RESPIRATORY MEDICINE WORKFORCE REVIEW 2018

The British Thoracic Society (BTS) exists to improve the standards of care for people living with respiratory disease and to support and develop those individuals who provide that care. The Society's members are drawn from a variety of healthcare professions, and a key strand of the Society's work is concerned with monitoring the state of the respiratory workforce so that effective support can be provided to safeguard and improve standards of care.

Our aim is **BETTER LUNG HEALTH FOR ALL:**

- We champion excellence in the diagnosis, treatment and care of people with lung disease and support those delivering it
- We influence NHS policy and services to help reduce the health & economic burden of lung disease
- We work with, and support, individuals and organisations across the NHS and beyond who share our vision.

The specialty of respiratory medicine is one of the largest specialties in the UK: in the 2017 RCP census, it was one of the 'big four' medical specialities, along with cardiology, geriatric medicine and gastroenterology. It is also the second largest specialty contributor to general internal medicine on call (1).

Respiratory medicine is a multidisciplinary, team-based discipline involving allied health professions (nursing, physiotherapy, respiratory physiologists, occupational therapy, speech and language therapy, pharmacy), and working with related specialties including primary care, radiology, palliative care, thoracic surgery, oncology etc. The Society's programme of work in relation to the respiratory workforce covers those working in respiratory medicine, as well as in respiratory nursing, and physiotherapy.

2018 Review

This statement is a 2018 update of the key issues facing the current respiratory workforce in secondary care, primarily in relation to the medical workforce but also in relation to issues facing respiratory nursing, physiotherapy and other allied health professions.

The burden of respiratory disease

The recent report from the British Lung Foundation "The Battle for Breath – the impact of lung disease in the UK, 2016" highlights the extent and impact of lung disease on the UK population: around 1 in 5 people (12 million) has had a diagnosis of lung disease at some stage in their lifetime, 550,000 people are diagnosed with lung disease in the UK each year,

lung disease kills approximately 115,000 people every year in the UK, and is responsible for over 700,000 hospital admissions and more than 6.1 million bed days in the UK each year. (2, 3).

Respiratory disease is a major factor in 'winter pressures' in the NHS, with twice as many respiratory admissions occurring in December compared to August (4).

The NHS Long Term Plan, announced in August 2018, included Respiratory as a clinical priority for the health service for the first time (5). The Long Term Plan also includes an emphasis on workforce, training and leadership.
Two further initiatives recognise the key importance of the workforce in underpinning the future of the health service:

- The announcement that NHS Improvement and Health Education England are working more closely on workforce planning issues (6)
- The Taskforce for Lung Health which has been set up to develop a 5 year plan for improving lung health in England, and this work includes an focus on the respiratory workforce (7).

The increased focus on Respiratory disease is echoed in Wales, through its Respiratory health delivery plan 2018 – 2020 (8) and in Scotland where most Health Boards have a Respiratory Managed Clinical Networks (9).

What respiratory specialists do

The medical respiratory workforce (both consultants and specialty trainees working in multi-disciplinary teams) plays a central role in the care of respiratory patients throughout the country; providing leadership and support for those in other specialties and the allied health professions that contribute to the care of this large group of patients. Respiratory physicians are involved in the treatment of patients with conditions including COPD, asthma, sleep apnoea, pulmonary fibrosis, cystic fibrosis and lung cancer to name just a few. A more detailed description of the breadth of the work undertaken by respiratory medicine staff can be found on the BTS website and the RCP Medical Care website (10, 11).

In addition, the respiratory workforce contributes both to acute and general medicine provision (1). The Joint Royal Colleges of Physicians Training Board (JRCPTB) describes Respiratory Medicine as one of the two major specialties of acute General Internal Medicine (GIM). The JRCPTB also states that approximately 30% of all acute admissions in GIM are for a primary respiratory problem, and respiratory physicians are essential and major contributors to the acute medical take in all acute hospitals (1, 12).

The respiratory workforce is a key advocate for respiratory patients, who are often elderly and less able to speak for themselves. Respiratory physicians provide care for those with chronic disease with an increasing number working across the community. 90% of respiratory consultants contribute to general medicine, and many work flexibly across both primary and secondary care and, in some cases, tertiary care environments. The recent Shape of Training report has stated that patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings (13). The respiratory medical specialty is one of a small number of specialties that continues to underpin general

medical care, as well as providing care for acutely unwell respiratory patients and those with chronic disease, in acute settings and community based roles.

