BSG GASTROENTEROLOGY WORKFORCE REPORT, Oct 16

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BRITISH SOCIETY OF GASTROENTEROLOGY

Key points:

- On 30th Sept 2016 there were 1455 substantive gastroenterology consultants in the UK, a 2.9% expansion from 30th Sept 2015. The mean annual expansion over the last 10 years has been 4.9% per year but this is lower that it could have been as there are many vacant posts, as well as locum consultants in post.
- In 2013 the RCP predicted that we need 6 whole-time equivalent consultants per 250,000 population (1 per 41,667) doing 11.5 PAs of gastroenterology & GIM, a total of 1516 consultants (61 more). As 14% of consultants work less than whole time (6.7 PAs on average) we need a total of 1610 consultants (1 per 39,243 population) or 155 more. If expansion continues at 5% per year then this will take 1-2 years to achieve. However, the UK population is expanding and aging, this figure does not take into account the provision of tertiary services and there have been major service changes that were not included (e.g. bowel scope & FiT testing, out of hours bleed rotas, 7 day services and increased access to endoscopy). There is a plan to expand the non-medical endoscopist workforce to help meet the increased demand for endoscopy, but further consultant expansion will still be required.
- There remains significant regional variation in consultant gastroenterologist provision in the UK; London & North East England have exceeded the RCP recommended number per population. South East Coast/South Central England, East Midlands and Yorkshire & Humber have the least consultant gastroenterologists per population. As most trainees would like a substantive consultant post in the region in which they trained, redistributing NTN posts to areas of consultant under-provision or those with recruitment difficulty could help consultant recruitment in these areas.
- The proportion of female gastroenterology consultants has increased (19% consultants) although remains much lower than other medical specialties (34% UK consultant physicians, 53% medical higher specialty trainees female), medical students (55%) and doctors in training (57%) presumably as some females struggle to see how GIM & endoscopy on call rotas are compatible with family life. Encouraging LTWT training & working and flexibility of job planning would help. This would also help older consultants who wish to return to work after taking their pensions.
- 48% of 172 advertised consultant posts in England & Wales were not filled from 1st Sept 2015 to 31st Aug 2016.
- Our gastroenterology & hepatology training programmes have produced an average output of 99 CCTs per year between 2011-2015. Once retirement posts have been replaced, this number is sufficient to produce a consultant expansion rate of 5.7% next year.
- The number of attempted consultant appointments in England & Wales increased 87% in 2015 compared to the average from 2008-2011. There has been a 22% increase in successful appointments but a 437% increase in unfilled posts in the same time frame. CCT output has increased from an average of 77 from 2007 - 2011 to an average of 99 from 2012 to 2016 (a 29% increase) but this increase is insufficient to meet the unprecedented demand.
- There is a shortfall of 300 CMT posts below requirements so it is impossible to fill medical ST3 posts beyond the 70-80% level. Gastroenterology remains a popular specialty filling 100% NTN posts. Health Education England (HEE) has no plan to increase the number of CMT posts in 2016/17 as all available funding is being used to create more GP training posts and without additional foundation trainees, they probably wouldn't be filled.
- There will be 1,500 more medical school places in 2018 to help tackle the shortfall in junior doctor numbers.
- There will be no change in the number of gastroenterology or hepatology NTNs in 2016/17 but HEE have stated that TPDs & LETBs should over-recruit NTN posts according to the number of trainees out of program to try to ensure that clinical training posts remain filled at all times (1.36 times the number of clinical training posts is a rough guide).
- The proposed conversion of clinical fellow posts to gastroenterology medical registrar posts (3rd year of internal medicine stage 1 training) with the introduction of shape of training may increase the gastroenterology CCT output.

Consultant gastroenterologists

Consultant expansion

On 30th Sept 2016 there were 1455 substantive gastroenterology consultants in the UK, a 2.9% increase from 30th Sept 2015 (tables 1 and 2 and figure 1).

