough manpower to deliver care and specialty on-call in the hospice setting. The SAC has raised these concerns with JRCPTB and suggested the option of backfill of these posts. Without these in place delivery of dual accreditation will be extremely difficult. HEE is supportive of the specialty suggesting various models to allow this to happen. The backfill options could include trainees from other specialties spending time working in palliative medicine. It is argued that these trainees would bring a useful skill set to the delivery of palliative medicine in the community and in voluntary hospices. However, they are likely to require increased supervision, will have a reduced level of expertise in palliative medicine and different curriculum requirements which may have an impact on service delivery. Another potential model for reducing impact on the voluntary/charitable sector is securing an increase in the number of specialty training posts or receiving compensatory funding whilst palliative medicine trainees are completing their Internal medicine experience, to employ more SAS doctors upon whom no requirement for dual qualification will be imposed.

3.3.3 New pattern of working and Seven-day working

The importance of round-the-clock and round-the-week availability of SPC services has been recognised for over a decade, with the 2004 NICE guidance identifying this as a minimum standard.

Over the last 5 years there has been growing support from professional bodies and NHS leaders to provide NHS services at weekends and bank holidays that look more like the care available during the working week. The evidence is compelling and suggests better outcomes for mortality, length of stay, readmission rates and patient experience with seven-day services in the general hospital population.

Where models of 24hour, seven-day access to care have been implemented, evaluation reveals

- Rapid access to SPC, across primary and secondary care, improving outcomes and experiences for patients and their families, and increasing quality and standards of care
- Access to hospice inpatient admission for patients requiring urgent transfer into a SPC bed, at weekends and on Bank Holidays
- Prevention of unscheduled acute hospital admissions
- Support for providers of general palliative care, throughout primary and secondary care

A guidance document was produced by the RCP and the APM in 2018[8], which recommends levels of SPC medical and nursing staffing for hospital, community and hospice settings at night, at weekends and on bank holidays. The document provides a consensus view on minimum and desirable levels of service for 24-hour telephone advice and face-to-face visiting at weekends and bank holidays in hospices, hospitals and in the community. It acknowledges that weekend and OOH services will not match usual Monday to Friday services, and that the individual clinicians (in particular, nursing clinicians) will be required to be of sufficient competency, as they may work with less supervision and support.

The consensus group identified that sound governance systems are required for cross sectoral and cross-organisational working. Notably, recent commissioning guidance has recommended that many services will require time and support to meet the levels of service suggested.

Despite the NICE guidance (2004), there are still currently significant gaps in SPC provision out of hours. There are some areas of the UK where there is seven-day face-to-face SPC visiting and senior telephone support 24/7. These services are often collaborations between the NHS and third sector organizations – often hospices. The APM workforce survey in 2016 identified that of responding consultants (67%), the majority (91%) provide some level of on call service. The majority of UK Consultants (>90%) provide telephone advice on call to hospices and community palliative care teams and 66% for hospital palliative care teams. 77% undertake emergency face-to-face reviews in hospices but only 32% are available for hospital and 29% for community face-to-face reviews. Commonly, Consultants cover multiple facilities for face-to-face or telephone support.

4 VIEWS ON PALLIATIVE MEDICINE WORKFORCE PLANNING

4.1 UPDATING MEDICAL WORKFORCE RECOMMENDATIONS

The current recommendations for SPC (Commissioning Guidance for SPC: Helping to deliver commissioning objectives, December 2012)[9] describes the minimum workforce to support working week services.

Per population of 250,000, the minimum requirements are:

- Consultants in palliative medicine – 2 whole-time equivalent (WTE)
- Additional supporting doctors (e.g. trainee/specialty doctor) – 2 WTE
- Community SPC nurses – 5 WTE

Inpatient SPC beds minimum requirements: 20-25 beds with 1.2 nurse per bed ratio

Per 250 bed hospital, the minimum requirements are:

- Consultant/associate specialist in palliative medicine – 1 WTE
- Hospital SPC nurse – 1 WTE

At the time these recommendations were issued they were referring to the previous decade and did not consider the changes that will be brought about by the Shape of Training. It also recognised the difficulty of forecasting how palliative medicine would be able to answer the needs of non-cancer patients. It could not predict the work carried out by SPC in hospitals following the Mid-Staffordshire Hospital report through the involvement of the specialty in preparing hospital and community services for CQC visits. The emerging of Enhanced Supportive Care (ESC) as a newly commissioned entity, the growing volume of cancer survivors as well as the involvement of the specialty in Acute Oncology services were not anticipated. These recommendations are now insufficient to meet growing levels of need in the population.

