

Workforce planning and trainee numbers for nephrologists

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CD Forum
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Workforce planning

An oxymoron!

JSC Workforce Group

- How many “consultants” do we ***need*** to manage the current and growing workload?
- How many trainees will complete training over the next 7-10yr.?
- Review trends in consultant appointments
- [Secondarily: How might working practices and the deployment of specialists change?]

Background-general

- Increasing numbers of doctors
 - 80% incr. med. students since 1996
 - ~7200 pa from ~2010

Consequences of large increase in numbers of doctors

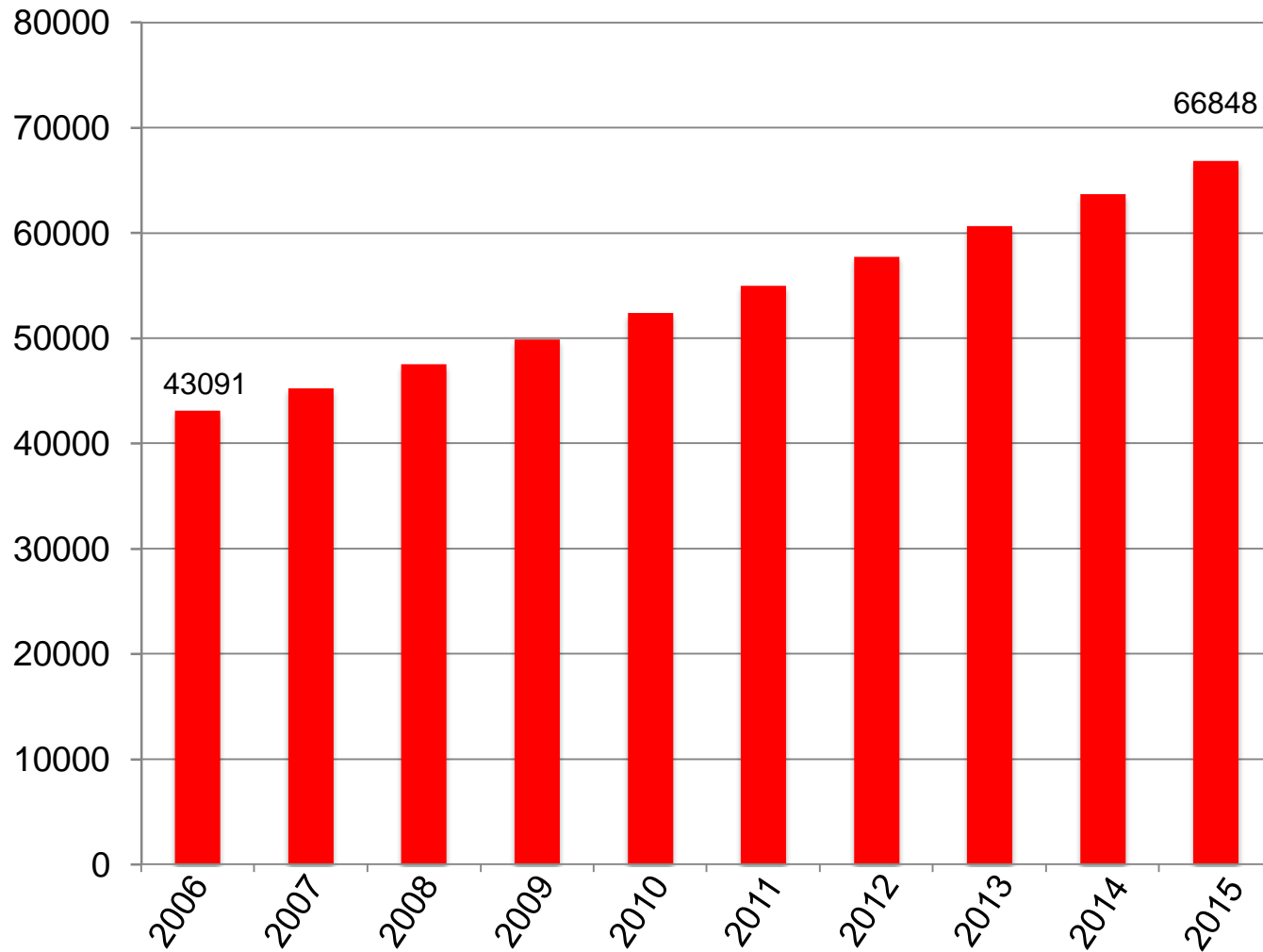
- The NHS can't afford 2-3x no. of consultants/GPs
- Only a proportion of Drs will get onto a post FY2 training programme
- By 2020 RCP Workforce Unit estimate there will be ~25% current no. trainees
- There will be many more non-training posts (not all fully trained ie CCT)
- A surplus of trained Drs will encourage specialist posts not paid as consultants

