

Medical Workforce Speciality Review for Genitourinary Medicine 2001 / 2002

England, Wales, Northern Ireland and Scotland

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Executive Summary

This document addresses medical workforce needs for the speciality of Genitourinary Medicine (GUM) for the next 10 years. Data on current Consultant numbers, working patterns and retirement are based on information from the Royal College of Physicians Workforce Unit annual census undertaken on 30th September 2000. Information on Specialist Registrars is from the JCHMT. SHO data are from the RCP's General Professional Training department. Data on Non Consultant Career grade Doctors is from the Association of Genitourinary Medicine Survey. Data on incidence of Sexually Transmitted Infections (STIs) are from KC60 returns on STIs collected from GUM clinics by CDSC. There is considerable movement of doctors in GUM between countries in the UK both during progression from SpR to Consultant and at Consultant level. Data are therefore presented as amalgamated UK data and also by country. It is essential that workforce planning takes this lateral movement into consideration when undertaking calculations for future workforce requirements.

KE Rogstad 15th October 2001
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Background

The speciality of GUM operates as a primary, secondary and tertiary care service. Patients are able to self-refer or be referred by General Practitioners, Family Planning and Youth clinics, Paediatrics, Obstetrics & Gynaecology, Urology, Emergency units, Ophthalmology, General Medicine, schools, social services and the police.

The service provides care to individuals but also has a major public health role for the prevention, detection and control of STIs.

Immediate access to services is essential

1. to prevent long term complications e.g. Pelvic inflammatory disease, ectopic pregnancy, infertility, orchitis
2. to prevent deaths e.g. from HIV related conditions such as Pneumocystis carinii pneumonia
3. to prevent onward transmission to others in the community.

Patients should ideally be able to access services on the same day but at the very least within 48 hours.

Workload in Genitourinary Medicine

Current Situation

Workload in GUM Clinics has increased significantly over the past decade, with the total number of new attendances doubling to 1.2 million by 1999. At the same time the number of HIV positive patients attending for care has increased because of a rise in new diagnoses and a reduction in HIV-associated deaths as a result of anti-retroviral therapy. There are more than 30 000 people with HIV under medical care. Patient care has become more time-consuming because of the complexity of drug therapy, the need to address compliance issues and the complications associated with treatment.

The increased attendances also result from a dramatic increase in sexually transmitted infections throughout the UK.

1. 27% increase in gonorrhoea between 1999 and 2000 (129% increase in females aged 16-19 years and 169% increase in males since 1995)
2. 18% increase in Chlamydia between 1999 and 2000 (145% in females and 213% in males aged 16 – 19 years since 1995)
3. 55% increase in infectious syphilis between 1999 and 2000
4. 3551 new diagnoses of HIV in 2000, with the annual total rising each year since 1994

Additionally there have been serious localised disease outbreaks

1. HIV in Doncaster
2. Syphilis in Bristol, Manchester, East Anglia, Brighton, London
3. Gonorrhoea in Lincoln

The increase in asylum seekers /economic migrants has brought additional burdens. This patient group tends to have a higher prevalence of HIV and other STIs. They often have additional psychological problems because of displacement and previous sexual or physical abuse and torture. These factors and the need to communicate through interpreters necessarily increase the consultation times for this group of patients in comparison to UK residents.

The above factors have resulted in a major problem with patients being able to access STD services. Recent surveys have shown that the median waiting time for routine appointments is 5-6 days (range 1-18). Only 54% of clinics were able to offer appointments to urgent cases within 24 hours and in 5% of clinics patients had to wait for at least 1 week. This is unacceptable for patient care and has serious implications for the public health. In order to reduce waiting times many clinics have had to lower their standards of care with shorter consultation times, reduction in Follow ups and less time for partner notification, advice on safer sex and outreach work in schools, and targeting of high-risk groups.

