



Dr Tim Stephenson

Why you have to update your entry in the electronic workforce database – yes, YOU!

In order to plan for pathology provision across the country, we need to know where the troublespots are, where we're spread too thin, where we're not there at all. The only way is to populate this database and keep it up to date. And only you can do it. Our Director of Workforce Planning explains more, and updates us on the current situation

We need you!

The Electronic Workforce Database was launched on 10 September 2007. This database is intended for all pathologists, not just College members. It is housed at Clatterbridge in the Wirral, funded by the College and aims to contain information on workforce in all areas of pathology in the UK.

The first part of the database is live and involves individuals. It was populated with information from the College database (ALMS) and will be simple to check on an annual basis. The second part will involve Trusts, universities, Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs). It is envisaged that Commissioners as well as The Institute of Biomedical Science and other specialty organisations will have access to see where posts are funded around the UK, in which specialties, etc. in order to get a better idea of the recruitment and distribution of pathologists.

Unfortunately, at the time of writing, only 4.8% of the medically qualified College workforce have logged on and updated their details.

The next phase – management data on jobs, their trends and vacancies – starts imminently via Regional Workforce Leads, College Tutors and Clinical Directors, but the value of the database will be undermined if poor personal correction of data persists.

Workforce Review Team

The 2008 Workforce Review Team exercise is iterative and consultative. Its output is only a workforce risk assessment for pathology and, unlike in the past, this is not automatically linked to funding of posts, but designed to advise Commissioners. This means that we have to be persuasive, armed with comprehensive and sound data. The Workforce Database is key to that.

Workforce trends and uncertainties in the high-volume 'medical' pathology specialties

I am grateful to the specialty representatives on the Workforce Advisory Group for their help with this brief review of supply and demand in the high-volume specialties. For the sake of brevity, I have

not included data on the 'smaller' specialties and would be happy to discuss those in a future update. However, the picture of an unstable system, with potential mismatch not only between senior workforce supply and workload but also of inability of the training system reliably to match with consultant vacancies, emerges.

Histopathology

The NHS Cancer Reform Strategy 2008 predicts a 48% expansion in consultant histopathologist posts from 1081 to 1611 between 2006 and 2012. No indication is given to how this would be funded or to what extent Trusts would be mandated to establish these posts. We believe that establishment of these posts is largely going to be driven through the National Institute for Health and Clinical Excellence's Improving outcomes reports, some of which increase the amount of multidisciplinary team attendance and some of which stipulate double reporting of certain categories of tumours for the sake of patient safety. For example, *Improving outcomes for people with skin tumours including melanoma* (February 2006) stipulates double reporting and it is estimated that the 20–30 suitable specialist dermatopathologists will be inadequate for this. An additional 50–60 would be required over the next few years. Considering all areas of histopathology, then, the NHS Cancer Reform Strategy numbers may be realistic.

Haematology

The NHS Cancer Reform Strategy predicts a 21% expansion of consultants driven by cancer developments from 663 to 804 between 2006 and 2012. Similarly, there is no declaration of monies or mandate for this, but presumably this relates to the tail-end of implementing haematological oncology improving outcomes guidelines (IOGs) with increased complexity of tests and increased clinical presence.

With the Workforce Review Team, a continuing expansion of consultant numbers of 50% from now to reach 1500 by 2020, i.e. 45 new posts per year, has already been agreed. There will be sev-

eral problems in supplying such expansion even if it occurs, but none of these are a reason to forgo that expansion.

Details of the supply problems are: there already are 60 vacant posts. Existing consultant workforce has a rate of reaching 65 years of age varying from 13 in 2010 to 48 in 2015, with a total of 294 over 2008⁶–2018; but predicted early retirement increases this total to 341 over the same period with a slightly less variable annual rate between 27 (2010, 2012, 2013) to 57 (2008). Hence there is a potential crisis this year if all the predicted early retirements occur. There are 383 trainees but we do not know with certainty at what rate they convert into consultants per year, but with simple arithmetic it cannot be more than 50 per year, so a shortfall is inevitable. We need an annual increase of 20 new trainee posts to feed the necessary consultant workforce expansion.

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Microbiology

Demand for clinical microbiology services is both high and increasing since infection prevention and control remain high priority for the Department of Health (DH), together with the threat from resistant organisms, both local and from abroad.

There are 585 (529 whole-time equivalent [WTE]) medical microbiology/virology consultants in the UK. We have seen some expansion of numbers in recent years: a total of 54 consultants were appointed to newly-created posts over 2004–2007 (48 of these were in England).

Across the two disciplines of medical microbiology/virology, there is a vacancy rate of 9% with 60 unfilled consultant posts. Virology as a specialty is grossly understaffed, with only 59 consultants in UK (of whom 41 are NHS, seven are academic, eight are vacant and three are part-time). There has been a very small increase in virology consultant numbers, but the numbers and distribution of virologists, both medical and scientific, varies widely across the country and the target to aim for is ideally 120 (based on 1 per 500 000 population, approximating to present staffing levels in Scotland on a population basis). To achieve such a target would require a 9% increase in medical microbiology/virology consultant posts in the UK.

Over the next five years (2008–2012), approximately 150 trainees will gain their Certificate of

Completion of Training (CCT) in medical microbiology/virology and this will help address the number of retirements (50–80 depending on choice of early retirement), the current vacant posts (60) and some expansion of consultant posts. There are only 23 trainees in virology and these numbers would need to be doubled if we are to start to address the deficiency of consultants in virology.

Clinical chemistry

The projected headcount running up until 2021 is substantially lower than the target figure by approximately 60. 115 consultants in the UK provide a 24-hour, 7-day, single-handed advisory service and laboratories are now functioning over a longer working day. It would take a 40% expansion in consultant numbers to reach compliance with the European Working Time Directive.