Changing working practices

- Tooke report:
 - need to urgently consider the bulge in medical graduates
 - consider “added value” of doctors

How many consultants/specialists
do we need?

Projected number of patients on RRT based on 5% pa increase (UKRR)



BRS National Renal Workforce Planning Group (2002)

- 1 physician/75 RRT patients
- 1 WTE nephrologist/100 RRT patients
- 2001 establishment: 290 (203 WTEs)
- Projected required by 2010: 803 (570 WTEs)

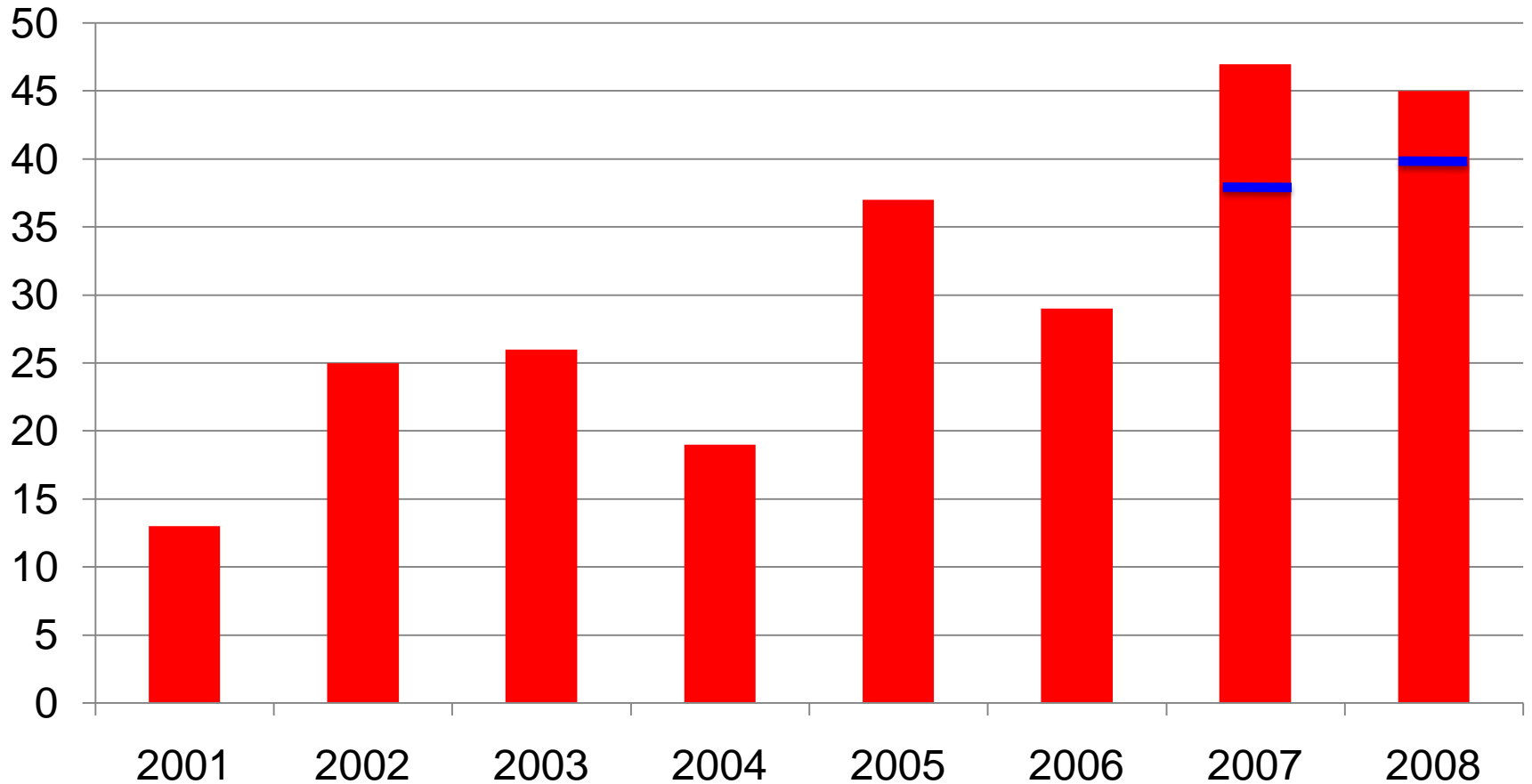
Response to BRS document

- DoH recognised need for urgent expansion of nephrology consultants
- 200 extra training positions offered (50 pa x 4yr)
- Not all were created because of lack of funding

What actually happened?

	Actual 2001	Projected 2006	Actual 2006	Projected 2010
nephrologists	290	688	362	803
nephrology WTEs	203	488	251	570

Consultant appointments England, Wales, N.Ireland



How many “specialists” do we need?

- Must be realistic, ***not*** aspirational
- Is the BRS 2002 figure realistic?
- 100 RRT (~50% transplant)
- Many factors may affect the estimate
- BRS/RA/RCP are reviewing this

Other factors to consider:
why we may need fewer specialists

- Reducing proportion of time spent on GIM

Other factors to consider: why we may need fewer specialists

- Reducing proportion of time spent on GIM
- Progressive decline over the last 5yr
- Opting out of GIM is happening
- GIM responsibility of renal teams diluted

Other factors to consider: why we may need fewer specialists

- Reducing proportion of time spent on GIM
- Specialist (& consultant) nurses, e.g.