Future Developments

The Sexual Health and HIV Strategy has now been published. This will further increase workload for those practising Genitourinary Medicine in the following areas:

1. the introduction of Chlamydia screening programmes, leading to increased numbers of patients and their contacts attending
2. initial and ongoing training of GPs, Family Planning Specialists and nurses involved in Level 1 and 2 services
3. setting up, developing, co-ordinating and supervising Level 2 services aimed at young people
4. increased number of patients with HIV infection attending for ongoing medical care as a result of increased testing
5. monitoring quality of services

Additionally there are indications that the incidence and prevalence of STIs including HIV are continuing to rise because of continuing unsafe sexual practices, particularly in the young and men who have sex with men.

It also seems likely that there will be a continuing influx of asylum seekers/economic migrants, at least in the foreseeable future. Extra resource will be needed to manage the demand from this group

Future Workforce Requirements

Consultants

There is an urgent need to increase the number of consultants over the next 10 years. Current consultant numbers are inadequate to meet demand for reasons described above. There are 73(26.7%) single-handed consultants, which raises concerns regarding clinical governance, on-call commitments and annual/study leave cover.

Over the past 10 years consultant numbers in GUM have increased by only 30% compared with 43.8 % for all Medical Specialities and despite the doubling of attendances. More recently, expansion has almost stopped; there was an expansion of only 1.6 % between the years 1999 and 2000, compared with 4.6 % for all Medical Specialities.

Consultants in GUM currently work on average 4.6 Notional Half Days (NHDs) more than they are contracted for and fail to meet the EU Directive on Working Times, with an average of 51.6 hours worked per week.

The recommendation in *Consultant Physicians Working for Patients* is that there should be 1 consultant per 80 –100 000 of the population for GU Medicine depending on HIV workload. This has now been more formally calculated and the new publication will recommend 1 consultant per 104 - 119 000 of the population.

This would ensure that no consultant worked single-handedly. This would address the need for increased consultant numbers to cover the increased workload due to reduction in junior doctor's hours, increased burden of HIV care, and increased requirements for Appraisal/Assessment/CPD/supervision and teaching of trainees. It would also ensure that at least 50% of patients were seen by a Consultant and that a consultant-delivered service was provided as recommended by the Government.

There are 273 Consultants in the United Kingdom but this equates to only 249 Whole Time Equivalents (WTEs). For England there are 248 Consultants but only 225 WTEs, Wales 8 (8 WTEs), Northern Ireland 3 (3 WTEs), Scotland 14 (14 WTEs). The proposed number of Consultants required is therefore 471 for the UK (389 England, 25 Wales 14 Northern Ireland and 43 for Scotland) i.e. an additional 222 consultants (165 England, 17 Wales, 11 N Ireland, 29 Scotland). Even to ensure that Consultants do not exceed their contracted NHDs or break the EU Working Time Directive, a significant increase in WTE numbers is required. To meet contracted NHDs an additional 114 consultants are needed for the UK (106 England, 3 Wales, 1 N Ireland, 6 Scotland); to meet EU directive 25 for the UK (22 England, 1 Wales, 2.2 Scotland).

Specialist Registrars

The appropriate numbers of Specialist Registrars (SpRs) need to be trained to allow for replacement of consultants leaving the speciality and to fill posts created through consultant expansion. The numbers will initially need to be high but then will fall once expansion has been achieved. A number of factors need to be considered when calculating the required number of SpRs.

1. Number of CCST holders required for 1 WTE post

On data available almost 1 in 3 of female consultants work part-time.

61% of present holders are female. 11% of SpRs are training part time. The assumption is that 25% will work 5 –7 sessions as a Consultant because of domestic commitments.

It is therefore recommended that 1.25 CCST holders are required for one WTE Consultant

2. Average training time for SpRs

The minimum training time for SpRs in GUM is 4 years. The average training time is expected to increase because

- MRCOG SpRs with an NTN may spend 6 months in general medicine
- sub-specialization will be undertaken by some in infectious diseases and in the future possibly medical gynaecology

The average training time is therefore 4.75 years.

