CENTRE
FOR
WORKFORCE
INTELLIGENCE

SHAPE OF THE MEDICAL WORKFORCE

STARTING THE DEBATE ON THE FUTURE CONSULTANT WORKFORCE

A DISCUSSION DOCUMENT FOR LEADERS

February 2012

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EXECUTIVE SUMMARY

This report, for leaders within the healthcare system, sets out the challenges and opportunities that employers, the medical profession and workforce planners face in relation to the future supply and shape of the consultant workforce. Looking ahead to 2020, the CfWI presents possible future scenarios, the associated risks and opportunities and sets out the need for urgent debate and action.

In 2010 the CfWI carried out a series of events to identify the areas that stakeholders wished us to prioritise when modelling possible future scenarios for the consultant workforce. This report describes the future scenarios that emerged from this process and their impact, should they become a reality.

This leadership report sits alongside the published *Shape of the Medical Workforce: informing medical specialty training numbers* (CfWI, 2011) which concludes:

- The system should reduce supply in a range of hospital-based specialties.
- The current growth in general practice is not strong enough to meet the predicted need.
- More evidence from service commissioners and employers on service demand would enable the system to make decisions on further specialty-specific changes across the training system.

The NHS currently relies on service delivery by trainees. A reduction in numbers of trainees would necessitate changes in the way services are delivered. This issue needs to be confronted if we are to continue to invest public money wisely to ensure the efficient supply of the trained doctor workforce.

It is vital that an urgent debate now takes place, to reach agreement on what the system should do next. This should include discussion on the interplay between the current trainee workforce and future service requirements, in the context of what is needed to secure high-quality and highly productive care for patients.

In this report, we share the results of a series of models that we have developed to project the configuration of the medical workforce. The models are built by projecting current trends and introducing a series of alternative scenarios for the future. We detail the scenarios in this report. The table below defines the seven scenarios.

Scenario	Overview
Scenario 1 – Business as usual	No changes are made to current patterns of recruitment and deployment of trainees and doctors. Trends continue as at present.
Scenario 2 – Shift to General Practice	There is a shift from hospital speciality training posts to General Practice to achieve a target 50:50 ratio.
Scenario 3 – Change in retirement age	Retirement is fixed at 60 years of age.
Scenario 4 – Set level of demand	The size of the consultant workforce is set using the Royal Colleges demand criteria.
Scenario 5 – Training consolidation period	A consolidation period is introduced during Certificate of Completion of Training (CCT).
Scenario 6 – Consultant-present service	Employers move to a service where a consultant is in the vicinity at all times (or able to return to the hospital within a short timescale) with accountability and responsibility for patient outcomes.
Scenario 7 – Graded career structure	A multi-level career structure is introduced which recognises different levels of expertise, competence and intensity of work.

The scenario modelling predicts that unless action is taken to alter the current trajectories, then there could be:

- more fully trained hospital doctors than the current projected demand suggests will be required
- an increase of over 60 per cent in the fully trained hospital doctor headcount by 2020
- an estimated £6 billion spend on total consultant[1] salary costs, an increase of about £2.2 billion on the 2010 figure, if all eligible doctors become consultants.

Should the decision be taken to continue the current trends in the supply of fully trained doctors, this offers a range of opportunities. These include the potential to drive up quality through increased competition for consultant appointments

[1] Consultant numbers are based on headcount and the pay bill is based on full time equivalent (FTE)

and the scope for developing new service models with new roles for doctors in community settings. The modelling also suggests that the numbers completing training overall would offer the capacity to move to a 'consultant-delivered or consultant-present' model of service, albeit with the need for significant rebalancing between specialties.

We recognise that discussion of a potential oversupply may raise concerns for hospital-based specialty trainees, many with expectations of employment as a consultant as part of their career progression. It is essential that trainees have access to better information to enable them make individual career choices. This will help secure future supply and a good return on investment, as well as help to maintain morale and motivation for current trainees who need to understand what their future is likely to hold.

This leadership report aims to stimulate a wide discussion and to gain consensus on the key areas of risk, such as unemployment, and the need to improve deployment of trained doctors across the system.

This debate should not continue in isolation. It should take account of wider workforce considerations, including skill mix, learning from successful models of care, and a whole-team approach to planning, already in place across England.

In addition, this debate should take account of the work of Medical Education England (MEE):

- *Better Training Better Care* (2011a): a programme that aims to improve patient care by improving the quality of training.
- *The Shape of Training* (2011b): a programme that is reviewing the roles and responsibilities of trainees and the day one consultant or GP, and the responsiveness of training programmes to the needs of patients, employers and trainees.

Recommendations for action

Over the next few months we will refine our modelling, incorporating your feedback, and will develop more detailed scenarios. This will include in-depth work with a range of employers to provide more detail at organisational and specialty level. In this way we intend to inform decision makers more effectively as they reach the conclusions that we believe to be necessary.

The **CfWI** is keen to continue to work with **Medical Education England** (MEE) and emerging **Health Education England** (HEE) and the **Royal Colleges** to:

- consider the data and information required for good medical workforce planning
- consider what is needed to improve longer-term workforce planning for the medical workforce as the new system emerges
- explore the commitment to plan and train for a consultant- or trained doctor-delivered service
- align this work with the work of MEE on the future shape of training.

MEE and the Joint Working Group (JWG) on specialty training numbers are asked to:

- continue adjusting future recruitment to training, so that it is more closely aligned with future service need, supported by the recent recommendations from the CfWI in *Shape of the Medical Workforce: informing medical specialty training numbers* (CfWI, 2011)
- agree an approach to offering quality information guidance to current and future trainees on career options, to mitigate disappointment in the future
- continue to develop thinking on flexibility and broad-based training to support future service needs.

Strategic Health Authorities (SHAs), deaneries and the emerging Local Education and Training Boards (LETBs) should engage with clinicians and work together to gain a good understanding of the future shape of their consultant workforce, and this should include:

- developing a greater understanding of career pathway options for doctors
- developing a clearer view on employers' needs for the medium and the longer term.

Employers are encouraged to:

- consider how they can maximise the benefits of trainees currently in the training pipeline
- consider the impact that any change in trainee numbers may have on service delivery

- consider other service delivery models that could maintain or improve quality and be more productive, such as a trained doctor-delivered service and skills mix changes
- keep abreast of the *Better Training Better Care* work of MEE and take account of, and plan for, emerging recommendations.

The focus of this report is the future **consultant** workforce and its supply. We will focus in other reports on the pressing parallel debate which has at its focus ensuring the supply of the General Practice workforce. In this report we refer to these needs only in so far as they interact with planning for the consultant workforce.

We are also working with employers, the Royal Colleges and others to improve our collective understanding of the current and future employment of doctors in roles which are not training posts, but are also not consultant posts, so that the models we develop can more fully reflect trends in the use of such posts.

Next steps

We encourage you all to contribute at our discussion forum at:

www.cfwi.org.uk/points-of-view/forums/medical-shape-2012-are-we-getting-it-right

Further comments can also be sent to moira.livingston@cfwi.org.uk

The deadline for comments is 30 April 2012.

1 CONTEXT

1.1 Key messages

- The current financial climate means it is essential for all organisations to consider the medium- and long-term plans for their workforce in order to maintain the highest standards of patient care.
- There is emerging evidence on improved outcomes for patients and productivity with a consultant-present model. Yet currently some services depend on trainees for service delivery, and too often trainees describe situations where they work beyond their competence or with less than adequate supervision, which is not good for patient care. The current model where trainees are needed for service delivery can impact on effective workforce planning. The work being led by MEE on the future shape of training should help shed light on future options.
- If safe and robust decisions on the future medical worforce are to be taken, it is essential that organisations work with their local partners to strengthen their workforce plans. This means employers being able to interpret NHS policy changes and local government commissioning intentions into new models of service delivery and consequent demand for doctors.
- The new education, training and planning system could provide an opportunity to clarify data flows, improve planning at local level and provide an appropriate forum for discussion about system requirements in the medium and long term for this workforce. All parts of the system should see this as a priority and each should play their part in supporting further discussion and decisions.
- Further work is needed to gain consensus on what is meant by a consultant-present/delivered service for individual specialty and service models.
- Planning the medical workforce should not be done in isolation. It should take account of the wider workforce and skill mix, maintaining a focus on high-quality, safe and productive healthcare.

1.2 Policy background

The NHS is facing unprecedented change with the challenge of finding £20 billion savings to be reinvested in front-line services. The new focus is on improved outcomes for patients supported by research, innovation and productivity (QIPP), *Equity and excellence: Liberating the NHS* (DH, 2010a).

Transforming community services; enabling new patterns of provision (DH, 2011b), will shift care closer to home and reduce unnecessary admissions. This will change not only the nature of workforce requirements but also where healthcare will be provided in the future.

