

RCPE



Royal College of Physicians of Edinburgh

Specialty Trainee Numbers 2014

**Response from the Royal College of Physicians of
Edinburgh**

June 2013

Royal College of Physicians of Edinburgh

Comments on Trainee Numbers proposed for Scotland for August 2014

The following recommendations reflect the detailed paper produced by the College in September 2012, updated by new information obtained in the past 9 months including that from the Specialty Advisory Committee (SAC) members in Scotland, the fill rates in round 1 of the 2013 recruitment process and the 2013 GMC trainee survey.

Key Points

The following recommendations are directly relevant to the current workforce challenges; most are the responsibility of the reshaping board, others fall to NES and the START alliance. The College is keen to contribute to the work of all parties.

- CMT numbers must be increased.
- StR numbers in acute medicine and geriatric medicine must be increased.
- Consultant capacity in specialties contributing to acute medical receiving must be increased
- Application rates to CMT and ST posts in Scotland must be monitored closely to be competitive with the rest of the UK.
- Attrition rates following CMT must be addressed.
- Emerging quality standards for CMT must be applied UK wide.
- Careers should be phased to protect “generalism”.
- The gender multiplier as applied to medical specialties must be reviewed and increased in many.
- International competition must be monitored carefully.
- Consultant job plans must support training responsibilities.

Increase Training Numbers

The College believes a combination of factors continues to argue strongly for an increase in trainee places in Core Medicine Training (CMT) to ensure all ST3 slots in the medical specialties are filled. In addition the College strongly recommends an increase in acute medicine and geriatric medicine StR places to deliver the required expansion in capacity at consultant level. Factors influencing these recommendations include:

- rising referrals and activity within the acute sector;
- incomplete recruitment and high attrition rates during training which result in gaps in the rota and add to the pressures on those trainees in post;
- continuing vacancies at consultant level (see below), and most importantly,
- ensuring quality of care and sustaining patient safety.

Vacancies at Consultant Level

The most recent vacancy factors published by ISD show consultant vacancies are increasing in the medical specialties with 58.3 wte in March 2013 (compared with 44.1 in March 2012) of which 11 wte have been vacant for 6 months or longer. The majority of these (43 wte) are in specialties contributing to acute medical receiving (19 in acute medicine and 8 in geriatric medicine) The situation is not improving. Data from the Scottish Academy External Adviser Service indicates that in the past 12 months (to end May 2013) there have been 79 appointment panels held for consultant physicians with a further 22 cancelled due to lack of applicants, in the main in acute medicine, geriatric medicine and gastroenterology. Five of the panels failed to appoint with the remaining 74 generating a total of 93 appointments. Exploring the data a little more closely reveals that the great majority of panels attracted 3 or fewer candidates and many shortlisted a single candidate for interview. The anticipated bulge of CCT holders applying for consultant posts is slow to appear in Scotland.

Improve the numbers applying to Scotland

Recruitment results thus far for 2013 indicate a marginal improvement in fill rates compared with 2012 but across the UK the fill rates for ST3 (for those specialties recruited nationally)

are still far too low at 87% for NTN, reducing to 76% when LATs are included. Scotland is performing slightly below the UK average at 85% dropping to 69% when LATs are included. In Scotland across all medical specialties we have 29 NTN vacancies yet to fill and 40 LATs. The expected bulge of trainees is not appearing in the medical specialties for a variety of reasons including trainees moving to general practice or to the lure of better prospects overseas.

The College suggests that a number of LAT posts could be converted to substantive training posts, where the rate and number of returning trainees permits.

The College acknowledges the early impact of the START alliance in terms of recruitment and would be keen to contribute to this valuable project.

Understand and combat attrition from CMT

It is impossible to over-estimate the impact of attrition in CMT and we must continue to strive to understand why young doctors choose not to apply for CMT or opt for alternate careers after CMT. The Joint Royal College of Physicians Training Board (JRCPTB), in association with the workforce unit at the Royal College of Physicians of London is undertaking a survey of career preferences of all CMT trainees across the UK. Results will be available later in the year. However we know from previous work and reports to educational and clinical supervisors that a combination of activity increases in acute medical receiving, limited access to specialty training, including practical procedures, staffing gaps and poor consultant morale all contribute to the unpalatable fact that few want to be the acute medical registrar or opt for specialties where there is a significant contribution to acute medical receiving.

The following 2 charts (A and B) illustrate the relative position of Scotland over the past 3 years in terms of overall trainee satisfaction as reported to the GMC through their annual surveys. Medical trainees in Scotland showed the lowest satisfaction across the UK and across the specialties in 2013 (Table A) and the position has not improved in the past 3 years (Table B).