Approximately 5.4 chemical pathologists are expected to retire per annum over the next 5 years and 72 anticipated over the next ten years. Approximately 40% of the workforce are aged over 55 years. The consultant vacancy rate is 3%.

Immunology

Consultant numbers in adult immunology will need to double in the next five years (an increase of approximately 60 posts) to achieve the desired workforce in consultant immunologists recognised by both the DH, The Royal College of Physicians and The Royal College of Pathologists, through *Consultant Physicians Working with Patients*.

The workforce projections that have gone in to the fourth edition (in press) of *Consultant Physicians Working with Patients* states that 114 WTE consultants are required to serve the population of England and Wales of 53.4 million.

The relevant paragraph is as follows: “On this basis, it is estimated that 114 WTE consultants in immunology are required to serve the population of England and Wales (53.4 million). This translates into one consultant immunologist per 513 400 of the population compared to the existing provision of one per 1.1 million of the population. This is 0.49 WTE for 250 000 population required, which is an expansion of 128%. This estimate is approximately in line with the DH’s own recent estimate of consultant requirements in immunology. Consultant numbers will need to expand by 5.5% per annum over the next ten years to achieve this figure.” None of these projections take into account the impact of the DH’s and House of Lords’ reports into allergy services, which recognise a major unmet service need that could generate a much larger need for consultant expansion in immunology and allergy for the benefit of patients. Again, there will be several problems in supplying such expansion even if it occurs, but none of these are a reason to forgo that expansion.

Details of the supply problems are: the College’s census recorded 59 adult immunologists in

2007 and 36 trainees. There are nine retirements due in the next five years and there has been one unexpected death. There are currently about ten un-filled posts in the UK and at least one in the Republic of Ireland. Consultant expansion will need to continue at approximately 10% per annum over the next five years to provide consultant jobs for these trainees and will result in 85 posts with a considerable number working part-time – estimate approximately 75 WTE posts. To meet the projected workforce needs for England and Wales alone (114 posts) in five years would require at least a doubling of trainee numbers immediately (100% increase) and a 20% increase in consultant adult immunologists.

Paediatric immunology and infectious disease posts in 2007 total 11 consultants and two trainees. This is grossly inadequate and requires massive expansion in trainee and consultant numbers. A

further 22 WTE consultants are needed and about 20 WTE trainees are needed over the next five years to meet workforce requirements.

Why your accurate personal data is so important

Until recently, consultant pathologist numbers (I am referring principally to histopathologists, haematologists, microbiologists, clinical chemists and immunologists) have been growing at an average rate of 5.2% per annum, but that masks deficits in certain specialties. Our early information is that growth has stalled, due largely to financial constraints upon NHS Trusts. Some posts have been frozen. Some of which were 'promised', but where there was difficulty in recruitment, have now been withdrawn and some have been replaced by other staff groups with a different range of clinical skills. The contraction has been seen in specialties such as clinical chemistry, and this contraction does not

UK members: please check your records are correct on the electronic database!



This multi-professional database is now available at:

www.canceruk.net/rcpworkforce.htm

UK College members can update their own records using their existing College website username and password. Please note that changes of address should still be sent to the College's Membership Department. If you need a username and password, please press 'Register' on the College homepage at www.rcpath.org

A helpdesk run by the database's designers is open 9am – 5pm Monday to Friday on 0870 840 8033

Figure 1: The screen is simple and easily completed
www.rcpath.org/index.asp?PageID=74

just refer to the conversion of medical consultant posts into clinical scientist posts – both types of senior posts have been reduced by some Trusts.

This stalling of consultant expansion needs to be replaced by genuine urgent expansion. Not only is the volume of pathology testing growing geometrically at the rate of about 13% per annum but the complexity, range, need for quick turnaround and clinical advice on tests is increasing. Increased automation and sophistication of analytical equipment alone will not provide for the provision of clinical advice and interpretation, which is becoming all the more important as the range of health professionals allowed to request tests widens, including some groups requiring more interpretation to be done for them.

I am grateful to Regional Workforce Leads for helping to provide this early intelligence on consultant trends at Trust level. The Leads' role will be changing with inception of the Electronic Database, but they will still play a vital role in providing early intelligence and helping to stimulate Trust directorates to supply management information on current and planned establishment of posts, vacancies and so on, to complement the personal data entered into the Database and provide regional overviews to the Workforce Advisory Group. I am revising the Guidelines for Workforce Leads nominated by Regional Councils to reflect this changing role.

Conclusion

To give a clear message, we need a comprehensively-completed Workforce Database, so please log on via www.rcpath.org/index.asp?PageID=74, view your existing data, check it and amend it where necessary.

The information is stored on a secure server and only used in aggregate form for workforce planning. The screen is simple and easily completed – see Figure 1.

Our message to the Workforce Review Team, to DH and to Commissioners is clear: consultant expansion has stalled and needs to be restarted. In some of the areas that we represent, this expansion needs to be substantial. The mere issuing of DH reports implying the need for consultant expansion will not lead to this unless there are new monies targeted towards this. If healthcare is funded only out of tariffs, and tariffs only pay for the existing levels of healthcare, it is not clear from where Trusts will identify the funding for such expansion.

In respect of disciplines such as pathology, where their impact on front-line patient care may be overlooked but is profound (pathology results underlie 70–80% of diagnoses), there is a risk that consultant expansion will not occur, with severe detriment to patient safety and throughput through the patient pathway, including the compromising of NHS targets.

Dr Jonathan Fielden, Chair of the Central Consultants and Specialists Committee, has extensively used the College's response in the British Medical Association's representation to the Secretary of State for Health over the need to restart consultant expansion, which shows the value of the College having accurate data.

Dr Tim Stephenson
Director of Workforce Planning