The Health and Social Care Bill sets out a new vision for the delivery of health and public health services in England. The NHS Commissioning Board Authority, a special health authority and the shadow form of the NHS Commissioning Board, is now in operation. Subject to the successful passage of the Health and Social Care Bill through Parliament, over the next twelve months, the Board Authority will focus on designing the business model for the Board, which puts patients and clinical leadership at its heart. It will also work in partnership with the DH, clinical commissioning group leaders and GPs to agree the method for establishing, authorising and running clinical commissioning groups (CCGs).

Further work is being carried out to develop a new system for education, training and workforce planning. The consultation *Developing the Healthcare Workforce* proposed a new framework where healthcare providers – with their local clinical leadership – take a lead role in planning and developing the workforce, taking on the associated functions from strategic health authorities (SHAs) and their postgraduate deaneries. These Local Education and Training Boards (LETBs) will provide a forum for workforce development to support research and innovation, coordinating workforce planning activity, and commissioning education and training locally.

A new national body – Health Education England (HEE) – will be established to ensure that the health workforce has the right skills, behaviours and training, and is available in the right numbers to support the delivery of excellent healthcare and health improvement. HEE will provide national leadership; authorise and support the LETBs; promote high-quality education and training; and account for the investment of NHS education and training resources and the outcomes achieved. HEE will be responsible for some national functions, including medical recruitment. An Education Outcomes Framework will set out the outcomes against which HEE and the wider system will be held to account.

The CfWI will continue as an independent body, working closely with HEE and employers, supporting their work, as well as providing intelligence on workforce planning across health and social care systems.

The Future Forum endorsed this approach in its report in June 2011, and again when considering education and training in its latest phase of work. The DH has taken account of its findings when publishing further proposals for the education and training system.

1.3 Improving quality outcomes for patients

Each year the Secretary of State for Health issues a mandate which identifies improved quality for patients.

The recommendations of the *Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust* (DH, 2010b), include a strong focus on the importance of the NHS workforce and its critical role in ensuring high-quality, patient-centred care.

As the NHS considers options to improve the quality of services within current financial constraints, care is needed to avoid making decisions for the short term without due regard to the longer-term requirements. This is particularly important for the medical workforce where the training pipeline is long.

Informed by an integrated approach to service, financial and workforce planning, future decisions need to take account of safety and quality but also the impact of innovation and research on future services. This requires awareness of where innovative ideas are likely to impact on services in the foreseeable future, and why the capability of the workforce to both participate in and use research is so important.

Alongside this, we need to consider the changing nature of service provision, with changes in skill mix, a more team-based approach to healthcare, and changes to where healthcare is delivered; which can all impact on the future deployment of the trained doctor.

1.4 The future consultant role: a consultant-delivered service?

The NHS Plan (2000) committed to a significant expansion in the number of medical staff working in the NHS[2]. The plan offered the opportunity for employers to move towards providing a consultant-delivered service, linking this with improving quality of care.

[2] The NHS Plan for Reform 2000 set out investment plans for 7,500 more consultants, 2,000 GPs, 20,000 extra nurses and 1,000 more medical school places by 2005.

In *Aspiring to Excellence*, Professor Sir John Tooke (2008) reported that the focus on the role of the doctor 'raises issues about the roles of other members of the contemporary healthcare team which require exploration'. He went on to say that the 'debate about the nature of the Certificate of Completion of Training (CCT) holder roles has been reignited, the resolution of which is crucial'. The report also recommended an extension to the duration of GP training which, if implemented, would have a significant impact on the shape of the workforce in future years.

Professor Sir John Temple's 2010 report *Time for Training: A Review of the impact of the European Working Time Directive on the quality of training*, emphasised the need, if we are to continue to improve the quality of healthcare in England, to maximise all opportunities to ensure doctors are trained to the highest level. In particular, in noting that traditional training models often failed to do this, he commented that 'consultant ways of working often support traditional training models' and that despite significant consultant expansion (60 per cent over the past 10 years), doctors who are not fully trained 'are still responsible for initiating and frequently delivering the majority of out-of-hours service, often with limited supervision'. The report highlights that other models of service delivery are safer and better for patients.

In particular, the report made three key recommendations:

- a consultant-delivered service where consultants must be more directly responsible for the delivery of 24/7 care
- consultants working more flexibly to deliver high-quality training and service
- clear alignment between service need and the number of new CCT awards, in terms of workforce planning.

Providing high-quality, safe, innovative, patient-centred care is core to the NHS. There is currently a debate around the different models of service delivery that will support this aim. The current climate of financial constraint accelerates the need to review and consider recommendations and options that emerged from the Tooke and the Temple reports.

1.4.1 *Better Training Better Care*

Medical Education England (MEE) has commissioned *Better Training Better Care* (2011a): a programme of work that aims to improve patient care by improving the quality of training through the delivery of recommendations from the Temple and Collins reports referenced in this section.

These reports called for better use of the expanded consultant workforce in response to concerns that service commitments may compromise training and

that some trainees feel expected to practise beyond their level of competence without appropriate supervision.

Better Training Better Care (2011a) sets out to:

- identify, pilot, evaluate and disseminate good education and training practice
- improve curricula and training frameworks to ensure training is fit for providing safe and effective patient care
- review training programmes to make them more responsive to the needs of the service and trainees.

MEE's *The Shape of Training (2011b)* work, governed by an over-arching sponsoring board comprising UK-wide representation, builds on these themes and focuses on the shape of the training programme, rather than the shape of the workforce.

It has four themes:

- roles and responsibilities of trainees and the day one consultant or GP
- responsiveness of training programmes to the needs of patients and society
- responsiveness of training programmes to the needs of employers and the service
- responsiveness of training programmes to the needs of trainees.

The project has identified four tensions within the current system that reforms must address: service versus training, generalism versus specialism, flexibility versus value for money, and innovation versus destabilisation.

The group has identified relevant projects under various stages of development and the next stage of the work will identify those deserving further support or piloting.

1.4.2 Policy and professions position on a consultant-present service

The NHS in England has been moving towards a model where a far higher proportion of care is delivered by doctors who have completed their training. More recent discussions have also focused on whether this means a service delivered by consultants, a service where consultants are present, or a service delivered by trained doctors.

There is professional consensus from many of the specialties on what this means in practice, and an emerging body of evidence that confirms the benefits to patient care and productivity when consultant-delivered or present services are implemented.

We have engaged with stakeholders in preparing this report and have explored these models in more detail. When developing our scenario models we used a working definition for consultant-present, which is one where a consultant is in the vicinity at all times (or able to return to the hospital environment within an agreed short timescale with employers) with accountability and responsibility for patient outcomes. In addition, this definition recognises that a proportion of clinical services are carried out by doctors in training, but these doctors are considered supernumerary and so the resources to deliver the service exist within the practising consultant workforce.

We recognise from discussions with employers and the medical profession that the nature of a consultant-present service will vary by specialty and in relation to the type of services provided. For example, in Paediatrics there is consensus that a consultant should be present 24/7 in their consultant-delivered model, whereas in Emergency Medicine there is consensus that there should be a consultant present 18 hours a day, seven days a week (18/7). Further work is needed to fully understand the range of scenarios that are labelled 'consultant present' and to understand what this means for the healthcare system.

The preliminary list used for the modelling in this report and tested with stakeholders from the medical profession and employers is included in annex 1. This list is being adapted as we progress this work by carrying out a deeper analysis with trusts and with specialties.

1.4.3 Consultant-present services and the impact on quality, safety and productivity

There is consensus across specialties that these models can lead to improved quality, safety, productivity and efficiency. We present some of the emerging evidence below. Many specialties have a different view on what consultant-present care means for their specialty, and this is different across specialties. However, there is a consensus across specialties that consultant-present services can lead to improved quality, safety, productivity and efficiency gains. Further views are presented in annex 2.

In 2008 the Academy of Medical Royal Colleges reported, following a review of the available evidence, that 'there is clear evidence that care delivered by trained specialists is associated with better patient outcomes' and 'higher levels of satisfaction' (Medical Workforce Project to identify the added value Doctors bring to the healthcare team, 2008). The Academy recognised that further evidence was required and after receiving written and oral evidence and carrying out an extensive literature review, in their report *The benefits of consultant-delivered care* (January 2012), the Academy concludes that

> '*the benefits of consultant-delivered care should be available to all patients throughout the week and recommends that work should be undertaken by clinicians and employers to map out the staffing requirements and service implications of implementing a consultant-delivered service throughout the week'.*

The *National Confidential Enquiry into Patient Outcome and Death* (NCEPOD) conducted an in-depth study into the process of care of patients who died in acute hospitals within four days of admission. It found that in 25 per cent of cases there was a clinically important delay in the first review by a consultant, and that consultant involvement in assessment and diagnosis became less frequent in the evenings and at night. The report recommended that hospital services should be organised to ensure that patients have access to consultants whenever they are required, giving support for the consultant-delivered service (NCEPOD, 2009).

