Candesic

It's not 'an apple a day' that's keeping doctors away

Candesic's **Dr Joe Taylor** considers the implications of the UK's shortage of doctors

A shortage of doctors is undermining NHS services and many private healthcare providers will soon feel the pressure too.

Over the next ten years, the NHS looks likely to face a significant staffing crisis in its clinician workforce and the consequent lack of consultants will have a knock-on effect for private hospitals. There will be fewer NHS trained consultants required to deliver high quality care in the private sector.

Although the NHS has a third more doctors than it did in 2004, we still lag behind other EU countries in the number of 'professionally active' doctors per head of population (*figure 1*). Our shortage of specialist clinical capacity looks set to continue as doctors choose to leave the NHS for foreign shores or non-clinical careers.

Current staffing trends are just the tip of the iceberg; the number of doctors available to a health service is complex but can be considered in terms of three key groups – entrants to medical schools, applicants to specialty training – who are on track to become consultants, and those choosing to take up a consultant post.

The actual number of doctors available can often lag behind the number needed as it takes many years to qualify as a doctor and further years of training to become a consultant (*figure 2*).

Medical schools in the UK have seen an 11% drop in applications from UK A-level students to study medicine and a 7% drop overall. While medical school places will still be filled, quality may decline and commitment to the profession amongst the next generation is falling (*figure 3*); 2016 was the first year in over a decade that places to study medicine have been offered in the UK university clearing system.

The staffing crisis will not stop at new graduates. The workforce pool will be depleted further as doctors shun specialty training in favour of alternative careers outside medicine or on foreign shores. Only 50% of foundation doctors applied to specialty training in 2016 and 14% took a 'career break' from practicing medicine (*figure 4*). Increasingly, doctors leave UK healthcare provision before maximising their value as senior clinicians.

What is keeping doctors away from the wards?

Doctors are voting with their feet and leaving the profession or the country; recent years have seen the attractiveness of a career in medicine eroded by a multitude of political, social and workforce factors.

The NHS has been used as a political football by many parties to garner votes and support in elections; how can we forget the Brexit promise of £350 million a week being redirected to the NHS? This political manoeuvring hit a pinnacle last year during the bitter and lengthy dispute between junior doctors and the Department of Health (DH) which resulted in the imposition of a contract after several high profile strikes and marches creating a generation of politicised doctors, many of whom decided enough was enough and left. This was manifest in the rise in applications to the GMC for a certificate of current professional status, allowing a doctor to work abroad, which coincided with the imposition of the contract in Autumn 2015 (*figure 5*). Many 'juniors' now find themselves feeling they can no longer do a job so different from their expectations (*figure 6*).