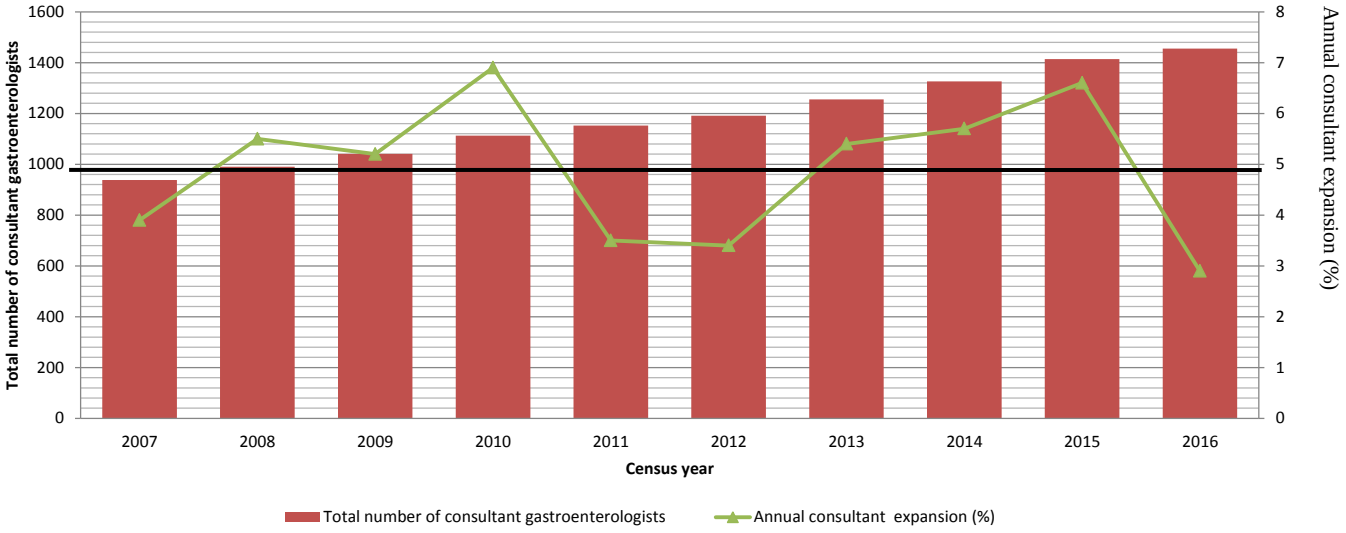
Table 1: Number of substantive UK consultant gastroenterologists by year

	30/9/7	30/9/8	30/9/9	30/9/10	30/9/11	30/9/12	30/09/13	30/09/14	30/09/15	30/09/16
England	780	824	866	926	957	996	1054	1107	1182	1222
Wales	45	48	49	48	52	52	55	59	64	66
Scotland	86	89	96	108	108	107	111	122	128	127
Northern Ireland	27	29	30	31	35	36	35	39	40	40
Total	**938**	**990**	**1041**	**1113**	**1152**	**1191**	**1255**	**1326**	**1414**	**1455**

Table 2: Annual expansion (%) of UK consultant gastroenterologists by year

	30/9/7	30/9/8	30/9/9	30/9/10	30/9/11	30/9/12	30/09/13	30/09/14	30/09/15	30/09/16
England	3.7	5.6	5.1	6.9	3.5	4.1	5.8	5.0	6.8	3.4
Wales	4.7	6.7	2.1	-2	8.3	0	5.8	7.3	8.5	3.1
Scotland	4.8	3.4	7.9	12.5	0	-0.9	3.7	9.9	4.9	-0.8
Northern Ireland	3.8	6.9	3.4	3.3	12.9	2.9	-2.8	11.4	2.6	0
Total	**3.9**	**5.5**	**5.2**	**6.9**	**3.5**	**3.4**	**5.4**	**5.7**	**6.6**	**2.9**

Figure 1: Number of UK consultant gastroenterologists and annual expansion (%) by year



Over the last 10 years the mean annual % expansion of UK consultant gastroenterologists has been 4.9% per year (Table 2 & figure 1). Expansion peaked at to 6.9% in 2010, attributable to financially supported recruitment driven by national bowel cancer screening and other political targets e.g. the '18 week pathway'. It fell to 3.5 & 3.4% in 2011 & 2012 as NHS resources were reduced during the UK recession, but increased again to 5.7% in 2014 and 6.6% in 2015 attributable to financially supported recruitment driven by bowel scope, as well as Trusts expanding gastroenterology services as they move towards 7 day services. Last year expansion was only 2.9% but this probably just reflects attempts to identify and remove consultants >60 years of age that have retired. 83 substantive consultant posts were advertised from Sept 2015 to Aug 2016 but not filled therefore actual expansion is lower than the potential expansion.