 - vascular access
 - anaemia
 - bone management
 - living-donor coordinators
 - support of clinics and associated work:
 - transplant, dialysis (esp. PD), pre-dialysis, conservative management
 - prescribing

Other factors to consider: why we may need fewer specialists

- Reducing proportion of time spent on GIM
- Specialist (& consultant) nurses
- Physicians assistants...
- Role of Primary care

Other factors to consider why we may need more specialists

- Early retirement

Retirement

Whole of UK

2009	2010	2011	2012	2013	2014	2015	2016	2017	Total	% specialty
2	4	7	4	11	9	9	9	13	70	19.4%

Retirement intentions (2005 RCP census)

Before 60	At 60	Before 65	At 65	Undecided
6.2%	35.6%	15.1%	17.1%	26.0%

Other factors to consider why we may need more specialists

- Early retirement
- “Less than full-time” working

Part-time working

	% female
Current nephrology consultants	20%
Current nephrology trainees	38%
Current medical students	65%

- Increasing number of trainees plan to work part-time
- BMA survey of 2006 graduates:
 - 21% women anticipated p/t work for most of career
 - 48% women & 15% men would prefer to train p/t
 - 80% women & 50% men expected a career break

Reduced nephrology sessions

- Medical management
- Education
- Academics

Other factors to consider why we may need more specialists

- Early retirement
- “Less than full-time” working
- EWTD: reducing to 10PA job plans
 - RCP census indicates average nephrologist work 13.8 PAs....?!
 - ⇒ 30% extra nephrologists required

How many CCT holders are we training?