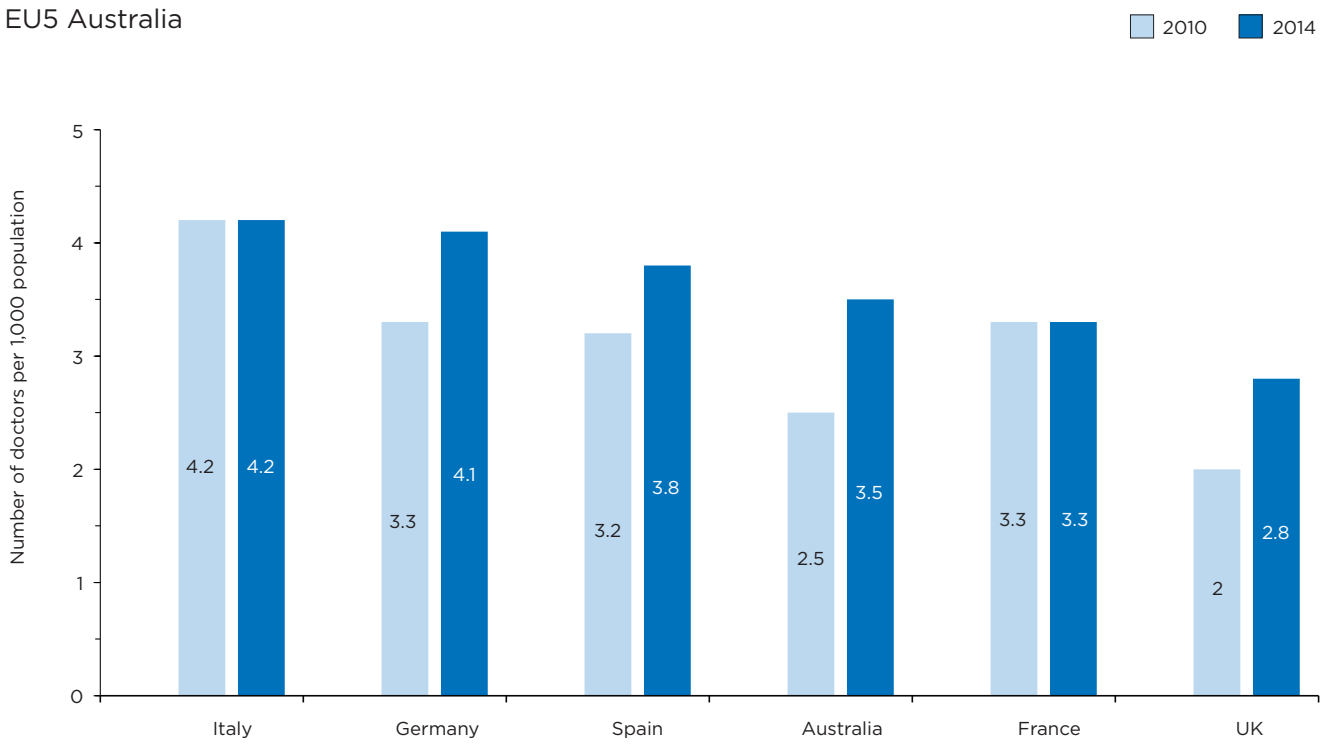
Gone are the days when doctors were willing to sacrifice their social hours to cover another understaffed rota or give up time with their children to stay late. Expensively trained and skilled doctors from the UK are looking to new careers, such as healthcare consultancy, or work in sunnier, more work-life balance friendly countries.

What do 'safe staffing' levels mean for providers?

Safe staffing was pushed into the limelight by the Mid Staffs scandal in 2009 and the subsequent Francis Inquiry which investigated the issue and published its findings in 2013; a chronic shortage of staff was identified as a primary reason for the substandard care and associated high death rate. Since then, safe staffing has remained in the public eye (*figure 7*). However, this attention has historically focused on safe ratios of nurses to patients, whilst doctor to patient ratios have remained largely ignored even within the NICE guidance.

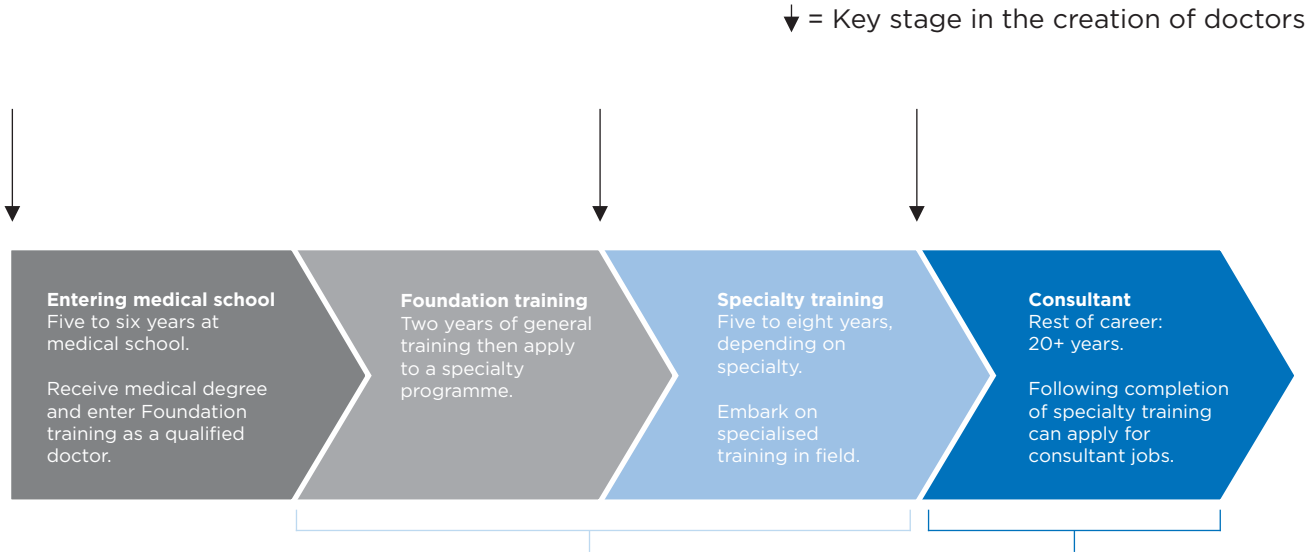
Investigations in 2009 revealed a wide range of doctor to patient ratios, with one area reporting an average ratio of five patients to a doctor at ▶