The NCEPOD also looked at the prevalence of death among elderly patients admitted to hospital with a fractured neck of femur. Whilst recognising the diagnosis for this condition is usually straightforward and can be undertaken by junior staff, in the case of elderly patients NCEPOD stated 'most had significant co-morbidities, and the recognition of these, subsequent optimisation, treatment planning and decision making requires senior input'. The report supports the view that, for some services, a trained doctor (or senior trainee) being available to make key decisions, leads to better outcomes for patients (NCEPOD, 2010).

One study in 2009 looking at in-hospital mortality in early August (when newly qualified doctors start work in NHS hospitals) found evidence that patients admitted on the first Wednesday in August have a higher 'early death rate' compared with patients admitted on the previous Wednesday. The authors concluded that this related to the lack of effective supervision of newly graduated doctors (Jen, et al., 2009). Also the 2011 Dr Foster Hospital Guide said that the hospitals with the fewest number of senior doctors available at weekends have the highest mortality rates.

The Collins report highlighted the quality and safety issues in the training environment for Foundation Doctors. The report found evidence of 'unacceptable practice in terms of the deployment and lack of supervision (of trainees) occurring in some places, which may affect patient safety' (Collins, 2010)

There is a growing body of evidence and emerging consensus from the medical profession about the importance of a consultant or trained doctor-delivered model of care to improve outcomes for patients and to provide more productive care. Many of the Royal Colleges have supporting policy documents that provide evidence of the benefits to patient care, as well as to training of the future generation of doctors.

Later in this report we will look at what this could mean for training numbers and for financial planning.

1.4.4 Reconfiguration of services and impact on work patterns and numbers

In addition to the move towards a consultant-present service, the likely reconfiguration of services, such as towards a smaller number of larger emergency units and a more devolved pattern of elective services, has the potential for significant impact on both consultant work patterns and numbers. Further analysis is required to understand the full impact this will have on the service. The work in this report starts this process.

1.5 International comparisons

In addition to modelling the situation in England the CfWI has also reviewed what is happening across Europe.

The European Union (EU) green paper on the European workforce for health, (Commission of the European Communities, 2008) shows that while EU countries have very different perspectives on the needs of their medical workforce, they all face similar problems. These include an ageing population, increasing public expectations, an increasing proportion of women, who are more likely to work

part time than men in the medical workforce, increasing worker mobility and, most importantly, limited finances (Goddard, 2010).

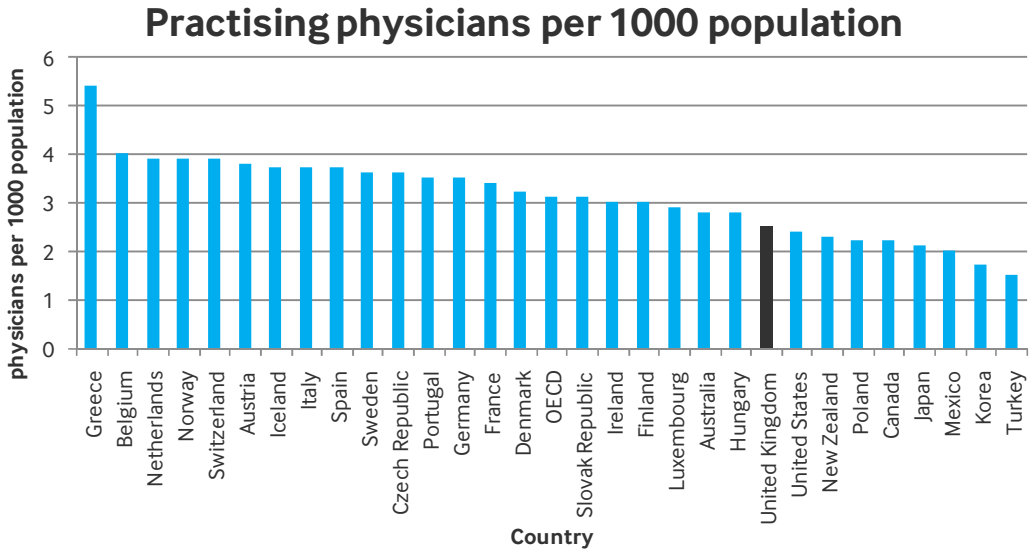
Across the Organisation for Economic Cooperation and Development (OECD) countries, healthcare systems are also under stress. They too face steadily rising demands for healthcare and pressure to contain costs. To assist in healthcare reforms, policymakers are looking to international comparisons to understand how different countries operate.

The OECD publication *Health at a Glance* (2009) provides background data that can help inform choices. This report shows that hospital admission rates have gone up in most OECD countries over recent decades and that the average length of stay has become shorter.

There are several European Economic Area (EEA) countries with more than three physicians per 1,000 population, while the UK has about 2.5 physicians per 1,000 population. (Figure 2) However, OECD countries have different definitions of physicians and therefore direct comparisons are not always helpful.

The UK continues to sit mid-table when comparing total OECD countries' health expenditure for 2008 as a percentage of gross domestic product (GDP).

Figure 1: Practising physicians per 1000 population



Source: *OECD (2010) OECD Health Data 2010*

When making comparisons across countries, we need to recognise that we are not always comparing like with like, since different countries will utilise a different healthcare workforce to undertake the same activities. However, based on the

current data, the UK is below the average for OECD countries for ratio of physicians per 1,000 population.

The linear trend from OECD data suggests that by 2020 the UK will have an estimated 3.5 physicians per 1,000 population. However, the trend for other OECD countries shows an increase and therefore the current planned expansion would continue to leave the UK around the mid-point for the range of ratios.

The current training and level of qualification, as well as definitions, do vary across OECD countries. But we can see the same shared challenges and response across OECD countries, such as to increase the numbers of trained doctors.

Further work is needed to understand what we can learn from other countries, in particular around service delivery models, models for training and the way we deploy trained doctors.

1.6 General Practice and primary care

We recognise that the future medical workforce needs to be understood as a whole. For the purposes of this preliminary work, General Practice and the wider primary care workforce is out of scope and will be the focus of more detailed work later this year. The impact of proposals in *Equity and Excellence* (DH, 2010a) and the policies to move care closer to home and to transform community services, could impact on choices doctors in training make, and in the shape of the primary care workforce.

The CfWI has produced a report on the General Practice workforce (as part of the *Shape of the Medical Workforce: informing medical specialty training numbers (2011).* This report recommends that England continues to increase the number of GP training posts so that we achieve a total shift in numbers of entry-level posts from 2700 to around 3250 within four years. We recommend this is achieved by reducing national training numbers (NTNs) and core training opportunities in hospital-based specialties. This figure is required to maintain the growth in the GP workforce at historical levels and achieving this expected growth in supply, even with this increase in trainee recruitment, is dependent on maintaining the trend of around 680 returners and international recruits into GP posts each year.

The CfWI is planning a deeper analysis, working with the Royal College of General Practitioners, in the coming months.

1.7 The academic workforce

The development of new advances in medicine and technology is important to improve outcomes for patients. Clinical academics make a substantial contribution to the provision of high-quality care and carry out research and support technological developments that will lead to improvements in outcomes for patients.

We recognise this important part of the medical workforce, both as trainees and as academic clinicians in hospitals and primary care. For the purposes of this work, however, this workforce has not been subject to a particular focus for analysis. For a more detailed analysis, please see our *Shape of the Medical Workforce: informing medical specialty training numbers* (2011) and associated workforce fact and summary sheet which are available at www.cfwi.org.uk.

We will continue to refine our understanding of this important part of the workforce and the impact of changes in the education and training of doctors on the need for medical educators.

1.8 Preliminary work by the CfWI

This report is part of the ongoing work within the NHS to improve understanding. If the NHS is to reap the benefits of designing and delivering the most productive, high-quality services, we need to understand the potential for improving outcomes for patients through:

- new approaches to service delivery
- the shift of care closer to home
- increasing flexibility within the medical workforce
- new roles and responsibilities within clinical teams.

The medical workforce has a long run-in time from the point of starting postgraduate training to attaining a CCT. This can take from 5 to10 years. This emphasises the importance of planning ahead. When we then consider that medical students in their first year will attain their CCT between 10 and 15 years from now, we are already investing in the future medical workforce for 2020 and we need to maximise this investment to benefit care to patients.

2 DEVELOPING THE SCENARIOS

2.1 Key messages

This section contains an explanation of our modelling and the data used to inform the modelling, including definitions.

- Recognised validated data sources have been used in our modelling.
- The future scenarios modelled emerged from stakeholder engagement.
- Where consensus on definitions, such as for consultant-delivered or present and specialty-specific definitions were not available, consensus was reached by engaging with professionals and service.

A technical guide will be available shortly and readers can register to attend workshops revealing the detailed modelling behind the work.

The CfWI uses data provided by key parts of the system. There are discrepancies in data recording and issues with quality. Definitions vary across the system, making consistency of data a problem. This can detract from the real issues that need to be debated. Further work is needed to align data systems for the medical workforce, to improve data integrity and support effective forward planning.