- No of trainees: ~400 registered with JRCPTB
- Average time in training?
- 5yr = 80 pa
- 6yr = 66 pa
- 7yr = 57 pa

Modelling consultant vacancies against number of trainees gaining CCT

- Incomplete data
- Multiple unknowns

-but here goes!

Model 1: assumptions

- 5% pa increase in RRT 2007-2015
- Nephrologist numbers increase at 5% to maintain current ratio
- 80 trainees get CCT pa after 2010
- RCP data on retirement are accurate and most do not retire <65yr.
- No significant change in # PAs worked or increase in p/t work



Model 1-number of specialists needed

Year	RRT estimate (5% growth pa)	No. Nephrologists needed	RRT/WTEs
2008	47508	400	119
2009	49883	420	119
2010	52377	441	119
2011	54996	463	119
2012	57746	487	119
2013	60633	511	119
2014	63665	536	119
2015	66848	563	119
2016	70191	591	119
2017	73700	621	119
2018	77385	652	119

Model 1- 1WTE/119RRT, 5yr training

Year	No. nephr. WTE	Incr no. WTE needed	Est. no. CCT	No. reaching 65yr	Est. XS trainees pa	Cumulat . XS trainees
2008	400					
2009	420					
2010	441					
2011	463					
2012	487					
2013	511					
2014	536					
2015	563					
2016	591					
2017	621					
2018	652					

Cumulative excess of trainees-different models

Year	1/119 5yr CCT						
2008	3						
2009	26						
2010	61						
2011	102						
2012	150						
2013	194						
2014	237						
2015	278						
2016	318						
2017	356						
2018	393						

Cumulative excess of trainees-different models

	1/119 5yr CCT	1/100* 5yr CCT					
2008	3	3					
2009	26	26					
2010	61	26					
2011	102	15					
2012	150	59					
2013	194	99					
2014	237	136					
2015	278	173					
2016	318	207					
2017	356	240					
2018	393	271					

* 1:100 ratio achieved by 2011

Cumulative excess of trainees-different models

	1:119 5yr CCT	1:100* 5yr CCT	1:100* 6yr CCT	1:100* 7yr CCT			
2008	3	3	3	3			
2009	26	26	26	26			
2010	61	26	26	23			
2011	102	15	11	-1			
2012	150	59	46	25			
2013	194	99	72	42			
2014	237	136	95	56			
2015	278	173	118	70			
2016	318	207	138	81			
2017	356	240	157	91			
2018	393	271	174	99			

* 1:100 ratio achieved by 2011

Cumulative excess of trainees-different models

	1:119 5yr CCT	1:100* 5yr CCT	1:100* 6yr CCT	1:100* 7yr CCT	1:100* 5yr CCT	1:100* 6yr CCT	1:100* 7yr CCT
					20% posts shared 50:50		
2008	3	3	3	3	17	17	17
2009	26	26	26	26	36	36	36
2010	61	26	26	23	22	22	22
2011	102	15	11	-1	-4	-8	-17
2012	150	59	46	25	34	21	3
2013	194	99	72	42	69	42	15
2014	237	136	95	56	100	59	23
2015	278	173	118	70	130	75	30
2016	318	207	138	81	158	89	35
2017	356	240	157	91	184	101	38
2018	393	271	174	99	208	111	39

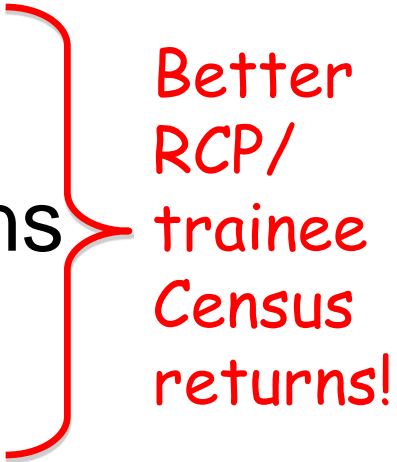
* 1:100 ratio achieved by 2011

Excess CCT holders might be less

- Significant increase in part-time working
- ?increase in independent units (Czar)
 - Who pays?
 - PBR may make this less feasible?
- Early retirements
- Reduced PA job plans
- ..but how large will these effects be?