Chart A : Trainee Satisfaction 2013

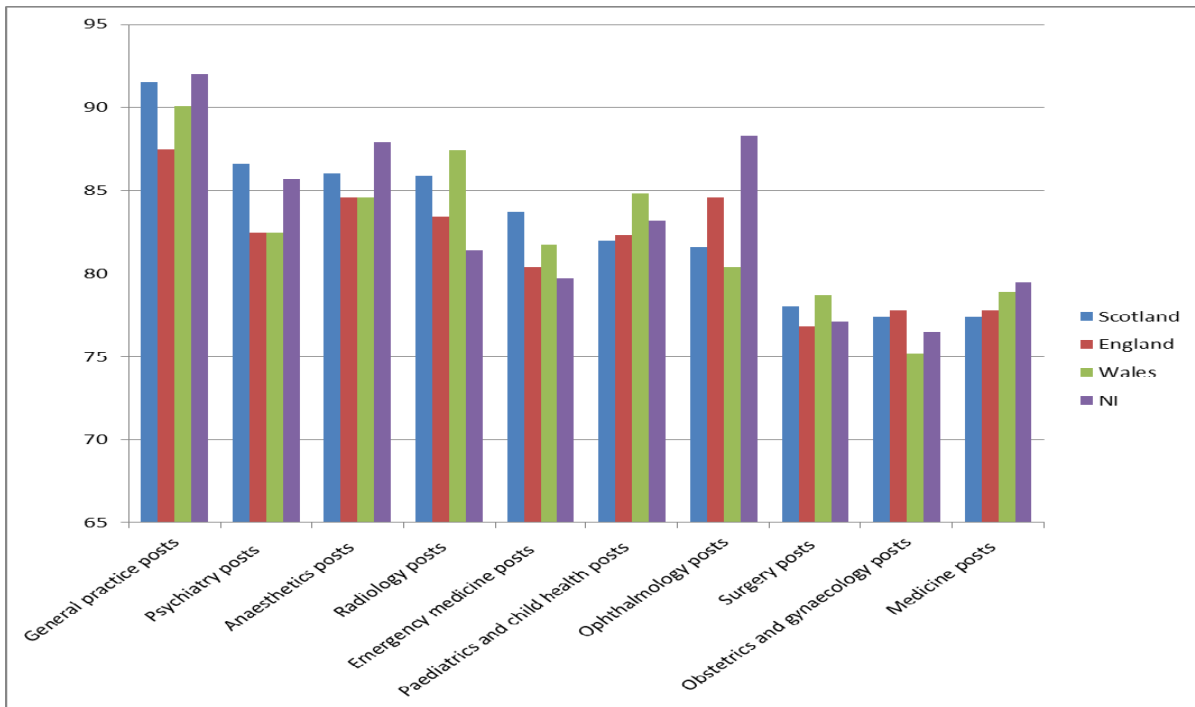
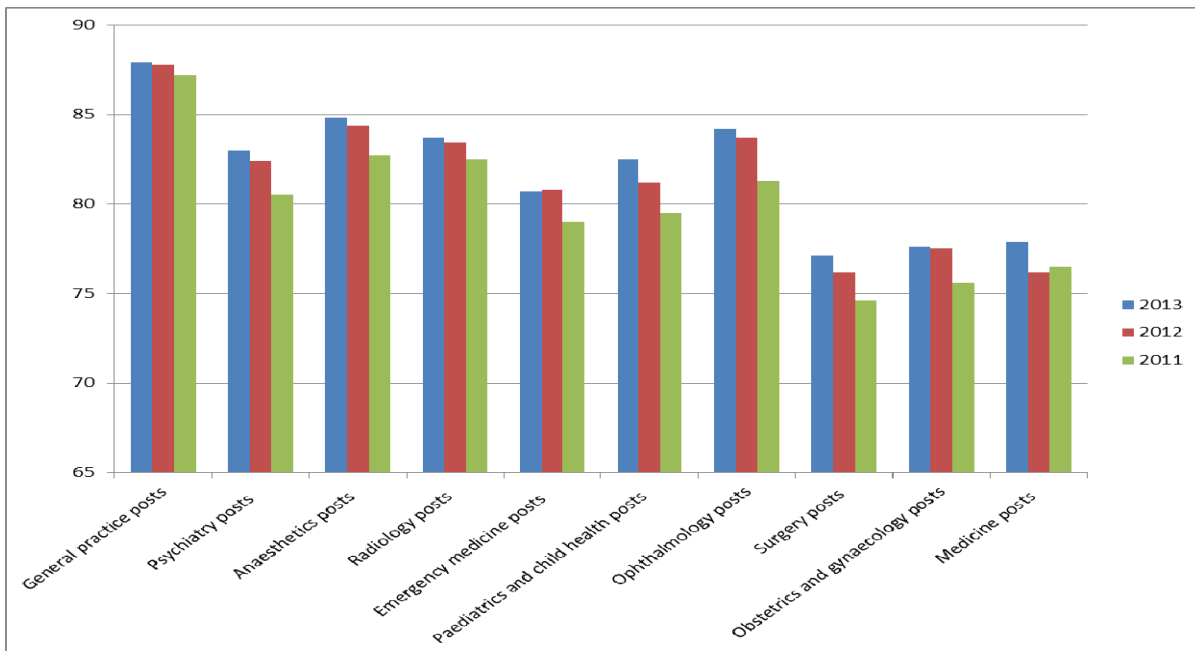