Defining the scenarios

The table below defines the seven scenarios. Further information on the assumptions made and the modelling approaches used are contained later in this chapter and in more detail in the technical report accompanying this document and available at www.cfwi.org.uk.

The CfWI has organised a series of events (the 'Open Box Reveal') where we share the detail behind our modelling. If you wish to attend one of these sessions then contact enquiries@cfwi.org.uk for further information.

Scenario	Overview	Description
Scenario 1 – Business as usual	No changes are made to current patterns of recruitment and deployment of trainees and	All doctors from F1/F2 go into specialty training.

	doctors. Trends continue as at present.	CCT holders become consultants in the same proportion as the historical distribution. Retirements from consultants and staff and associate specialists (SAS), associated grades and trust doctors (TDs) follow the historical distribution.
Scenario 2 – Shift to General Practice	There is a shift from hospital speciality training posts to General Practice to achieve a target 50:50 ratio.	As scenario 1, but not all doctors enter specialty training. There is a 17.5% reduction in existing ST3 training posts to account for the shift to General Practice.
Scenario 3 – Change in retirement age	Retirement is fixed at 60 years of age.	As scenario 2, but all consultants and SAS, associated grades and TDs retire at 60.
Scenario 4 – Set level of demand	The size of the consultant workforce is set using Royal Colleges demand criteria.	As scenario 1, but requirements for consultants are set at the level predicted by the Royal Colleges.
Scenario 5 – Training consolidation period	A consolidation period is introduced during CCT training.	As scenario 1, but 50% of trainees accept the opportunity to work for a year at ST4, before returning to where they left off to complete their training. There is no attrition during the consolidation year.
Scenario 6 – Consultant-present service	Employers move to a service where a consultant is in the vicinity at all times (or able to return to the hospital within a short timescale) with accountability and responsibility for patient outcomes.	Trainee numbers are adjusted to give the required number of consultants. It is assumed that all consultants work 10 PAs, and service configuration does not change. Apart from the exceptions described below, the current five-day-per-week service with out-of-hours commitment is assumed. Specialties that are already consultant delivered are treated separately. For some specialties the number of consultants is increased to allow for 24/7 working or a seven day-per-week service assuming between 8 or 10 hour days.

Scenario 7 – Graded career structure	A multi-level career structure is introduced which recognises different levels of expertise, competence and intensity of work.	Three bands, A, B and C, are introduced. Existing consultants are split with 10% in band A, 40% in band B and 50% in band C. Band A is the entry salary band and band C the highest. Consultant salaries are not changed. New consultants enter and remain in the lowest band for the duration of the modelling. As consultants retire from bands B and C they are not replaced.

2.2 Supply and demand modelling

Each scenario modelled in this report is based on a supply model with different assumptions applied. The assumptions range from varying the total number of doctors in training to changing the career structure of consultants. The supply model follows the well known stock-and-flow method, where we study the relationship between the joiners (newly qualified doctors with CCTs), the leavers (retirements and other non-retirement exits from the workforce) and the existing workforce (current workforce) to give the forecast workforce. Factors such as participation rates and actual length of training are embedded within the model as a delay factor.

2.3 Scenario generation to modelling

The scenarios emerged from a wide consultation exercise across the health sector. They consider the impact of different sizes of workforce, training, service delivery and career steps. They are not the only possible scenarios but they were identified as areas of interest by stakeholders. It is possible to combine scenarios and develop new scenarios recognising that employers will consider a range of options that work best for the services they provide and so combinations of different future scenarios may well support employers in understanding the impact of a range of decisions or emerging situations they come across.

Each of the scenarios was analysed using a workforce modelling tool specifically developed to predict consultant workforce numbers to 2020. Outputs of the scenario modelling exercise were then analysed to assess

- deployment of the medical workforce
- workforce numbers

- potential salary costs.

2.4 Data sources

A range of data sources (Table 1) was used to populate the model, including the NHS Information Centre (IC) Census and statistics from the Office for National Statistics (ONS). These data sources have gone through validation and assurance processes and are widely recognised. The iView data used in this report is provisional management information which has subsequently been updated by finalised published information.

Table 1: CfWI data sources

SOURCE OF DATA	DATA USE
Office for National Statistics (ONS) Population estimates and forecasts (2008)	Used to assess demographic drivers of demand growth
IC Census from the NHS Information Centre for Health and Social Care (published in 2010)	Gives the size of the current workforce and is the baseline for supply modelling as well as retirement calculations
NHS iView provisional management data, accessed in October 2010 and subsequently overtaken by finalised published information	Consultant and specialty training salary calculations
IC Deanery monitoring (2009 data) [NB at the time of this report there continueto be inconsistencies in the 2010 data and so 2009 data has been used]	Number of doctors in training to CCT, validated with colleges, also attrition rates (see below)
CfWI intelligence and discussions with the Royal Colleges	Used as input to supply modelling for attrition rate assumptions
IC Salary of doctors by age band and Medical Pay Circular (2010) from NHS Employers for pay scale of newly qualified consultants	Used as check for pay bill calculations of gross salary (pay bill excludes all other workforce costs)

Although the quality of data in the NHS has improved greatly in recent years, there are still variations in reported numbers between some data collections. This

may be due to errors in collection and coding, or data being updated at different times. Our approach recognises that all data will have errors and inaccuracies. To reduce these variations, aggregated data collections were used and triangulated where possible. Where reliable data was not available, for example on retirements or maternity leave, assumptions were made based on the best intelligence available.

2.5 Out of scope

The supply model and scenarios do not consider inflation or quantified productivity gains. The scenarios do not focus on individual specialties, nor do they identify specific service models. Instead they provide a high-level approach, which is informing more detailed work with specific services and specialties.

2.6 Definitions used in the modelling

In order to model the **consultant salary costs,** actual salaries were taken from NHS iView provisional management data (which has subsequently been overtaken by finalised published information) and the assumption was made that new CCT doctors would enter at the lower end of the consultant salary scale. The actual salary includes clinical excellence awards as well as the total number of programmed activities (PAs). iView does not allow a deeper analysis into the actual number of PAs a consultant works. .

For the purposes of this report we have presented workforce numbers as **headcount.** The CfWI model uses **full time equivalents** (FTEs) as well as headcount in the calculations. However, calculation of FTEs requires assumptions around participation rates, including changes in the rate over time, and the FTE needed to deliver a specific level of service. This area requires more in-depth investigation, in particular, in relation to the sensitivity of model outputs to changes in participation rates. Headcount allows us to focus on the scenario assumptions and findings, and not on the FTE assumptions. FTE numbers are available, if required, from the CfWI.

It is also important to note that when considering the whole medical workforce, evidence suggests that trainees who train flexibly often choose to work as a full-time consultant. We appreciate that this varies across specialties; however, the models in this report do not analyse individual specialties, although we recognise this work is needed and will be the focus for further work.

When considering the impact of the training pipeline we believe that the headcount is a more reasonable figure to focus on, as the actual headcount will more closely reflect the numbers of doctors seeking consultant posts.

The CfWI is conducting a deeper exploration with a range of specialties and organisations which will help us understand how **programmed activities** (PAs) relate to FTEs in a more specific way. Our modelling does recognise that trusts employ consultants on varying numbers of PAs according to their current job description and we make the assumption in modelling that the actual salary of a consultant will include the variations in PA level. Royal College surveys show that the actual number of PAs worked is more than is currently recognised in PAs paid by employers.

While we recognise that over-participation is a feature of today's consultant workforce, we do not have the information to calculate the cost of the additional PAs. This will be a focus for the next stage of modelling, as this data is only available from employers.

For the future scenario modelling of the consultant-delivered service in this report, we assume every consultant in the future will be on a 10PA contract.

Trainee participation rates were based on NHS IC data and deanery monitoring from 2009. This showed an increasing number of trainees in slot shares, rather than standalone part-time training posts. However, the total numbers remain relatively small as an overall percentage of trainees. This information will become more meaningful as we model individual specialties.

This and **other participation** effects were incorporated into a delay factor that was embedded in the model.

Attrition was based on deanery monitoring data from 2009 and information from the specialty societies and Royal Colleges.

When modelling the **three-tiered consultant model**, we recognised that the scenario that we have modelled was only one possible future scenario. Further scenarios can be modelled as requested by employers and the profession.

2.7 Caveats

The modelling approach combined all hospital specialties and it should not be assumed that the impact would be the same for specific specialties to the same degree, because of recognised differences between specialties. More in-depth work therefore will be done to explore the potential outcomes of the scenarios in specific specialties.

All of the scenarios are modelled for the consultant workforce and do not take into account savings that can be made by changing the shape of the rest of the medical workforce. Further work needs to be done but requires more accurate

workforce data, available from individual employers, and so will form part of the work in coming months with employers.

In addition, this work does not specifically review the variable impact of the feminisation of the workforce in particular specialties, although it does take account of participation rates across the whole trained and training medical workforce, where it is less than one FTE. We recognise that participation may exceed the number of paid PAs for consultants, and to fully understand 'over participation,' further work is needed.