A number of important innovations in patient care have been developed by respiratory teams for example: non-invasive ventilation in acute hypercapnic respiratory failure; the investigation of pleural effusions using ultrasound; COPD care bundles; asthma self-management plans; pulmonary rehabilitation; home ventilation services; MDT lung cancer management; interventional bronchoscopy; CPAP for sleep apnoea and recognising the importance of effective end-of-life care.

The involvement of the respiratory specialist in the care of those with lung disease has been shown to be of benefit, both in relation to the efficiency of health services and to improved standards of care experienced by the patient (14, 15, 16). With recognition of the need to provide highly specialised care for the wide range of complex conditions managed by respiratory specialists, subspecialisation by consultants within respiratory medicine is increasingly necessary. National guidance for the care of complex respiratory conditions mandates subspecialist involvement in care, in specialist centres and via MDT meetings: this improves the quality of care for patients but increases workload for respiratory physicians, further contributing to workforce pressures (17).

Those working in respiratory medicine support, in principle, the introduction of new models of care including 7 day working, which will, with appropriate investment, undoubtedly improve the experience of care for respiratory patients.

A workforce appropriate to meet the increasing burden of respiratory disease

The burden of respiratory disease is increasing as evidenced by recent publications from the British Lung Foundation (2, 3). Those working in respiratory medicine are well placed to make a positive contribution to improving standards of care for patients in the future health service provided this key workforce is maintained and encouraged at both trainee and consultant level.

Recognising that those working in respiratory medicine have a vital role to play in the planning and delivery of health care services that are fit for the future, the Society is concerned that the current medical workforce is not sufficient to meet current and future needs.

Data from the Society's members, as well as information provided from sources such as the Royal College of Physicians, confirm that a significant number of UK hospitals have vacant consultant posts, and in many cases encounter continued difficulty in recruitment. The existence of unfilled posts in hospitals across the country imposes a strain on the health system, jeopardises the development and delivery of services, and places the health and safety of patients at risk (18, 19).

Recruitment and retention

While the number of respiratory consultants has remained relatively static over the past few years (20), a recent BTS survey of respiratory departments has highlighted high levels of unfilled respiratory consultant posts in hospitals across the country (over 50% of hospitals

with advertised consultant posts report problems with recruitment – either a lack of applications or the absence of suitable candidates) (1, 18, 19).

The respiratory specialty training programme equips high-calibre doctors with the skills and expertise necessary to maintain the UK's specialist respiratory workforce (comprising consultants, associate specialists and other permanent specialists). The respiratory training programme has long been a popular choice for those wishing to pursue a career in specialty medicine and is a career well suited to those who wish to train and work flexibly.

Respiratory specialty trainees make a significant contribution to the medical registrar workload, but there are increasingly recognised problems with the recruitment and retention of trainee doctors to those specialties that cover general medicine. The number of trainees graduating from specialist training needs to be sufficient to ensure that healthcare organisations which advertise vacant consultant and other permanent posts receive enough applications from appropriately qualified doctors to enable these vacancies to be filled in the great majority of cases. Current data collected by the Society show that over 40% of hospitals in the UK had at least one vacant consultant post in 2018 (a situation which has persisted for at least 2 years) , and over 50% of hospitals reported difficulties in making appointments to consultant positions (lack of qualified applicants) (1, 18, 19). There are also reports of rota gaps which have resulted in 30% of consultants having acted down into specialty trainee roles to ensure that the service can continue, and 19% of consultants reporting significant patient safety concerns (1). There are reports of increasing attrition from Core Medical Training resulting in unfilled ST3 posts. A recent reports from the JRCPTB highlights the fall in application numbers at both CT1 and ST3 levels across medicine as a whole. In respiratory medicine, as in other larger specialties, applications at ST3 level have been falling over the past 5 years (from 272 in 2013 to 217 in 2017). However fill rates in 2017 have recovered to 97% following a dip to 80% in the previous year (21).

At the present time, the UK respiratory specialty training programme is not training enough doctors to meet the current demand and, given the increasing call on the medical respiratory workforce to contribute to 7 day services, the number of respiratory trainees required must be increased. To meet future demand, the Society supports the call for the creation of an additional 100 training posts in respiratory medicine to be introduced over the next 5 years (20 per year over the next 5 years) (7).