Data from the 2015-16 RCP census shows that together, gastroenterology & hepatology are the third largest medical specialty (1380 headcount in the UK). Geriatric medicine is the largest medical specialty (1488) and cardiology the second largest (1487) (figure 2). The RCP census report is written from data that is one year behind the BSG data.

Figure 2: Graph of consultant workforce by specialty and gender (RCP census 2015-16)

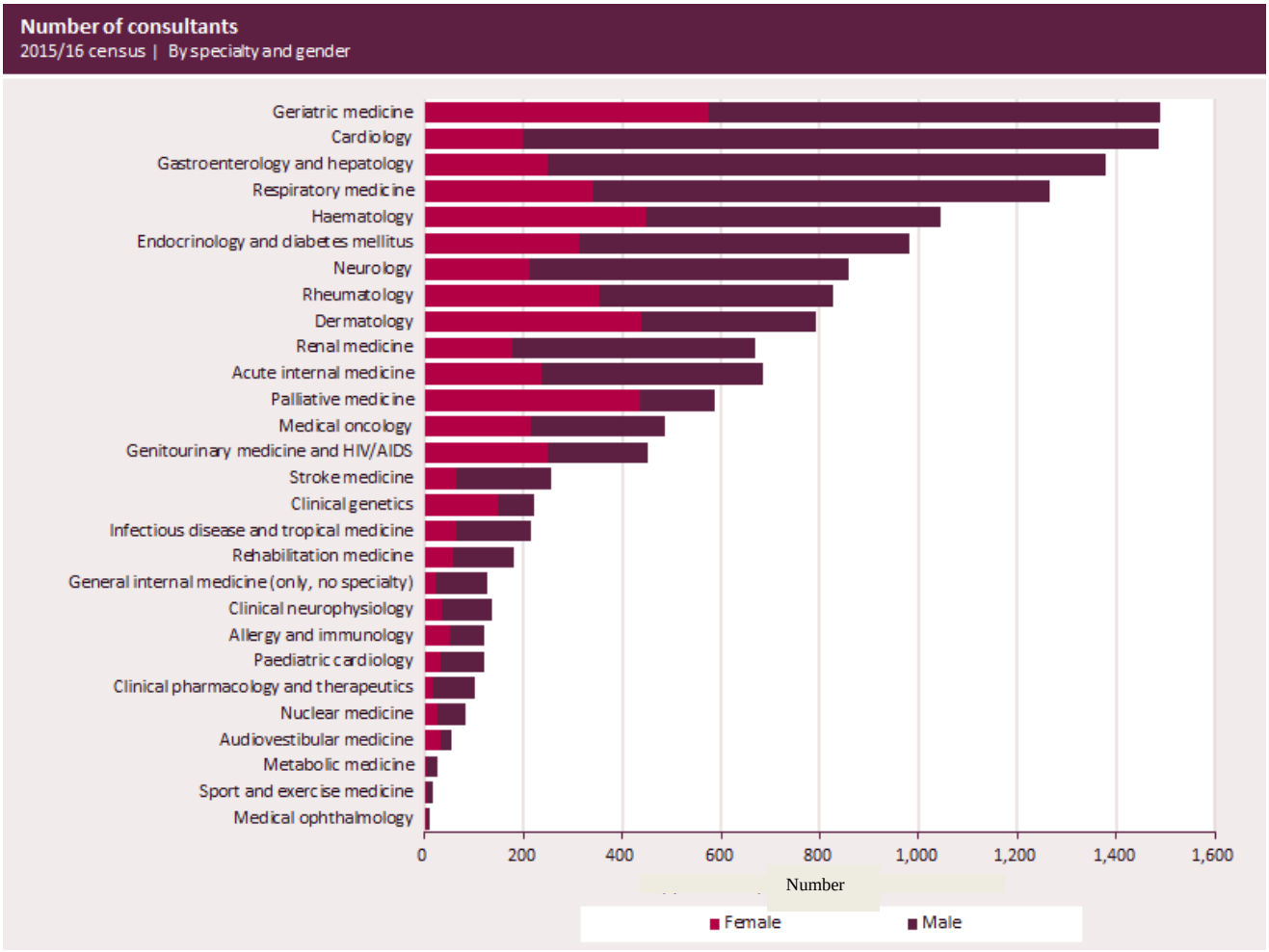
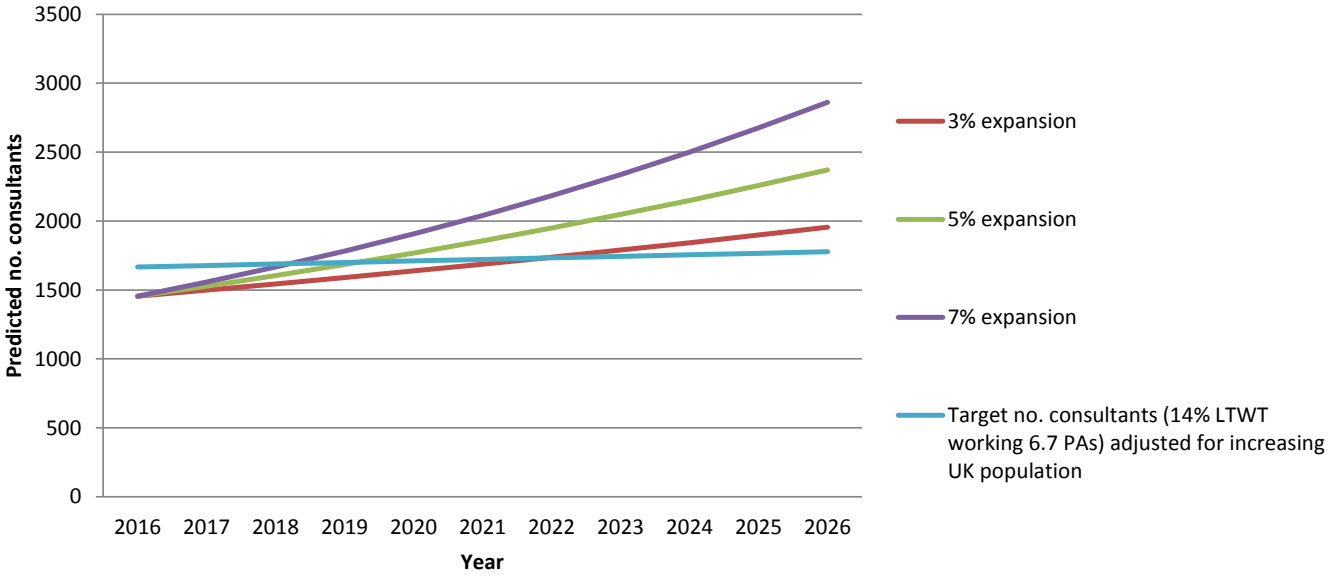