3 MEDICAL WORKFORCE TRENDS

3.1 Key messages

- The medical workforce has been steadily increasing since 1999.
- The biggest increase has been in the consultant workforce.
- There has been an increase in finished consultant episodes (FCE) during this time.
- The percentage of female consultants has also increased in the consultant and medical student groups.
- Participation rates at consultant level have consistently been lower for females than males.
- Participation rates have consistently increased since 1999 for males and females.

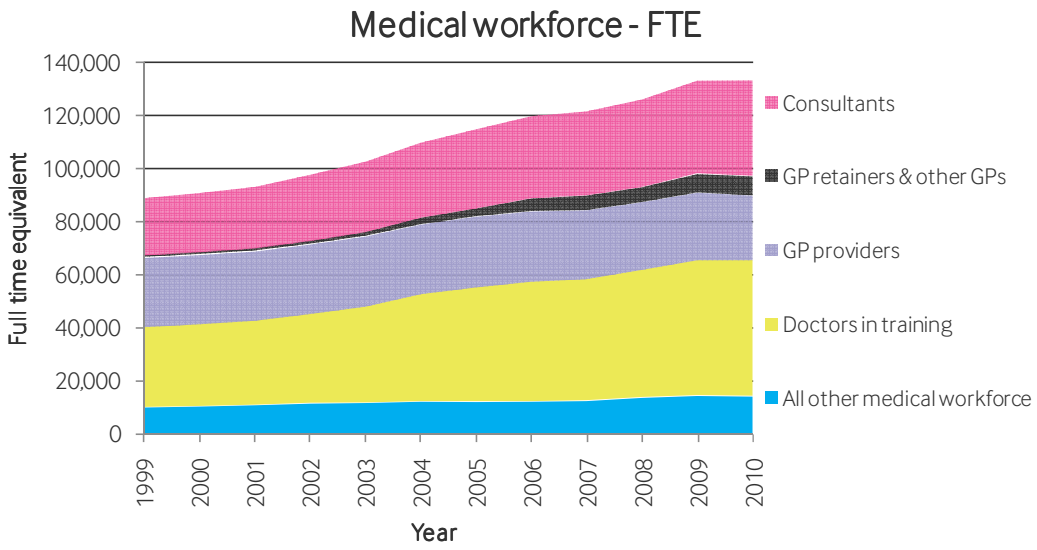
3.2 Graphs

The graphs below show trends, over time for:

- FTEs in the workforce (graph 1)
- numbers of doctors in training (graph 2)
- participation rate (male and female) (graph 3)
- gender balance of the workforce (graph 4)
- relationships between activity and consultant numbers (graph 5).

Graph 1: *FTE in the* ***medical*** *workforce*

Graph 1 shows that there has been a steady growth in the FTE of the medical workforce over the last ten years.



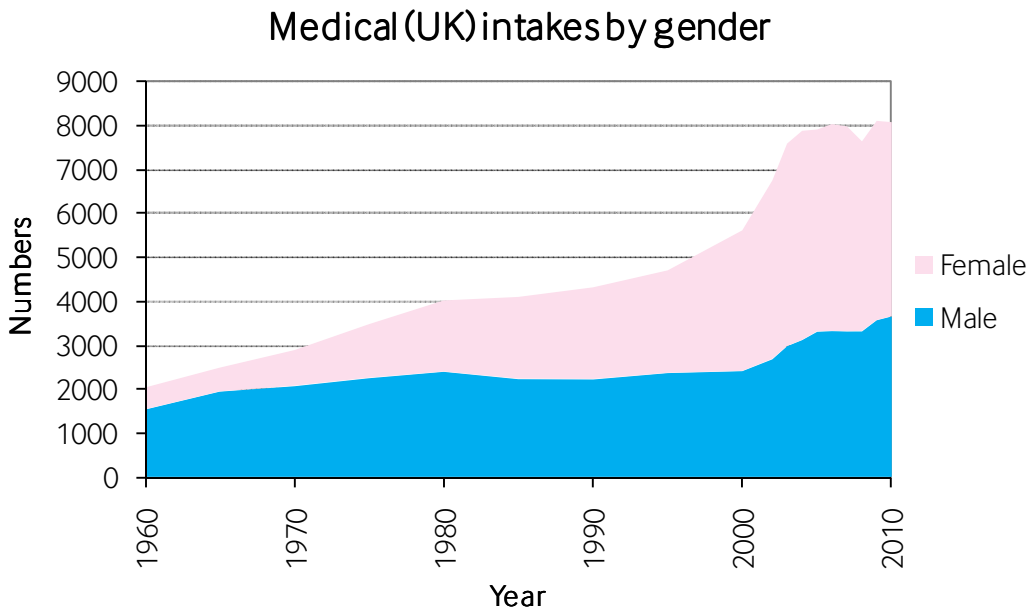
Source: *NHS Census*

The graph above shows FTE. When we compare the headcount of healthcare professional groups between 1999 and 2009, there was a 62 per cent increase in consultant workforce headcount, a 27per cent[3] increase in General Practitioner headcount (from 31,000 HC (28,000 FTE) in 1999 to 39,000 HC (35,000 FTE) in 2010), a 29 per cent increase in all of the nursing workforce and a 48 per cent increase in scientific therapeutic and technical staff. This consultant expansion was planned expansion as part of the NHS Plan. The change in the workforce is mainly due to the large increase in trainee numbers, which rose from about 31,000 in 2000 to over 51,000 in 2010.

Graph 2, below, illustrates the investment in medical training over recent years, as evidenced by the steep rise in medical school intakes from 2000 onwards, now levelling off. There has been a significant increase in the number of women entering medical training. This growth runs through the system, as university graduates progress into postgraduate training and subsequently, jobs.

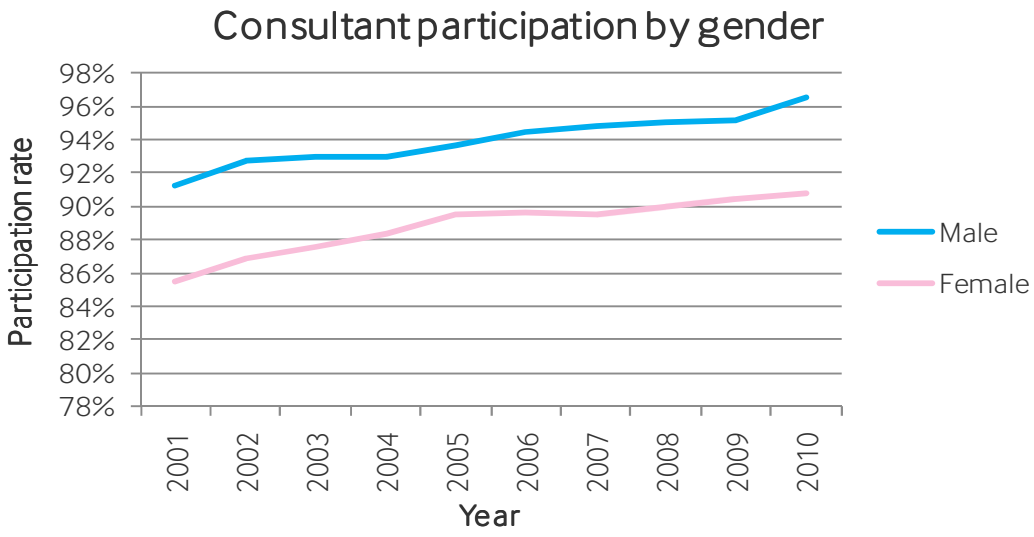
[3] This percentage is calculated using the actual data values rather than the rounded values which appear in this report.

Graph 2: *Headcount of **UK** medical students by gender from 1960 to 2010*



Source: *Medical School Intake*

Graph 3*: Overall changes in participation rate (ratio of FTE to HC) of hospital consultants.*

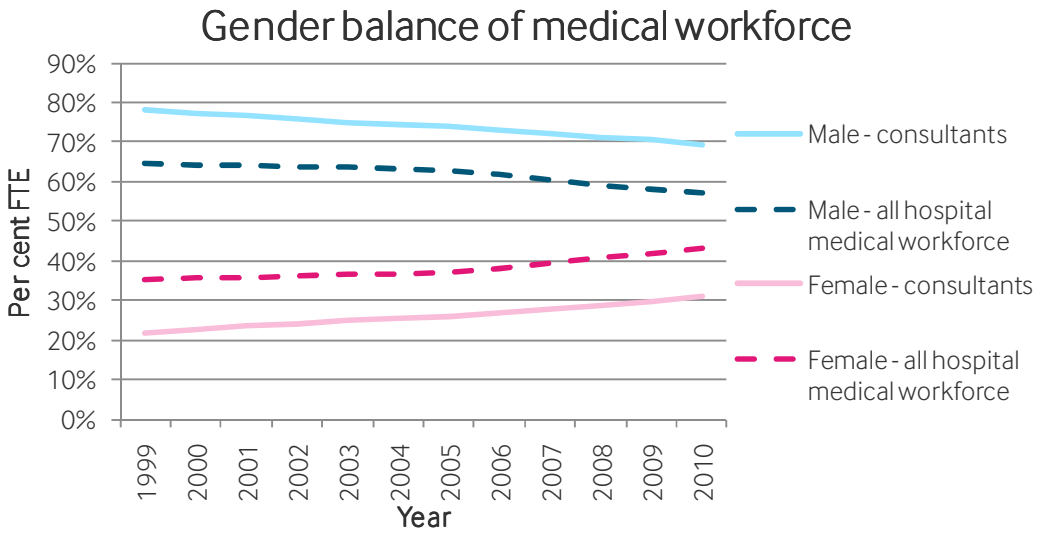


Source: *NHS Census*

Graph 3 shows the overall changes in participation rate of hospital **consultants** over the last ten years. It confirms that females work at a lower participation rate than males. The participation rate is increasing for both males and females.