Since the recommendations were issued, some hospitals have interpreted the above numbers as additive rather than inclusive. By this we mean that the population-based evaluation only applied to the community and specialist inpatient beds. The needs of hospitals were believed to be additional and based on their size accounting for involvement in End of Life care, ESC and SPC corporate role.

We would rather suggest a population-based figure in line with the Ireland recommendations of 2.2 WTE per 100,000 population or with Australia 1.5 WTE per 100,000 population, two countries with a comparable specialty development (page 17). The current UK population-based recommendations equate to 0.8 WTE per 100,000 population. We suggest that a new commissioning guidance and target population requirements should be determined by consensus between key stakeholders. We suggest that guidance should be based on best existing models that include all components of services provisions and supports the needs of all patients requiring Specialist Palliative and Supportive Care. We urgently need to start the process of evidencing and then adopting these new recommendations in line with those of the two countries with a comparable specialty development.

4.2 PROVIDING SEVEN DAY WORKING

With training occurring over multiple sites, current changes to the structure and terms of junior doctor training, and a predominant LTFT trainee workforce, unique challenges to the provision of a seven-day SPC service arise:

- With 32% working LTFT, combined with out of programme experience and parental leave, the average length of training is currently reaching 5 years.
- The new Junior Doctors in England contract will impact upon Stage 1 IM and HST availability to provide out of hours, on call cover and telephone advice will require “time of in lieu” during the “normal working week”.
- Shape of Training will result in a shorter length of time in specialty training that may influence voluntary sector hospices to fund specialty doctors rather than specialty trainees (StRs) that could potentially reduce training numbers.

The key clinical governance areas for seven-day working are threefold: structure, processes and accountability. When a service may be delivered across different settings by health care professionals who are employed by different organisations, have differing skills, varying clinical practices and different levels of understanding of the organisation with which they are delivering care, the governance issues become increasingly complex. Communication processes, continuity, operational issues and accountability are all key to safe delivery of cross sectoral and cross organizational services out of hours and across seven days. Notably, recent commissioning guidance has recommended that many services will require time and support to meet the levels of service suggested.

4.3 GROWING THE CONTRIBUTION OF SAS DOCTORS TO THE WORKFORCE

SAS doctors make a significant contribution to services in the voluntary sector to provide core staffing and out of hours (OOH) and weekend working. SAS doctors will need expansion and appropriate development to support service models, which require these doctors to be available on Saturdays, Sundays and Bank Holidays.

This career path may become an attractive option for those who do not want to train through the MRCP route or go through dual accreditation training.

4.4 SUPPORTING NURSING WORKFORCE

There are significant challenges facing the nursing workforce. It is difficult to recruit and retain to senior, advanced and consultant level nursing posts. Specific factors contributing to nursing workforce issues have been identified, including:

- Opportunities for personal / professional development
- Patient choice and preferences at the end of life
- Poor continuity of care
- Low staff morale
- Risk of burn out

MacMillan Cancer Support has made recommendations to address these identified risks to the nursing workforce. It may not provide the alternative workforce solution that it had been portrayed to be. The support of nursing colleagues may continue to be a potentially growing activity of palliative medicine clinicians of all grades.

4.5 INFLUENCING RETIREMENT AGE

The self-reported planned average retirement rate was 4-5 consultants per year in 2016-2020 increasing to 13-14 annually for 2021-2026 (RCP census 2015-2016).