1. *SpR Wastage*

Estimate 5 %

2. *Proportion of VTNs remaining after obtaining CCST*

50%

3. *Consultant Retirements*

Over the next 10 years 56 Consultants will reach the age of 65 years in the UK (England 51, Wales 2, N Ireland 0, Scotland 3). The number reaching 60 years in the same time is 89 (England 80, Wales 4, N Ireland 1, Scotland 4).

20 % have indicated they plan to retire at or before the age of 60 and 12.8% do not plan to retire early. For 66.5% retirement plans are not known. The number retiring early may increase as a result of pressures on older consultants due to changing working practices and need for IT skills.

There will be approximately 67 retirements in the next 10 years.

4. *Outflow from consultant grade*

There is a net outflow of consultants due to transfer to other specialities, industry or abroad. There is also the hidden loss as consultants take on Clinical or Medical Director posts, educational roles etc.

This is estimated at 4 WTE per year.

5. *Additional information*

There is inequality of distribution of NTNs across England and Wales.

It may not be possible for Wales to train their required number of NTNs themselves. There is also likely to be a net outflow of CCST holders to Northern Ireland and Scotland. Ideally planning should take this into consideration.

Senior House Officers

There are 51 SHO posts in the UK (42 England, 1 Wales, 4 N Ireland, 2 Scotland). These posts are not usually training posts for those who intend to obtain SpR and Consultant posts in GUM. They are primarily for those who require experience in Sexual Health and will subsequently follow a career in General Medicine, General Practice or Obstetrics and Gynaecology. Any decrease in their numbers would have serious implications for the quality of training of O & G Consultants and GPs, particularly in the light of the Sexual Health and HIV Strategy and Level 1 and 2 care. An increase in SHO numbers would be of great benefit to the training provided to those practising in these specialities and enable more GPs to gain the required experience to provide community based sexual health service at Levels 1 and 2 according to the strategy.

Non Consultant Career Grade Doctors

Genitourinary Medicine is one of the specialities most dependent on Non Consultant Career Grade Doctors. They vary from those undertaking 1-2 sessions, whose primary career is another speciality such as General Practice, to those who may be full time in GUM. They include GP Clinical Assistants, Associate Specialists, Staff Grades, Hospital Practitioners and Trust Grade Doctors. They provide a significant amount of the GUM service and recent data suggest that 592 doctors undertake 1686 STI clinical sessions in the UK. The majority

spend all their contracted hours seeing patients and have no provision for CME or CPD. This is inappropriate for quality of care, clinical governance issues, appraisal, revalidation and their own morale/job satisfaction.

Consultant expansion alone will not meet all the current and future demands on the GU service. There needs to be a corresponding increase in NCCG numbers, with an increase in paid sessional commitments of those already in the speciality to allow them time for non-clinical activities, including CME/CPD. This is now a matter of urgency as the RCP is recommending that all NCCGs, irrespective of how many sessions they undertake, must obtain 50 credits of CME/CPD, and some of these must be in the Speciality in which they are undertaking the NCCG sessions.

Based on current available information, and assuming Consultant numbers are increased as proposed, 852 additional NCCG sessions are required to meet service needs and an additional minimum 592 sessions are required to address the CME/CPD requirements of those already in post i.e. a minimum of 1444 additional NCCG sessions. The NCCG GUM Group, in collaboration with the Royal College of Physicians Workforce Unit, is in the process of collecting more detailed information on this group and therefore more specific workforce data should be available in the next year.