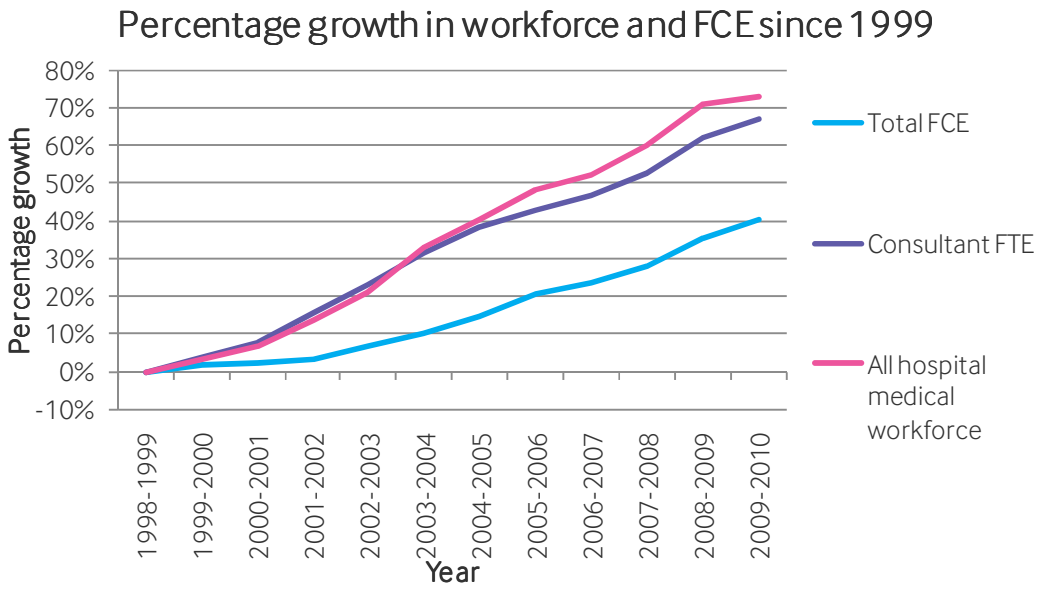
Graph 4: *Gender balance of the medical workforce in FTE*

Graph 4 illustrates that the gender balance of the medical workforce is predominately male, but this is steadily decreasing in line with a growth in female consultants.



Source: IC Census

Graph 5: *Activity, **FTE** consultant and **FTE** all hospital medical workforce*



Source: *HES data*

Graph 5 shows the substantial growth in the medical workforce since 1999 and the associated increase in finished consultant episodes (FCEs). Using the crude measure of FCEs per consultant, productivity declined steadily during the first part of this period, after which it remained fairly constant. This analysis, however, does not reflect any changes to the complexity of episodes or to their outcomes.

4 'WHAT IF' SCENARIOS

4.1 Key messages

From the possible future scenarios modelled:

- In the business as usual scenario, we will see an increase in consultant headcount by 2020 of more than 60%.
- If we change nothing other than the predicted shift towards general practice training numbers, the consultant headcount will still increase by over 60% by 2020.
- If the service sets its requirements for consultants at the level predicted by the Royal Colleges, then by 2020 there could be an excess of around 2,800 hospital specialty trainees.
- If employers moved to a consultant-delivered service, by 2020 it is likely that there would be enough training posts currently in the system to provide sufficient consultants, but not necessarily in the right specialty areas.

4.2 Scenarios

This section reports the preliminary findings of the possible future scenarios modelled. The scenarios are designed to illustrate some possibilities of how the future might unfold, according to different sets of assumptions and conditions. The scenarios are not designed as a prediction of the future but as possibilities for further consideration and discussion. The scenarios emerged from discussions with stakeholders and do not represent CfWI preferences.

Through modelling the possible future scenarios we hope to stimulate debate on some key issues for employers and the professions to consider when planning the future workforce.

Modelling possible futures to inform current thinking

The following graph (graph 6) illustrates the forecast consultant numbers to 2020 based on three future scenarios, all of which assume the current envelope (2010) for training numbers remains stable. The top line (scenario 1) represents

'business as usual', which is what will happen if nothing changes, and all trends continue as at present.

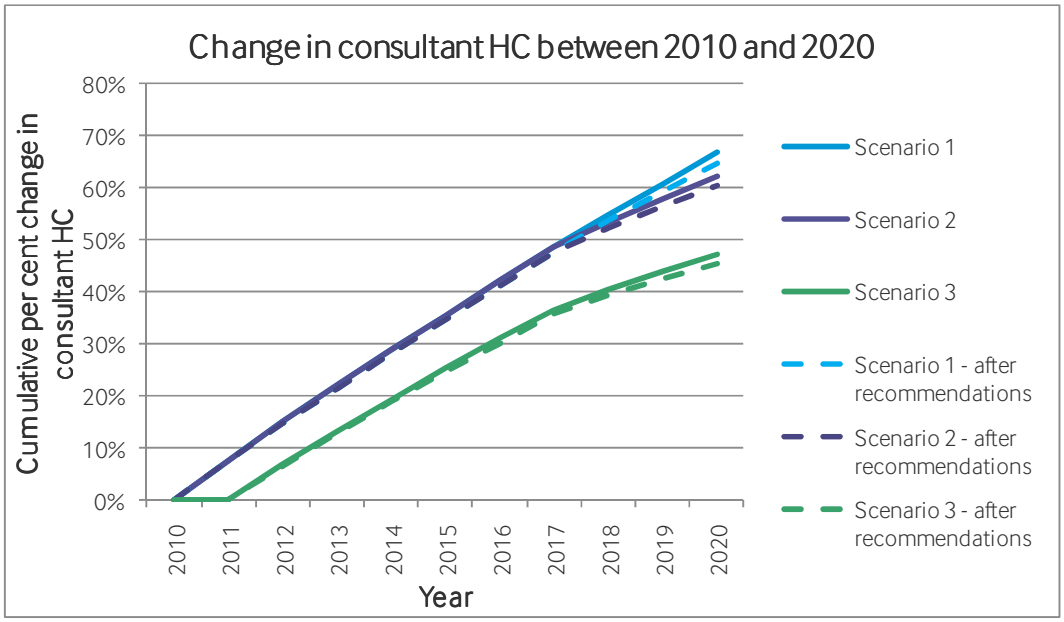
The middle line (scenario 2) represents a future where we see the impact on consultant numbers of a 17.5 per cent decrease in hospital specialty trainees and an equivalent increase in GP trainees, to achieve the target shift to General Practice.

The bottom line (scenario 3) represents a situation where all consultants retire at 60 years of age, and where scenario 2 still applies.

[NB. The number of retirees in 2010-11, due to the condition that all over 60s retire, is coincidentally almost the same number of doctors who gained a CCT, explaining the nearly flat line during this time period.]

The dotted lines in the graph below represent the impact if the CfWI specialty training number recommendations (CfWI, 2011) are fully implemented.

Graph 6: *Forecast ranges of consultant headcount expansion, based on scenarios modelled by the CfWI*



Scenario 1 – Business as usual

If no changes are made to the current system and the current numbers of trainees in hospital specialty training get a consultant job on entering the specialist register then...

By 2020 the consultant headcount could increase by over 60 per cent[4] to over 60,000.

The 60 per cent figure for consultant growth is a conservative estimate as it falls below the expected growth; even if we achieve the full shift to General Practice training that is predicted. The total salary costs of the consultant workforce could increase similarly by almost 60 per cent to roughly £6 billion. In the current climate this puts an added burden on the productivity savings required and also assumes that doctors will continue to work in the same way. This does not take account of need, demand or the changing ways of working that can result in greater efficiencies within the medical and wider workforce.

Scenario 2 – Shift to General Practice

If there is a shift from hospital specialty training posts to General Practice (GP) specialty training posts to achieve the proposed 50:50 split then...