Figure 3: Graph of predicted WTE consultant expansion at 3%, 5% and 7%



The 2013 RCP document *Consultant Physicians Working for Patients* predicted that we need 6 whole-time equivalent (WTE) consultants in gastroenterology (with GIM) all working 11.5 PAs per week per 250,000 population (1 consultant per 41,667 population). For the 2011 UK population of 63,181,775 (office for national statistics (ONS) population census 2011) this is a total of 1,516 WTE, or an additional 61 WTE. With consultant expansion at 7% this would be achieved in less than 1 year, with consultant expansion at 5%, less than 1 year and with consultant expansion at 3%, 1-2 years (figure 3).

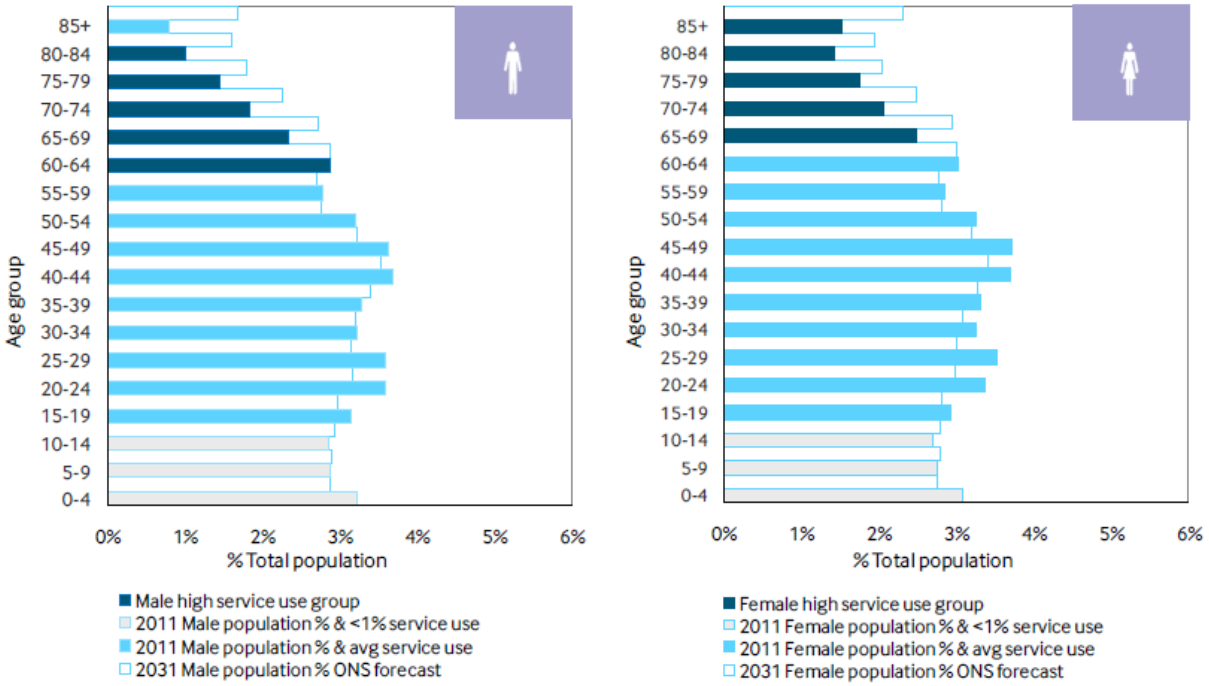
If we assume that the number of less than whole time (LTWT) consultants (anyone working <10PAs) will remain at 14%, and they will work 6.7 PAs on average, this gives a total of 1610 consultants (1 consultant per 39,243 population) or 155 more new consultants over and above retirement replacements. This would be achievable in 1-2 years if expansion is at 7%, 2-3 years if expansion is at 5% and 3-4 years if expansion is at 3%.

If we assume that the number of LTWT consultants working 6.7 PAs on average increases to 30% (as the proportion of females and number of returning retired consultants increase) this would mean we would need a total of 1,718 consultants or 263 more. This would be achievable in 2-3 years if expansion is at 7%, 3-4 years if expansion is at 5% and 5-6 years if

expansion is at 3%.

The ONS predicts that the UK population will increase to 68.0 million by 2022 (1% expansion per year from 2011). This would require 1,632 WTEs (177 more) or 1,733 with 14% LTWT (278 more) or 1,849 with 30% LTWT (394 more). However, the elderly population is expected to grow by 3% per year and the elderly population is a high user of Gastroenterology services (figure 4).

Figure 4: 2031 population estimate and indication of age and gender of the 2011 population using gastroenterology (*Centre for Workforce intelligence medical specialty workforce factsheet gastroenterology Aug 2011*)



Source: HES Data provides the specialty specific age range that is applicable to the population using Gastroenterology (NHS IC, 2011b). Population statistics updated July 2008 (ONS, 2010).

Tertiary services are not included in the 2013 RCP workforce predictions and since then there have been further drivers to expand gastroenterology services (including bowel scope, NICE recommendations for out of hours GI bleed rotas and 7 day services) which were also not included. There is a push for this additional expansion now, but it has not been adequately planned for, hence the inability to fill advertised consultant posts. There are more drivers for expansion around the corner: replacement of FOB by FIT testing in bowel cancer screening with a gradual increase in its sensitivity and 5 year forward view (DOH).

Medical Care is the online evolution of the well-known RCP publication *Consultant physicians working with patients.* Written by leading medical specialty experts, it is a comprehensive web-based resource for efficient and effective design of medical services.

http://www.rcpmedicalcare.org.uk/

The website has been designed to help those involved in the planning and provision of services get a clearer picture of the specialty services that need to be in place to provide great patient care. In particular, it allows medical specialty experts to describe how principles of the Future Hospital Commission report, such as 7-day services and integrated care can be put into practice.

Medical Care provides a practical guide to:

- implementing overarching themes in service design, such as person-centred care, patient safety and integrated care
- specialty-specific best practice service design
- creating a suitable environment to encourage the development of physicians and their teams to deliver high-quality services.

Medical Care is divided into two sections:

- designing services, which describes what high-quality services look like
- developing physicians, which details how to best develop the physician workforce to deliver those services.