Chart B: Trainee Satisfaction (by Specialty) 2011-13



Ensure any Future Quality Standards for CMT are adopted across the UK

The JRCPTB is considering the development of quality standards for CMT placements to improve consistency in delivery of training standards and to raise expectations among trainees – examples of standards include the frequency and duration of meetings with

educational supervisors, access to simulation training, handover arrangements after nights shifts and attendance at outpatient clinics and procedure lists. The unilateral adoption of such standards in England would be disastrous and Scottish Deaneries must be supported to contribute to these developments. We recommend that this is monitored closely by NES and will ensure that JRCPTB thinking on this is shared in a timely manner.

Monitor International Competitors Carefully

Workforce planning in Scotland also requires a keen awareness of national and international competition. Discussion at the American College of Physicians meeting this year identified a future recruitment drive in USA to deliver the expansion of public health services following the Obama reforms and Australia and New Zealand continue to look very attractive to our young doctors. While anticipation of the precise impact of the Obama reforms on recruitment of trainees from the UK is difficult it should be obvious that unless this is taken into consideration the potential for even worse recruitment to medical specialty training is enormous and the actual effect on care delivered in Scottish hospitals disastrous.

Phasing careers to Protect “Generalism”

It is clear that the NHS in Scotland requires greater capacity in acute medicine to deliver a high quality service over extended hours to emergency medical patients. Encouraging trainees to achieve dual CCTs in GIM/AIM and their preferred specialty will improve their employability and address these important service needs. Trainees starting in dual specialties should be discouraged and/or prevented from dropping their commitment to GIM.

Gender Effects

The numbers of female trainees in specialties contributing to acute medicine continues to increase and the multiplier of 1.6 as applied to dermatology should be applied much more broadly. Gender preferences by specialty in Scotland indicate that the proportion of female trainees opting for medical specialties is rising and indeed in many is at such a level to question whether even 1.6 is an appropriate multiplier - 86% female in GUM, 63% in medical oncology and palliative medicine is fast becoming a male free specialty.

Therefore the College recommends a full review of the multiplier as applied to all medical specialties, in particular rheumatology, endocrinology and diabetes, geriatric medicine, acute medicine, renal medicine and respiratory medicine.

Improve the job plans and morale of current consultants

The damaging loss of morale among the consultant workforce, professional restrictions on newly appointed colleagues through 9:1 contracts and lack of time to train all contribute to dissatisfaction among consultants and, the College believes, transfers to trainees. Consultants are expected to supervise and assess trainees with no time allocated in their job plans are struggling to support them adequately, appear unapproachable and elusive and, through no fault of their own, are poor role models for aspiring physicians. The impact of 9:1 contracts on time to train and support trainees should be raised again with employers.

Data accuracy

ISD base data remains inaccurate in terms of the split between acute and general medicine and other medical specialties and requires thorough review to allow workforce planners to assess the gap between current staffing levels and the service requirements of health boards. This work has been held up pending the appointment and release from a training programme of a clinical fellow working with the Scottish Government and RCPE but results are expected to inform projections for 2015.

The 2011 physician census indicated that consultants across the UK in those specialties contributing significantly to acute medical receiving spend between 2 and 3 PAs in the acute take. A progressive move to extended working hours will not be feasible without an expansion in consultant support for acute medicine but the specialty commitment of these other consultants must not be forgotten. Therefore the College continues to call for expansion in numbers in those specialties *significantly* contributing to the acute medical receiving workload e.g. Acute Internal Medicine (AIM), Geriatric Medicine, Endocrinology & Diabetes, Gastroenterology and Respiratory Medicine.