The NHS needs to work harder to retain the talents of older doctors, according to a new investigation by the BMA: supporting an ageing medical workforce[10]. The BMA says the NHS risks losing a “valuable human asset” when doctors retire early. This is not just because of their clinical skills but also because of their ability to act as role models, supervisors, trainers and mentors. It says that the NHS cannot “easily” replace their experience or expertise. The report also says that older patients also place “high value” in being treated by a clinician of similar age to themselves. The BMA found that when considering retirement, health and wellbeing was the most important factor followed by workload and burnout. Job satisfaction and working patterns also play a significant role in the decision to retire. The most important factors that would influence a decision to work past retirement age are the ability to work flexibly, job satisfaction, having time to practise the most enjoyable aspects of medicine and support with workload. Providing flexible working arrangements was the most important way in which employers could support older doctors who are still in the workforce. The BMA says that the government must tackle the anomalies in the pension system leading to doctors to take retirement. “The medical workforce is ageing, and many experienced older doctors are finding that working in today’s NHS is too taxing on their work-life balance, health and wellbeing, particularly as they age, causing some to seek early retirement. Palliative medicine is already at the forefront of flexible working as 2/3 of consultants work less than fulltime. This is true for both male and female consultants. We should go further by allowing some consultants to work annualised working patterns to facilitate involvement with voluntary work abroad, short term carers leave or involvement in research or short-term project work.

4.6 INCREASING CCT OUTPUT

There has been almost no expansion of UK Consultants in palliative medicine in the last two years, with a significant number (66%) working LTFT (RCP Census 2017-18). The UK consultant in palliative medicine vacancies were 56 posts (43.9 WTE) in September 2018 (SAC data), with approximately 86 new posts in development in the next 5 years in addition to 68 retirement. Hence the current average annual number of about 30 doctors completing PM training is alarmingly inadequate to meet the existing and anticipated annual consultant vacancy rates.

Over the last 5 years, considering parental leave, LTFT in both male and female trainees, and out-of-programme experience, the average length of training has increased to 5 years.

The estimated need is for 60 StRs to undertake HST annually to achieve the number of CCTs required each year to fill the current consultant vacancies, the anticipated new posts to support the increasing workload of existing post-holders and the retirements. However, no increase in training numbers has so far been offered in the current financial climate.

There are regional variations in the number of Consultant WTEs per population. To address this, consideration needs to be given to the recruitment of additional funded National Training Numbers in the geographical areas with lower WTE consultants per population.

5 PALLIATIVE MEDICINE WORKFORCE IN IRELAND AND AUSTRALIA

5.3 IRELAND

The 2017 Review of the Palliative Medicine Workforce showed there are 38 'approved' (approved for government funding) consultant posts in palliative medicine. (One of these is a paediatric post). Separately, there are two specialists working exclusively in the private sector.

There were 61 non-consultant hospital doctors working in palliative medicine, 23 were on the Trainee Division of the register, including those doing basic specialist training, and those doing higher specialist

Ireland's ratio of Palliative medicine specialists is 0.8 per 100,000. The National Clinical Programme for Palliative Care (NCPPC) recommends that Ireland should ultimately increase the number of consultants in palliative medicine to 109 WTE, a ratio of 2.2 per 100,000 of the population, given population growth expectations, by 2026.

5.2 AUSTRALIA

The National Health Workforce Dataset (NHWDS) shows that there were 228 specialists in palliative medicine in 2015. With a population of 23,490,736 this equates to an actual ratio of 1:100,000. In terms of recommendations, the Australian and New Zealand Society of palliative medicine believe that palliative medicine specialists are integral to the functioning of a SPC Service.

The ratio of 1 (WTE): 100,000 population represents the minimum number of palliative medicine specialists required for a reasonable provision of service. In terms of industry benchmarks for the palliative medicine workforce, Palliative Care Australia (PCA) recommends 1.5 (WTE) per 100,000 population, which equates to a ratio of 1.6 (HC) per 100,000.

6 EXECUTIVE SUMMARY AND RECOMMENDATIONS

The Association for Palliative Medicine (APM) of Great Britain and Ireland Workforce Committee has compiled the 2019 palliative medicine workforce report to summarise the current workforce situation for the specialty extracted from 3 distinct sources (RCP census 2017, September 2018 palliative medicine SAC Data collection and the 2018 APM Workforce Survey).

Country	Number of **consultants** (WTE)		Number of **STR** (WTE)		Number of **SAS** (WTE)
England	**517**		**179**		**449** (250.7)
Northern Ireland	**20**		**7**		**26** (10.6)
Scotland	**49**		**15**		**32** (21.5)
Wales	**36**		**11**		**22** (14.6)
TOTAL	**622** (520.1 WTE)		**212** (185.1 WTE)		**529** (297.4)
Female / Male	475 76%	147 24%	180 85%	32 15%	Unknown ratio

Table based on 2017 RCP Census data for Consultants/STR and 2018 SAC data for SAS.