By 2020 fewer doctors will emerge seeking consultant posts. If this happens, and all of those doctors are successful in getting a consultant post, then the consultant salary costs could increase by about 50 per cent. This shift towards General Practice training is thought to be required to meet the needs of our changing population.

Scenario 3 – Changes in retirement age

If we assume scenario two is the future and we then model a small change in the average retirement age then...

By 2020 there will be a larger impact on consultant headcount, with an increase of nearly 50 per cent. This scenario demonstrates the sensitivity of modelling the future workforce to small or sudden changes in retirement age.

Scenario 4 – Set level of demand

4 Workforce numbers and costs were modelled for each scenario using a three-point estimation method, with a best-case, worst-case and most likely estimate. These were combined to give the numbers presented in this report.

If the service sets its requirements for consultants at the same level as predicted by the Royal Colleges (57,500) then...

By 2020 there could be around 2,800 more doctors with a CCT than the projected requirements suggest will be needed. By 2020 the total consultant salary costs could increase by over 50 percent, if all doctors who complete training are successful in securing a consultant post under this scenario. This would be an opportunity to consider how these trained doctors could be deployed to benefit patients and how this could impact, in turn, on future training numbers.

Early discussion is needed to confirm whether the current supply is what is required for the future, and if not, to support the system to take any necessary action now in order to:

- find solutions for current trainees
- maximise benefits from the investment made in training
- consider other service delivery models that could maintain or improve quality and be more productive, such as a trained doctor-delivered service.

Scenario 5 – Consolidation period in training

If the nature of the training pathway changes so that half of trainees accepted the opportunity to work for a year after ST4, before returning to complete their training then...

This would provide an opportunity for employers to reconsider how their services are delivered. It would also enable trainees to embed their learning before picking up their training and progressing to a CCT and then into a consultant post.

This model has little impact on the total consultant salary costs but may support the development of more cost-effective services. It could enable employers to take the opportunity to reconfigure their more junior non-training medical workforce. If this is an interesting model to employers, the professions and trainees, then further modelling work can be done to consider the impact on the wider workforce.

Scenario 6 – Consultant-present service

If employers moved to a consultant-present service (as previously defined on page 14) then...

By 2020 there may be sufficient consultants to provide a consultant-present service, with all trainees being supernumerary. This scenario assumes that, other

than service being consultant-present, service configuration does not change, although we accept this is unlikely to be the case.

Potentially, there could be a 60 per cent increase in the consultant salary costs associated with this model if no other changes are made to skill mix, models of care and more productive working patterns.

In order to model this future scenario we made the following **assumptions** after discussion with stakeholders from the profession and service:

- that in the future all consultants will work 10 PAs
- that projections were based on no change to current working patterns, current headcount and current service delivery models and included a five-day-per-week service with 'out of hours' commitment
- a future scenario modelling a combination of 24/7 consultant-delivered service for some specialties and a seven-day-per-week service delivery for the rest, assuming between eight- or 10-hour days, depending on the specialty. (see Annex 1)

This model simplifies a very complex set of changes. In dialogue with employers and other stakeholders we will clarify:

- the differential impact of such a change on different specialties
- the justification for such a change in improved quality, safety and efficiency of care
- the potential for offset of reductions in the cost of non training grades and less onerous trainee rotas.

In the coming months, as the work of MEE on *Better Training Better Care* and *The Shape of Training* progresses, we will work in parallel with a range of specialties and trusts to explore what this could mean for them. In addition, we will continue to review service changes and new models of delivery, and consider the impact on future training requirements.

Scenario 7 - Graded career structure

If a new multi-level career structure for consultants is introduced which recognises different levels of expertise, competence and intensity of work then...

If this was introduced now then by 2015 it could be possible to reduce the consultant salary costs by approximately 2 per cent, compared to scenario 1, with a further reduction of about 7 per cent by 2020. By 2015 at least 35 per cent of consultants will be newly qualified consultants who will not be automatically promoted up the pay scale.

This scenario could also add value if in some specialties the CCT is awarded earlier, with the doctor continuing to then develop more specialist skills on the job, while working as a fully trained doctor. This would require a new training structure and was of interest to many of those attending the workshops that helped set the scope for this work. MEE is also aware of the interest of this shift to a more generalist workforce and will be considering this tension in their work on *The Shape of Training*.

For this illustration, three consultant bands were defined, referred to as A, B and C. Each of the bands has a different salary and expectation of experience, expertise, contribution to service and the wider organisation. Grade A is the entry salary band and grade C the highest. The model populates the bands with consultants according to set percentages. Consultants were assigned to a band based on their current salary, with 50 per cent in band A, 40 per cent in band B and the remaining 10 per cent in band C. For the purpose of the modelling, the salary range of each band was adjusted to get the desired percentages. This scenario therefore defines a new set of pay bands. Salary here, as in all other scenarios, excludes on-costs of employment, such as the cost of providing facilities and the costs of supporting the workforce.

As consultants retire from the middle and upper bands they are not replaced; new consultants enter and remain on the entry band. As there is no automatic progression within this model, doctors will progress based on the roles they have. This has the effect of increasing the numbers in band A leads to around a 2 per cent reduction in salary costs.

This model is for illustrative purposes only and there are significant assumptions associated with this scenario. Further modelling would be needed to fully understand the implications of a graded career structure for consultants. We would need to work with stakeholders to consider the percentage allocation of consultants to bands, taking into account not just salary but also factors such as experience and clinical expertise, management responsibilities and contribution to the national picture, recognising the differences across specialties and geographies.

In light of the current financial pressures facing the NHS, the increasing age profile of the population and continuing increasing service activity, we need to look at all the options open to employers and the profession to support the delivery of cost-effective and sustainable, flexible, high-quality services.

5 WHAT NEXT?

This report presents a set of future scenarios that consider changing roles of the consultant, changes in training models and in the structure of the consultant grade.

In the *do-nothing scenario* we foresee large increases in trained doctor numbers by 2020, which appear to exceed the highest projected demand, based on the evidence currently available.

Enough is not yet known about future service models, the impact of service transformation, the shift of care closer to home, the impact of skill mix and productive models of care on the future medical workforce.

However, we need to make decisions now to avoid a situation in the future of unplanned oversupply. In order to inform improved decision making now on the future shape of the consultant workforce, we need to have the debate and agree actions that will take us forward to help secure the future supply of the medical workforce, maximise investment in training, provide meaningful career opportunities for doctors and enhance the quality of patient care.

5.1 Potential risks

This preliminary work describes some early future scenario work and highlights potential risks in the system of an oversupply of CCT doctors for hospital-based specialties. This needs to be carefully considered and planned for.

In terms of participation and feminisation, the current evidence is that this has a differential effect on specialties and is not currently impacting on the overall workforce, as behaviours suggest increasing participation in both men and women at consultant level. The system currently recognises that consultants work beyond their paid PAs and there is a risk that future generations may not take the same approach to work. We could underestimate the likelihood of a future generation of consultants opting to reduce their participation, as has happened in General Practice. We do not yet understand enough about this and further work is needed as the impact of the effect of reduced consultant sessions per FTE will have an impact on future requirements of the workforce.

Currently, the impact of transforming community services and the shift of care closer to home is not well understood in relation to the medical workforce. One risk of this is that we may not be currently training a medical workforce to meet future needs.

If the policy of a consultant-delivered service is to be pursued by employers, then further work is needed to understand what this would mean for each specialty and for current and future training.

New options should also be debated, such as what a trained doctor service might look like and the impact this would have on current and future training.

Urgent discussion is needed:

- to inform recruitment in the short term, to minimise any long-term risk to oversupply
- to agree ways in which the system can maximise the investment already made in training the future trained doctor workforce to make sure we have the doctors we need, where we need them and with the right skill set to deliver the services of the future
- with current trainees and the profession on the potential risk of displaced trained doctors, if no action is taken
- on the need for a more flexible medical workforce, the changing nature of the consultant role and of service delivery, in particular to more community-based care.
- on the work currently underway by MEE on *Better Training Better Care* and *The Shape of Training*.

5.2 Improving the knowledge base to improve workforce planning

In carrying out this work we have identified gaps in knowledge and information and more work is needed on:

- data assurance
- understanding employers' long-term plans for the medical workforce, including the commitment to a consultant-delivered service
- understanding the potential changes in the shape of the **whole workforce**, in light of the quality, innovation, productivity and prevention work and transforming community services
- improving the evidence base for the workforce design of high-quality services
- understanding specialty-specific differences
- understanding the impact of hospital-based models of new ways of working

- managing the career expectations of current medical students and trainees, including the need for flexibility across specialty, geography and environment, and also new ways of working such as increased responsibility for directly delivering care 24/7 and potentially different career structures
- understanding the impact of new technologies on the future medical workforce
- understanding the impact of a more integrated approach to service delivery (including new patient pathway development) across primary, community and secondary care settings on the future medical workforce
- understanding changes that are planned across the whole workforce and what this means for the future medical workforce.