Additional specialty specific content will be added in December 2016 to cover 28 specialties in total.

The number of training posts is currently at a level that produces, on average over the last 5 years, an output of 99 CCT holders per year. This is because the average training time is 6.8 years rather than 5, there are some trainees that leave gastroenterology before CCT and it has not been possible to backfill all posts when NTN holders go out of programme leaving gaps in rotations. 99 CCTs per year is only sufficient to enable a consultant expansion rate of 5.7% over the next year once estimated retirement posts have been replaced.

LAT appointments were ceased in England on 1st January 2016. HEE have stated that the aim should be for TPDs & LETBs to fill clinical training posts in programmes by increasing NTN appointments to compensate for trainees out of programme. If the average training time for trainees on a 5 year programme is 6.8 years we should therefore be recruiting 1.36 NTNs for every clinical training post. There are currently 523 clinical training posts in the UK. This would therefore require 711 NTNs in total. The actual number would vary in each LETB according to the proportion of trainees going out of programme, the number taking parental leave and the number working LTWT.

Gender

On 30.09.16 1,175 (81%) of substantive gastroenterology consultants were male and 280 (19%) female. This is an increase in the proportion of female gastroenterology consultants from 18% in 2015. Across all medical specialties 34% consultants are female (RCP census 2015-16). Figure 5 illustrates the percentage of female gastroenterology consultants in different age ranges. Younger consultants are more likely to be female: 33% consultants younger than 35 years, 28% of 35-39 year olds, 12% of 55-59 year olds and 7% of 60-64 year olds are female.

Within UK medical specialties, those now female-dominated (>50% female) are those with a lower GIM or out of hours commitment: palliative medicine, clinical genetics, audiovestibular medicine, dermatology and genitourinary medicine & HIV/AIDs (RCP census 2015-16, figure 2). The distribution of trainees suggests that this trend will continue.

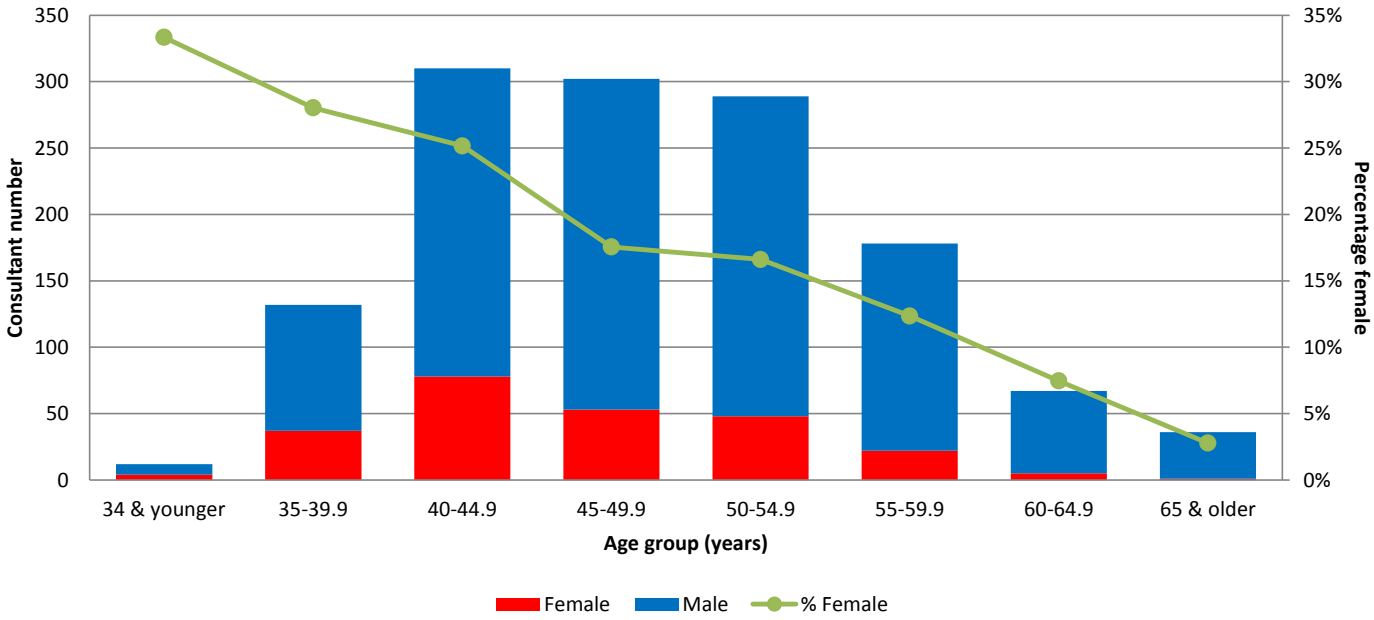
The 2015 GMC report "The state of medical education and practice in the UK" states that in 2014 females made up 55% of medical students and 57% of doctors in training. The RCP predicts that the number of female doctors will outnumber men sometime between 2017 and 2022.