FIGURE 1: DOCTOR DENSITY



Source: National data sets; Candesic analysis

FIGURE 2: TIMELINE FOR CREATING A CONSULTANT CLINICIAN



Undergraduate student

- Not GMC registered, cannot prescribe
- Sees patients only under direct supervision and cannot prescribe.

Junior doctor

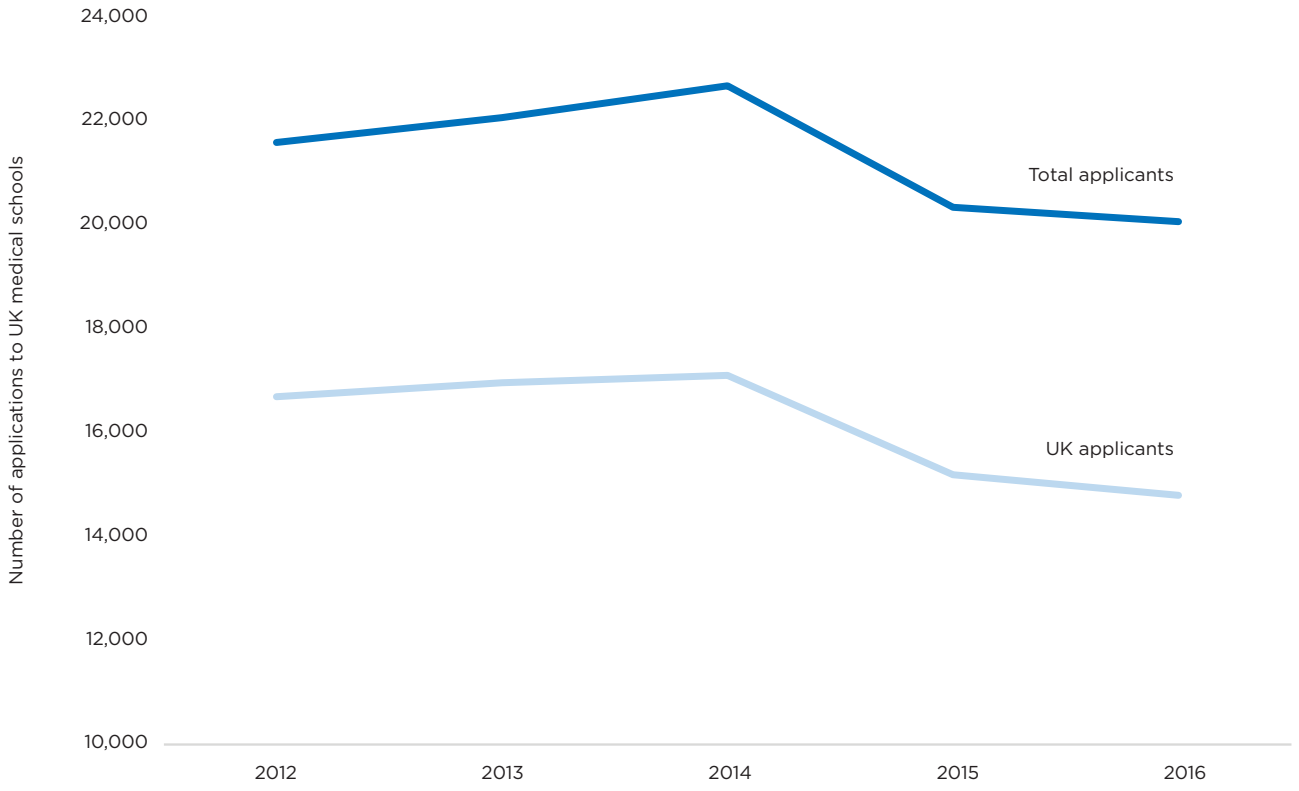
- GMC registered, can prescribe
- Works independently within a team with indirect senior supervision.