5.3 Opportunities to consider

Initially this report might be seen to expose a significant problem: that, unchecked, a substantial oversupply of trained specialists will emerge during the next decade.

An alternative perspective is that this specialist capacity gives a series of major opportunities:

- to provide consultant or trained doctor services and improve quality of care and outcomes
- to maximise productivity benefits through implementing new ways of working and new models of care through investing in a consultant-delivered service
- to provide new job opportunities across primary and secondary care settings, supporting the shift to care closer to home
- to provide more flexible training opportunities for doctors to redirect their career options to where they are needed most
- to encourage employers to plan now how their organisations might benefit from this valuable resource.

5.4 Recommendations for action

The CFWI would like to work with MEE and emerging HEE over the next six months to:

- define the required data and information needed for good medical workforce planning and how that data can be quality assured
- define what is needed to improve longer-term workforce planning for the medical workforce as the new system emerges
- explore the commitment to plan and train for a consultant- or trained doctor-delivered service
- align the current training pathway through ***The Shape of Training*** work MEE is embarking on, so it meets the future needs of patients and employers.

MEE, the Joint Working Group (JWG) on training numbers and the Royal Colleges, during 2012 should:

- continue adjusting future recruitment to training, so that it is more closely aligned with future service need, taking into account the recommendations from the CfWI on *Shape of the Medical Workforce: informing medical specialty training numbers* (2011)
- agree an approach to offering improved information and guidance to current and future trainees on future career pathways and career opportunities for fully trained doctors, to avoid disappointment in the future.

SHA clusters with the deaneries and the new LETBs should:

- develop a strategy for the next 12 months with clinicians and work together to gain a good understanding of the local future consultant workforce.

This should include consideration of:

- what being a 'consultant' will mean in the future
- the local commitment to a consultant-delivered service and what this means for future workforce planning
- developing a greater understanding of career pathway options for doctors

- developing a clearer view on employers' needs for the future to answer questions such as:
    - Will there be sufficient consultant posts, or alternative opportunities, for doctors currently in training?
    - Will there be sufficient doctors in training in the areas where they are most needed?
    - Are we training the future consultant workforce in a way that is sufficiently flexible to meet future service delivery models in community and secondary care settings?

Employers should start to plan now to:

- maximise the benefits of trainees currently in the training pipeline
- consider the impact that any change in trainee numbers may have on service delivery
- consider other service delivery models that could maintain or improve quality and be more productive, such as a trained doctor-delivered service and skills mix changes
- keep abreast of the *Better Training Better Care* work of MEE and take account of and plan for emerging recommendations.

The CfWI:

1. Has made recommendations to inform future medical training numbers based on current evidence. This provides the system with recommendations for the next few years, supporting a medium-term view for future medical training that fits better with the length of training.

2. Will continue to build on work with employers and the professions in the next six months. We will carry out further modelling across nine specialties, using the scenarios described previously. We will also undertake modelling within hospital settings to explore the full benefits and risks of different scenarios. Consideration will be given to whether additional scenarios should be modelled in the future, including combinations of scenarios that are of interest to employers and the profession.

3. In the next six months will do further work with a selection of employers to understand their service plans and the impact on the medical and wider workforce. As the new planning system develops, the understanding of service need will improve and the longer-term planning should also

improve. The outcome of this work will be discussed with the new local provider arrangements that will take on the education and training functions of SHAs, as they develop and with employers and SHAs, to improve understanding of employers' needs across primary and community care settings.

4. In 2012 will undertake a review of undergraduate medical school numbers to advise the joint review between the Department of Health (DH) and the Department for Business, Innovation and Skills (BIS).

5. In the next six months will work with the system to identify appropriate data requirements and responsibilities and accountabilities for data quality.

5.5 How can you contribute?

Workshops at the CfWI annual conferences this autumn have been used to inform this debate. We are seeking more volunteers to inform this debate. Please post your views on the issues raised in this report on our discussion forum at:

www.cfwi.org.uk/points-of-view/forums/planning-for-the-future-shape-of-the-medical-workforce-are-we-getting-it-right .

The deadline for contributions is 30 April 2012.

ANNEX 1 PRELIMINARY WORKING ASSUMPTIONS FOR A CONSULTANT-DELIVERED SERVICE BY SPECIALTY

NB the CfWI recognises this list will change as further thinking is done with the Royal Colleges.

24*7 SPECIALTIES defined for the purposes of this table as present 24 hours per day	**7 DAY WEEK SPECIALTIES** Assumes either 8 or 12 hour days 7 days per week
Anaesthetics and Intensive Care Medicine	Allergy
Cardiology	Audiological Medicine
Cardiothoracic Surgery	Chemical Pathology
Emergency Medicine	Child and Adolescent Psychiatry
Endocrinology and Diabetes Mellitus	Clinical Genetics
Gastroenterology	Clinical Neurophysiology
General Internal Medicine and Acute Medicine	Clinical Oncology
General Surgery	Clinical Pharmacology and Therapeutics
Geriatric Medicine	Clinical Radiology (although will be on call 24/7)
Haematology	Community Sexual and Reproductive Health
Infectious Diseases (as part of Acute Medicine)	Dermatology
Neurology	Forensic Psychiatry
Neurosurgery	General (Adult) Psychiatry
Obstetrics and Gynaecology	Genitourinary Medicine
Oral and Maxillofacial Surgery	Histopathology
Otorhinolaryngology (ENT)	Immunology
Paediatric Cardiology	Medical Microbiology and Virology
Paediatric Surgery	Medical Oncology
Paediatrics	Medical Ophthalmology
Plastic Surgery	Nuclear Medicine
Renal Medicine	Occupational Medicine
Respiratory Medicine	Ophthalmology
Trauma and Orthopaedic Surgery	Palliative Medicine
Urology	Public Health Medicine
	Psychotherapy
	Psychiatry of Learning Disabilities
	Psychiatry of Old Age
	Rehabilitation Medicine
	Rheumatology
	Sport and Exercise Medicine

ANNEX 2 – SELECTION OF VIEWS ON A CONSULTANT DELIVERED SERVICE

The Royal College of Physicians (RCP) supports 'investment in consultant-delivered services - consultants and fully trained doctors, underpinned by the Certificate of Completion of Training and the national contract, are the foundation of high-quality healthcare' (RCP, 2011).

The Royal College of Ophthalmologists (RCO) has stated that ophthalmic services should be consultant delivered. Other team members will participate in this service delivery under the umbrella of responsibility of the consultant who is aware of the needs of the patient throughout their patient journey. It has been stated that the management of ophthalmic conditions requires a mixture of knowledge, experience and insight that allows the analysis of the complicated interplay between the medical, sociological, psychological and historical aspects of a patient's care. This type of holistic care, bringing together experience, expertise, skills and understanding, can only be provided by a team led by a consultant. It represents the optimum standard of care which the patient expects to receive (RCO, 2009).

The Royal College of Surgeons (RCS), in its position statement, defines consultant-delivered services where 'the consultant surgeon is clinically responsible for the care the patient receives during the course of treatment. The consultant will either deliver or closely supervise, in the clinical setting, all aspects of the care the patient receives. Care may be delivered by other members of the surgical team but only under the supervision of the consultant who is alert to the needs of the patient being treated at all times'. The college 'advocates a service that is consultant delivered because the consultant surgeon is central to the delivery of high-quality surgical care by assuming overall responsibility for his or her practice, within a defined area of clinical practice. The quality of care and the safety of the patient is the primary concern of the consultant during their treatment' (RCS, 2009).

An article in the Emergency Medicine Journal highlighted recent research around consultant based service delivery for emergency medicine. The study found that consultants often saw more patients than middle- or lower-grade doctors, admitted fewer patients during a night shift, discharged more outright, referred fewer to clinics and had a faster turnaround time for every triage category. In conclusion, the report found that 'a consultant based service delivery offers many advantages. These cannot be matched by either junior or middle grades' (Sen, 2011).

In April 2011, the Royal College of Paediatrics and Child Health (RCPCH) published a report describing a set of 10 service standards which the college considers minimum standards for all acute paediatric services. The report sets out the implications of these standards for the configuration of paediatric services and the workforce. If implemented, the Royal College says that proposals would help contribute to better outcomes for children and young people and ensure greater efficiency in the system. Key recommendations in the report aimed at improving quality of care, are to increase the number of consultants and the use of resident consultants, while expanding the number of advanced or enhanced neonatal nurse practitioners (RCPCH, 2011).

This example of a consultant delivered service highlights the importance of a multi-disciplinary team, which is essential in providing the highest quality of care to patients. Skill mix and ways of working are also contributing factors, which all add to the complexity of attributing quality directly to the shape of the workforce.

A report from the Greater Manchester Children, Young People and Families' NHS Network (2008) provides evidence of how the consultant-delivered (or resident) model improves the delivery of acute medical services and the quality of care.

ANNEX 3 – REFERENCES

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