Age

Figures 5 and 6 show the age & gender distribution of UK substantive consultant gastroenterologists. The majority of gastroenterology & hepatology consultants are young (in the 40-44.9 year age group). The mean and median age for consultants of either gender

is 48 years, the mode 49 years. The mean age in females is 46 years (median 45 years, mode 41 years); the mean age in males is 49 years (median 49 years, mode 49 years).

Figure 5: Age/gender distribution of UK consultant gastroenterologists: age groups & percentage female



Retirements

Actual retirements

Table 3: Number of substantive consultant posts vacated by calendar year

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
No. posts	23	26	21	26	21	13	13	5	9	7

There have been 7 substantive consultants who are known to have left their NHS posts between 1st Oct 2015 and 30th Sept 2016. All 7 have retired. The mean retirement age was 63 years (61 years in 2013, 63 years in 2012 & 2014 and 64 years in 2015). The range of age at retirement was 60-65 years. Table 3 shows the number of posts vacated by calendar year for the last 10 years. The average has been 16 posts per year although this has dropped to 9 per year on average for the last 5 years. After asking various BSG officers from around the UK, a further 23 consultants were identified that had retired at some point over the last few years & who were therefore removed from the analysis. If these are added to the number of retirements over the last 5 years, the average number of posts vacated increases to 14

per year.

Predicted retirements

Table 4: Number of consultants aged 60 years or more then number reaching 60 years

	2016	2017	2018	2019	2020	2021	2022
England	86	34	16	22	34	39	50
Wales	6	1	2	0	2	0	2
Scotland	10	2	3	3	11	3	3
N Ireland	1	0	1	1	2	1	1
Total	**103**	**37**	**22**	**26**	**49**	**43**	**56**

On the 30.09.2016 there were 103 consultant gastroenterologists in the UK who were 60 years or older and who were thought to be still working although ideally this needs checking (table 4). The number of consultant gastroenterologists reaching age 60 each year from 2017 to 2022 is estimated in table 4 giving potential numbers of retirees.

There have been a number of important changes to pension rules that may have influenced a consultant's chosen retirement age:

1. Change to usual retirement age. Compulsory changes to the NHS pension scheme on 1st April 2015 linked usual retirement age (previously 60 for those in the 1995 scheme & 65 for those in the 2008 scheme) to State Pension age (increasing to 66-68 years depending on year of birth). Consultants within 10 years of retirement will have protection arrangements. In April 2026, when protection arrangements cease, the usual NHS retirement age will jump from 60 to 66 years overnight. This could result in a 6 year retirement vacuum leading to an excess of CCT holders over jobs. It has been proposed that in the Isle of Man the State Pension age should rise to 74 years for those born in 2011 or later. It is likely that the UK state pension age will rise again in the future.
2. Reduction in the lifetime allowance (£1.8 million in 2011 now £1 million from April 2016).