Consultant

- GMC registered, can prescribe and can practice in the private sector
- Leads clinical team of Junior Doctors and has clinical oversight.

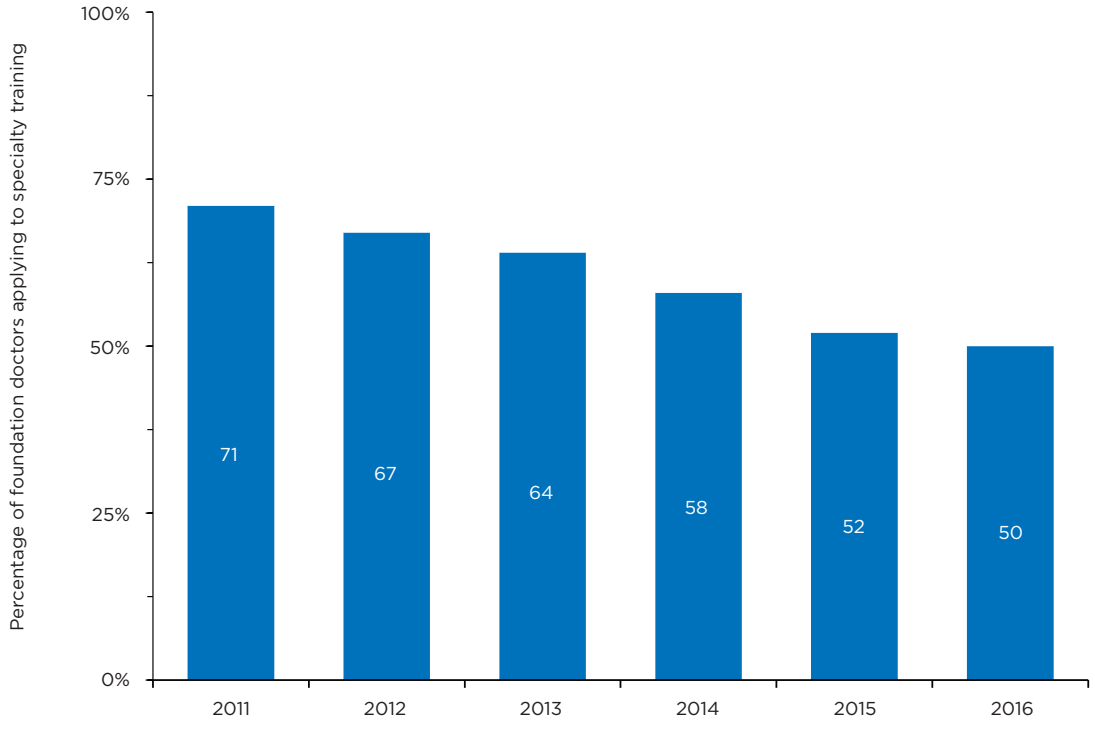
Sources: Candesic

FIGURE 3: MEDICAL SCHOOL APPLICATIONS



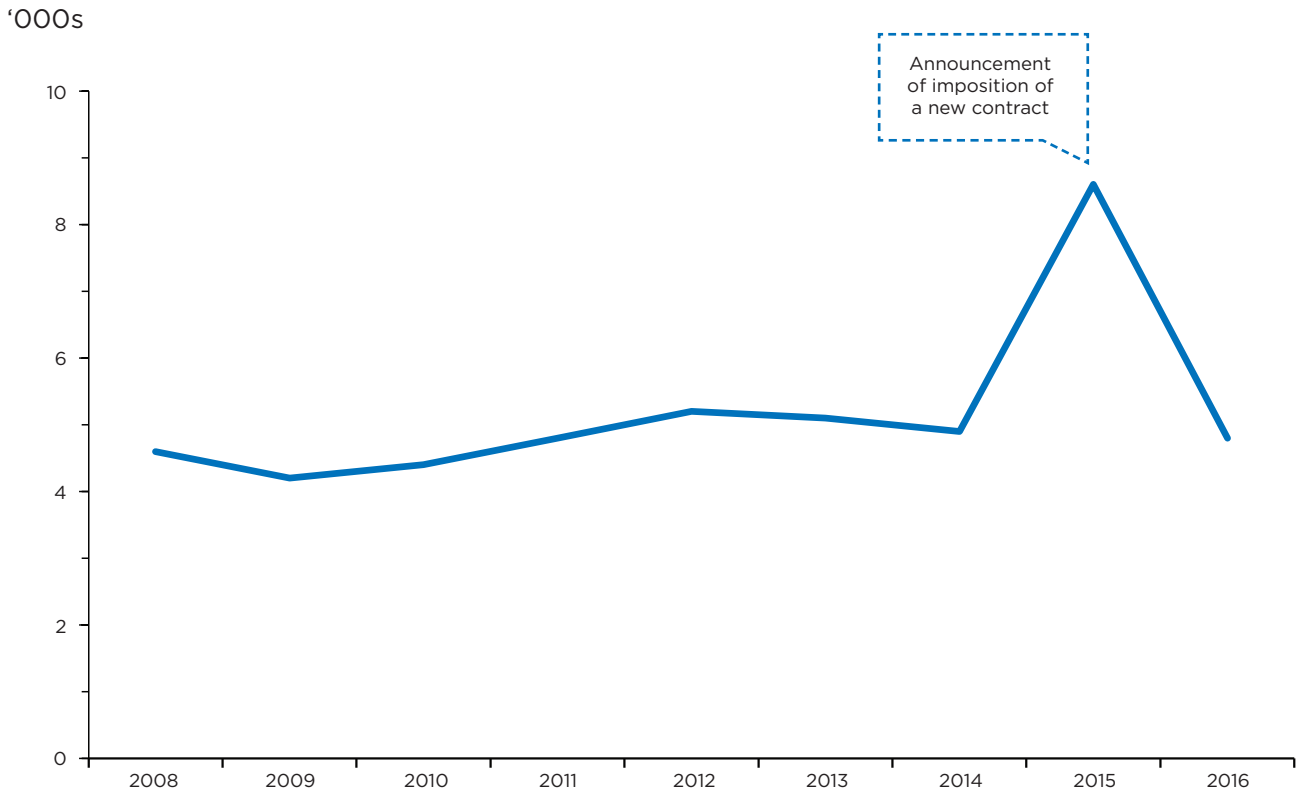
Sources: Candesic

FIGURE 4: PROGRESSION TO SPECIALTY TRAINING



Sources: Candesic

FIGURE 5: NUMBER OF APPLICATIONS FOR GMC CERTIFICATE OF CURRENT PROFESSIONAL STATUS



Sources: Candesic

▶ 11am and 71 patients to a doctor at 11pm. It is time to introduce medic rotas that are aligned with clinical demand, something the NHS has been very slow to introduce.

Can better rostering support more effective doctor deployment?

eRostering has had a presence in nursing for over a decade yet clinicians are often still rostered on paper or using a 'copy and paste' MS Excel rota often developed by a junior member of the clinical team. Manual rostering takes time away from clinical duties to create, monitor and trouble shoot rosters, making that clinician less efficient and making staffing levels less safe.

The introduction of an eRostering system in a hospital can help to streamline a roster for medics allowing instant offering of shifts out to internal bank workers or out to selected agencies with whom specific rates have been calculated in line with locum caps introduced by the DH. All of which can help to not only fill dangerous rota gaps but also save hospitals money; Candesic has calculated that when used optimally one of the now numerous and increasingly innovative leading eRostering software suites can save a potential £2.6 million per annum for a trust when factoring in admin savings and optimisation of the roster when covering short-term absence. The opportunity for doctor rostering is clear.