Respiratory Nursing

A recent report on the respiratory nursing workforce (22) provided a current snapshot of the respiratory nurse specialist workforce in the UK.

It highlighted the breadth of the services provided by respiratory nurses across the country, revealing that respiratory nurses are working in the majority of respiratory sub specialties. Reassuringly there is little evidence of frozen positions, but concerningly, there are anecdotal reports of specialist nurses being required to work on the wards, to cover ward vacancies. This affects the ability of the respiratory nurses to fulfil their roles, impacting on the delivery of patient care, provision of services to enable early discharge and can result in the cancellation of specialist clinic (23). This consequently affects staff morale. It is also reported that many respiratory nurses spent a significant amount of time on administrative duties, again impacting on patient care.

The report highlighted that the current respiratory nursing workforce is drawn from an ageing population, with potentially 50% of the respondents being eligible to retire by 2022. To attract the next generation of respiratory nurses, there is a need to develop to undertake work to explore in more detail the issues contained in the Yorke et al paper.

Respiratory Physiotherapy, Physiology and Pharmacy

In addition to medical and nursing colleagues, the respiratory team comprises those working in physiotherapy, physiology, pharmacy, speech and language therapy, and increasingly Physician Associates and Advanced Clinical Practitioners.

A recent survey by the Association for Respiratory Technology & Physiology (ARTP) found that the expansion of the medical workforce has an impact on the activities and workload of all members of the respiratory team (24). When planning for the appointment of a new Consultant post to a department the organisation needs to consider the effects of such an appointment on the wider workforce. The study found that each Consultant in Respiratory Medicine post needed a 0.6 WTE physiologist to support their clinical activities in order to provide good patient care. Currently less than 10% of physiology departments are involved in planning for the appointment of new Consultant medical staff.

At the present time there is no data available on numbers of NHS staff employed specifically as respiratory physiotherapists or pharmacists.

What does this mean for patients and the wider NHS?

While posing immediate problems for the respiratory teams concerned e.g. in relation to lengthening waiting lists; lack of specialist input which lead to poorer outcomes for patients; and an increased length of stay, the existence of vacant posts within the respiratory team presents a significant challenge to the development and introduction of 7-day hospital services.

There is a disparity between hospitals in urban centres and those in more rural areas in terms of difficulty in recruitment and retention of the medical respiratory workforce. This will need to be addressed and solutions may include allowing some local flexibility in national terms and conditions or centralising acute medical services in larger hospitals.

The future workforce

Data collected by BTS over the past 3 years (18, 19) supports the recent response from the Royal College of Physicians London to the HEE workforce strategy consultation which called for a number of specific actions (25):

- The number of medical school places to be doubled to 15,000 per year, with the aim of a small surplus of supply
- Doctors in training should be encouraged to take up posts in specialties and locations with the largest recruitment gaps, by providing them with incentives such as protected time for leadership, education, training, research and quality improvement

- The UK to be made more accessible to doctors and other professionals from outside the European Economic Area with an immediate increase in the size of the Medical Training Initiative scheme to 2,000 places
- More flexibility in working patterns, regulation, moving between training programmes, moving between specialties, and meeting the aspirations of current and future physicians

The 2018 Respiratory Taskforce report (7) explicitly calls for an increase in respiratory specialty training posts, as well as a focus on recruitment and retention of respiratory nurses, additional training places for respiratory physiologists and an increases in physiotherapy training places.

Conclusion/Future plans

In order to maintain high quality care, it is imperative that the respiratory medical workforce is able to attract the right number of people into the specialty, ensure that those joining the specialty remain within it, and do all they can to attract the younger generation of medical professionals in future. Respiratory trainees and consultants make a major contribution to general medical on-call rotas and the provision of high-quality emergency care in UK hospitals and it is vital that these services are maintained.

The Society supports those working in respiratory medicine in order to promote and maintain professional standards, and to ensure the specialty can recruit and retain high calibre staff.

The Society welcomes the recognition of respiratory as a clinical priority for the health service, and it will continue to work to focus attention on specific aspects of the respiratory workforce and engage with other organisations and institutions that have a role to play in maintaining standards across the wider medical workforce including the Royal Colleges, Health Education England and other bodies involved in workforce planning across the 4 nations.

Further information on the Society's work in this area can be found here:
https://www.brit-thoracic.org.uk/working-in-respiratory/

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