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	UK	England	Wales	N Ireland	Scotland	E/W/NI
No of Consultants	273	248	8	3	14	259
number of whole time equivalents (WTE)	249	224	8	3	14	235

increase in consultants needed						
for 1 per 119 000	222	165	17	11	29	192
of population						
based on excess	114	106	3	1	6	108
NHDs worked						
to satisfy EU directive	25	22	1	0	2.2	23
retirements						
number reaching 65 in 10 years	56	51	2	0	3	53
number reaching 60 in 10 years	89	80	4	1	4	85
No of	124 (14)	112 (14)	3	2	7	117 (14)
Specialist Registrars						
male (number flexible)	48 (1)	44 (1)	0	1	3	45 (1)
female (number flexible)	76 (13)	68 (13)	3	1	4	72 (13)
No of	51	42	1	4	2	49
Senior House Officers						
No of	592	527	26	5	34	558
Non Consultant Career Grades						
number of sessions	1686	1542	50	10	84	1602

Summary Of Information On The Consultant Workforce In Medical Specialities In The United Kingdom 2000
Produced By KE Rogstad And The Medical Workforce Unit Of The Royal College Of Physicians

Number of consultants by country						
	UK	England	Wales	N.Ireland	Scotland	E/W/NI
total	273	248	8	3	14	259
WTE	249	224	8	3	14	235
full time	146					
maximum part time	6					
part time	15					
not known	106					
Distribution of consultants						
	UK	England	Wales	N.Ireland	Scotland	E/W/NI
NHS	245					
NHS/Academic	24					

Academic/research	2					
NHS/private	1					
other/private	1					

Number of consultants by year						
	UK	England	Wales	N.Ireland	Scotland	E/W/NI
1993						198
1994						220
1995						228
1996						241
1997						254
1998						255
1999						255
2000	273					259

Consultant expansion							
	UK	England	Wales	N.Ireland	Scotland	E/W/NI	all specialities
1999 to 2000 actual						1.6%	4.6%
potential						2.2%	
1993 to 2000						30.0%	43.8%

Distribution of Consultants by teaching and non-teaching hospitals						
	UK	England	Wales	N.Ireland	Scotland	E/W/NI
non-teaching						
number	154					153
WTE per individual	0.94					0.93
WTE	148					143
teaching						
number	119					106
WTE per individual	0.87					0.86
WTE	103					92

Gender of Consultants						
	UK	England	Wales	N.Ireland	Scotland	E/W/NI
male	187	169	6	3	9	178
	68.5%	68.1%	75.0%	100.0%	64.3%	68.7%
female	86	79	2	0	5	81
	31.5%	31.9%	25.0%	0.0%	35.7%	31.3%

Retirement							
	UK	England	Wales	N.Ireland	Scotland	E/W/NI	all specialities
average retirement	61years						61years

age							
plan to retire early							
before 60	9.2%						
at 60	11.4%						
61-64	0.0%						
at 65	12.8%						
undecided	17.6%						
no answer	49.1%						
number reaching 60							
in next 10 years	89	80	4	1	4	85	
in next 5 years	41	37	1	0	3	38	
number reaching 65							
in next 10 years	56	51	2	0	3	53	

Excess workload

	UK	England	Wales	N.Ireland	Scotland	E/W/NI
All consultants						
excess hours in 48hr week	3.6	3.4	5.3	4	6	3.5
excess NHDs worked	4.6	4.7	4.2	4.4	4.4	4.6

Increase in Consultant workforce needed

	UK	England	Wales	N.Ireland	Scotland	E/W/NI
to satisfy EU directive on working times	25	22	1	0	2.2	23
based on excess NHDs worked	114	106	3	1	6	108
based on 1 per 119,000 of population	222	165	17	11	29	192

on call commitment

any	100%
main location only	64%
secondary location only	9.3%
both locations	26.9%

single-handed

in work location	73 (26.7%)
in speciality	58 (21.2%)

distribution of work

average contracted hours	37.8
hours in GIM	0.3
hours in main speciality	26.4
hours in additional speciality	3.2
general duties	22
average hours worked	51.9

average excess hours	14.1
general duties	
total	29
training	2
CPD	2.4
teaching	2
deanery	0.3
clinical/medical director	8.5
admin	4.8
travelling	2.4
BMA/RCP	0.3
meetings	2.4
academic/research	2.7
audit	1.8
other	1.1

Supervision of staff	
	ratio of consultants to staff member
SpRs	1 to 0.38
SHOs	1 to 1.52
HO	1 to 0
NCCGs	1 to 0.4