If medic rostering is used to this level of sophistication the savings potential for NHS trusts could be significant given the ever-growing cost of agency locums and the increasing number of unfilled spaces on medic rosters.

How do we get doctors back into clinical practice via the private sector?

The Royal College of Surgeons called for greater independent sector provision of training as early as 2013 and hosted a working group on this in 2006, identifying certain specialties which they felt the independent sector would cater well to including orthopaedics, urology and plastic surgery. As many more operations are offered out to the independent sector to help the NHS cope with growing waiting times, many trainees feel they miss out on surgical experience and theatre time.

This perceived lack of training leads trainees into disillusionment and cynicism, either driving them out of medical practice or creating less able consultants. Provision of training by independent sector hospitals would help to produce more well-rounded and better trained consultants of the future, benefitting the independent sector by increasing the pool of consultants from which they can hire. It also enables attraction of the best and the brightest trainees to your hospitals via more innovative training, world-leading trainers and premium equipment; securing their service within your business and their knowledge of your brand early in their career.

How do we bring doctors back into the health service?

To bring doctors back into the health service we must look to where they are going and emulate what they do; we must transform the health landscape to make it attractive to not just the best and brightest but every doctor by looking at what is drawing them away.

For many who leave for foreign shores it is the attraction of renewed professional respect and lesser political interference in the environment that they will work within. For some it is the improved work life balance and not having to cover a shift that has been empty for weeks but with little action taken to fill it, a problem that could be addressed by better rostering.

For those who leave for industries like ▶

FIGURE 6: THE REALITY OF LIFE ON THE FRONTLINE OF MEDICINE

"We all have our arms twisted into working additional locum shifts on top of the normal working week, with seemingly no choice in it. It's a totally unmanageable working pattern and volume, and despite being a core surgical trainee I'm learning nothing and just providing service provision."

– Specialty trainee – paediatric surgery

"Our rota should have 14 doctors but only half of this number are permanently employed, all our shifts overrun. Weekends are particularly dangerous, with trainees reviewing over 100 patients, and doctors often taken off days to cover nights at short notice. Despite requesting locums, there is nobody left to do these extra shifts, morale is gone and we are burnt out."

– Medical registrar

"We are so stretched with rota gaps that we have no capacity to accommodate sickness. We will often be on one ward in the morning and covering another in the afternoon taking away continuity of care for patients leaving us worried about them and our training. The situation is unsafe and physically exhausting. It is incredibly demoralising & damaging mentally, I don't know if I'll be able to continue,"