The “mean intended age of retirement”, for consultants in palliative medicine, is 61.2 years (2017 RCP census). The data indicates that over the next 10 years approximately 207 consultants in palliative medicine, representing 33% of the workforce, are likely to exit the workforce due to retirement. In addition, unscheduled retirement for various personal reasons will increase the percentage of the current workforce leaving unless we offer sabbaticals and highly flexible working for those prepared to continue to provide their precious skills to patients for a few more years.

In the last two years fewer than 35 STR per year completed their training (CCT holders) whilst an ongoing demand of between 50 and 60 consultant vacancies (SAC Data) across the UK were on offer. Success in appointing at Appointment Advisory Committees (AAC) varies considerably between the regions and countries of the UK. We only have data for England, Wales and Northern Ireland. It tends to follow the availability of local CCT holders. Over the period 2012-2016 the most successful regions in appointing consultants were London, East and West Midlands followed closely by North West, Yorkshire and Humber and Wessex. The least successful regions were KSS, Northern, Thames Valley and East of England with around 50% or less success rate. These regions need to increase their training numbers to “grow” their own future consultants. SAC data shows that 2 doctors successfully achieved specialty registration via the CESR route in 2016, with a further 4 achieving the same in 2017 and 3 in 2018. The 2018 APM survey showed that 11 of those who responded currently pursue this route, whilst 3 will apply for palliative medicine specialist training.

The major drivers of change to the future palliative medicine workforce are the changes in population health care needs, the transformation of palliative medicine training for future consultants in our specialty who will be dually accredited in PM and IM, and the new patterns of working including seven day working. Cancer services are still referring large number of patients to SPC. There is also a growing demand for services for other life-limiting conditions, especially those associated with severe symptom burden and complex clinical and ethical decisions – where referral is for clinical advice and holistic support. The pattern of referrals is also changing in hospitals where readmission rates are high in patients with complex clinical and social needs. This is likely to increase as the “shape of training” reform is implemented, and palliative medicine is more involved in the acute take.

The specialty must stand firm in claiming an increase of training numbers to compensate for on-call gaps and current and future dearth of CCT holders particularly in regions that struggle to recruit consultants at AACs. The current recruitment of just over 30 NTNs is too low given that existing funding may sometimes be left unused due to lack of pooling of funding in some deaneries.

This report suggests:

1. A review of the formula to define palliative medicine requirements of Consultant and SAS is needed. The existing commissioning recommendations are not clearly distinguishing the needs related to population size from those of acute hospitals. The latter are based on the number of beds available in each hospital independently of the population they serve. The risk arising from the current well-defined hospital requirement is that it may favour hospital posts above those of the community. We should also define clear minimum requirements for SPC both in the community setting and in SPC inpatient units(hospices).

   We would rather recommend a population-based figure in line with the Ireland recommendations of 2.2 WTE per 100,000 population or with Australia 1.5 WTE per 100,000 population, two countries with a comparable specialty development (page 17). The current UK population-based recommendations equate to 0.8 WTE per 100,000 population. We suggest that a new commissioning guidance and target population requirements should be determined by consensus between key stakeholders. We suggest that guidance should be based on best existing models that include all components of services provisions and supports the needs of all patients requiring Specialist Palliative and Supportive Care. We urgently need to start the process of evidencing and then adopting these new recommendations in line with those of the two countries with a comparable specialty development.
2. Recommendations for establishing 7 Day working in line with the best level of service.
3. Growing the contribution of SAS doctors to the workforce.
4. Continue supporting smart working with multi-disciplinary teams and providing support to nursing colleagues facing increasingly complex patients to be managed in the community and kept at home whenever possible and desirable. It should go hand in hand with outpatient and community work including requesting appropriately targeted investigations and interventions away from hospitals.
5. Influencing retirement age by offering highly flexible working to discourage early retirement.
6. Finally, almost doubling CCT output by increasing to **60 new trainees** appointed nationally every year to meet the growing demand in the right regions to rebalance the offer according to regional needs.

Palliative medicine is at a turning point in terms of delivering new service models with the advent of Shape of Training. We are called upon to champion the model of integrated care between community and hospitals to deliver on the GMC recommendations of increasing care in the community. We should not underestimate the important role of the charitable sector in providing high quality care in specialist centres which are increasingly integrated with NHS service provisions.

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