Better modeling is needed

How many “specialists” do we need?

- Retirement intentions
 - Part-time working patterns/intentions
 - GIM/other non-renal activity
 - Average time in training
 - What is a reasonable ratio of nephrologist/RRT patient no.?
- 
- Better
RCP/
trainee
Census
returns!

What can our specialty do

- Little influence on consultant appointments
(but we can lobby!)
- Argue for an “appropriate” number of trainees
 - e.g. trained life ~30yr; training 6yr; ratio 5:1
2018, 800 specialist \Rightarrow $800/5=160$ trainees

What can our specialty do

- Little influence on consultant appointments
(but we can lobby!)
- Argue for an “appropriate” number of trainees
- Consider how trained specialists might be utilised

How might trained specialists be utilised if there are insufficient consultant posts?

- CCT holders are trained and will have clinical autonomy (& be incl. in physician/RRT calc.)
- “Unit Nephrologists” or “Specialist Nephrologists” deliver service
- Eligible to compete for more senior “consultant nephrologist” posts with wider brief

Medical training and careers – the employers' vision

Key points

- Employers favour a modular approach to postgraduate medical training built around care pathways that provide recognised 'credentialing' to support doctors' development over a range of flexible career routes.
- A multidisciplinary approach to workforce planning based on the needs of health service provision, with more refined tools and systematic engagement with employers, is essential.
- A clear balance between service delivery and creating a supportive environment for learning and development is required.
- A small planned oversupply in the medical workforce is desirable to enable a flexible response to changing staff and patient demographics.
- The future NHS will not require all doctors to progress to the current role of consultant. New roles and structures must be developed that will meet the needs of employers and patients with the flexibility to adapt the structure to suit local circumstances.

The medical workforce in the UK has received intense scrutiny within the NHS and in the public arena over the last 18 months. In delivering his report on the future NHS for the NHS Next Stage Review, Professor Lord Ara Darzi outlined a healthcare system which needed strong clinical leadership to succeed.

In the year that the NHS turned 60, this briefing sets out the employers' vision for the future direction of medical careers, ensuring that we are training the doctors that we need to provide high quality healthcare for all.

Background

NHS Employers, in consultation with employers and key stakeholders, set out its position on medical workforce issues in October 2007 in our publication *The future of the medical workforce*.

Difficulties recruiting to Modernising Medical Careers (MMC) training programmes in 2007 prompted parliamentary and independent inquiries, not just into the recruitment and selection systems, but covered the entire training structure

and what this will mean for our doctors of the future.

Since then the Douglas Review into MMC recruitment and *Aspiring to Excellence*, the final report of the Tooke inquiry into MMC, have been published. There has also been a Health Select Committee Inquiry, and a Government response to it, and lastly *A High Quality Care For All: the NHS Next Stage Review* final report and its associated report on *A High Quality Workforce*.

The reports all made clear suggestions and proposals for

- “Employers are clear that the future role for doctors on the specialist register, whether achieved through CCT or CESR, is going to be different to the current role of consultant, working as they do today”
- “They [employers] will continue to make use of consultant roles where this reflects value for money, but the expansion expected in the number of CCT and CESR holders cannot all be accommodated in the current consultant grade.”

- “....Some believea period of employment in a post-CCT career post focused on service delivery. This would provide a quality service for patients, an opportunity to acquire more experience, and would enable the doctor to become a better applicant for a ‘traditional’ consultant post after two to five years.”
- “More senior doctors would be responsible for the service succession planning for the next generation of clinical leaders.”