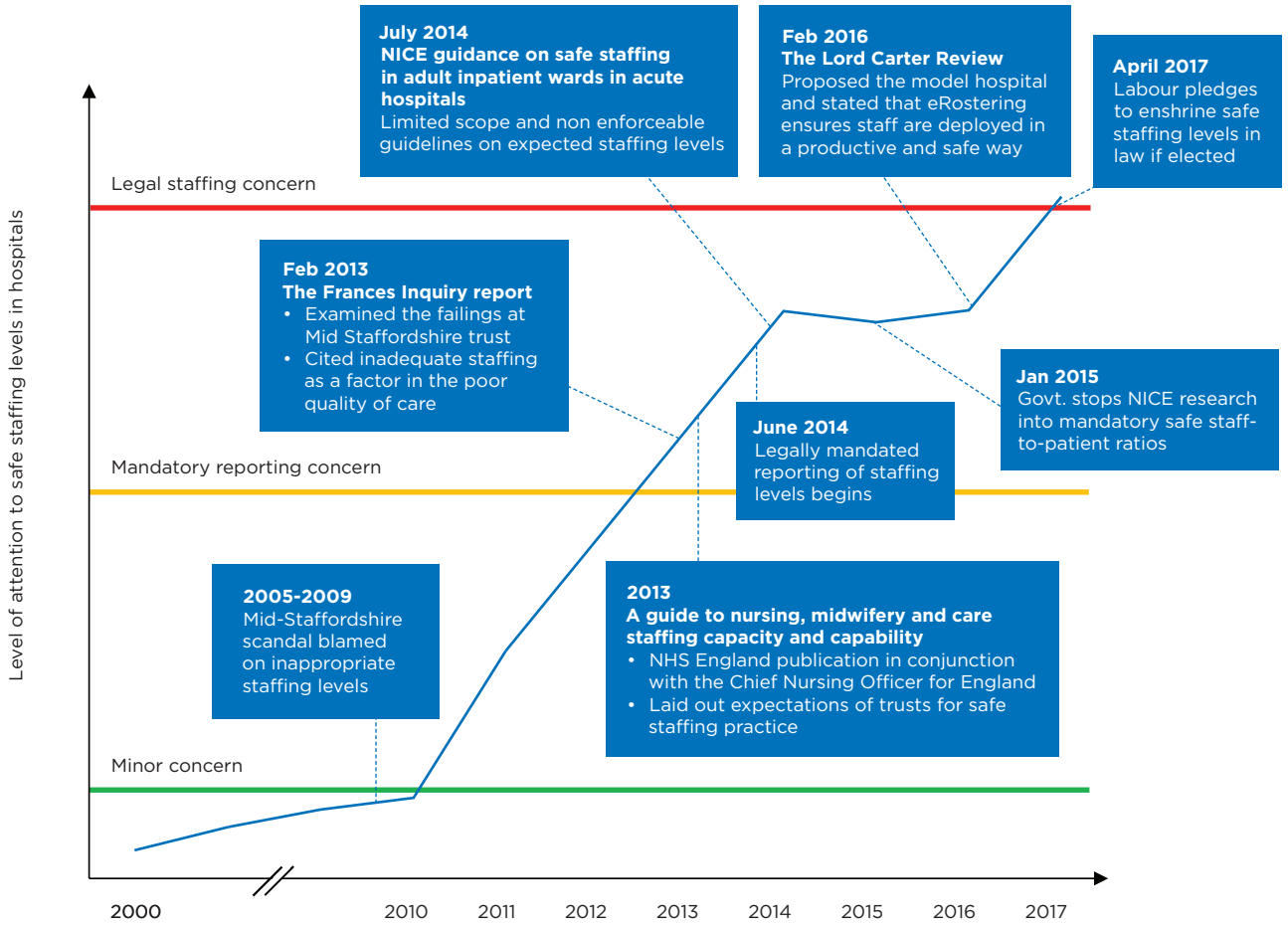
– Foundation year trainee

"I used to work a rota with five doctors covering the jobs of 10; we would often find ourselves being switched between clinic, theatre and even acute areas, like labour ward within a single afternoon session. It's not only draining but its dangerous, I'd often get home amazed that no errors leading to patient harm had occurred. A training job had become pure service provision and demoralised our team."

– Obstetrics and gynaecology registrar

Sources: Candesic

FIGURE 7: EVOLUTION OF SAFE STAFFING CONCERNS



Sources: Candesic

pharmaceuticals, the 'City' or management consultancy, it is often the draw of a new challenge and the ability to work across a broad spectrum of fields with varied workload. The current medical training curriculum takes the brightest and best of our A-level students and shoe horns them into a carbon copy print of 'the consultant', for many clinicians this hoop jumping is not fulfilling enough and so they seek it elsewhere.

The private sector has a chance to move in an provide these solutions; the rolling out of eRostering services for medics will help streamline rotas and give doctors their work-life balance back and provide an answerable audit trail where this fails. Alternatively, independent hospitals can seek to provide training of junior doctors, as HCA has already started to introduce, giving them greater access to procedures they would have to fight for in the NHS – a process enabled by the Health and Social Care Act (2012), which encourages independent involvement in training.

Doctors are haemorrhaging from the NHS and it is up to the independent sector and the government to work together with HEE and the Royal Colleges to stem it through embracing new technology, opening up training and making medicine attractive again. Otherwise, no amount of political rhetoric about safe staffing will save the profession. ■

Dr Joe Taylor is principal at Candesic. Candesic is a health and social care strategy consultancy (www.candesic.com). Please contact jtaylor@candesic.com or 020 7096 7680. This article benefited from the contribution of Candesic's clinical advisor, Dr Matteo de Martino

Candesic