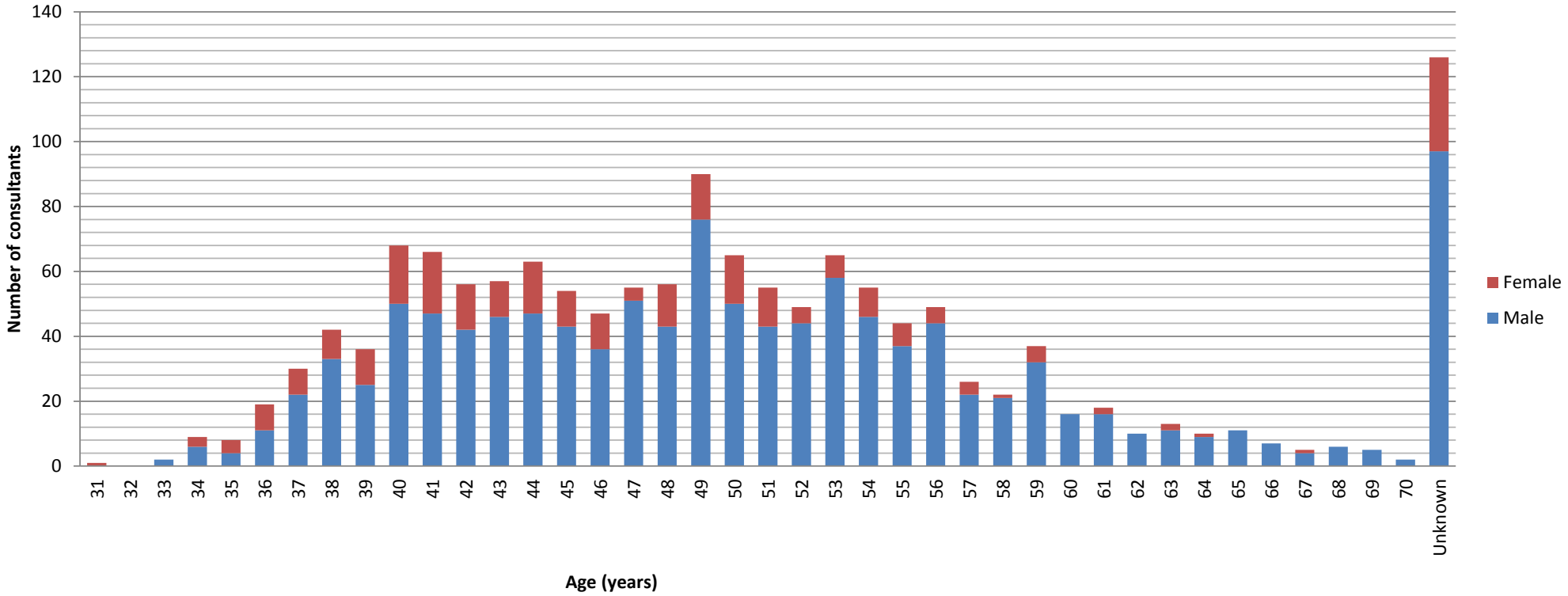
3. Reduction in the pension annual allowance to £40,000 from April 2014.
4. Tapering of annual allowance for all income over £150,000 from 6th April 2016.

In the 2016 survey we asked substantive consultants whether the age they planned to retire had changed as a result of the changes to the pension rules. 289 consultants answered this question and the results are summarised in table 5. There had been no change in 185 (64%), later retirement in 46 (16%) and earlier retirement in 58 (20%). However it appears that 30% of consultants aged over 50 expect to retire earlier than originally planned compared to just 14% of those 50 years or less. This has not been planned for and will limit consultant expansion further.

Table 5: Change to planned retirement age according to current age

Age (years)	N	Earlier retirement	No change	Later retirement
≤50	179	25 (14%)	114 (64%)	40 (22%)
>50	110	33 (30%)	71 (65%)	6 (5%)
All	289	58 (20%)	185 (64%)	46 (16%)

Figure 6: Age/gender distribution of UK substantive consultant gastroenterologists: numbers



General internal medicine (GIM) commitment

42% of gastroenterologists & hepatologists reported participating in the acute unselected medical on call (RCP census 2015-16). This is a reduction in the proportion compared to 2014-15 however many more contribute to GIM by looking after GIM in patients or by seeing specialty patients or referrals that come in acutely. 95% of gastroenterology trainees are dual accrediting in gastroenterology and GIM (RCP census 2015-16).

Distribution of gastroenterologists nationally: regional variations

The 2013 RCP document *Consultant Physicians Working for Patients* predicted that we need 69 PAs per week or 6 whole-time equivalent (WTE) consultants in gastroenterology (with GIM) all working 11.5 PAs per week per 250,000 population. For the current UK population of 63,181,775 this is a total of 1,516 WTE. Therefore ideally 1 WTE consultant should serve a population of 41,677. Adjusted for 14% LTWT working we need 1610 consultants (1 consultant per 39,243 population). The average gastroenterologist in the UK currently serves a population of 43,424. In England the average is 43,382, in Wales there is one consultant per 46,416 population, in Northern Ireland one per 45,272 population and in Scotland one per 41,693.

Table 6: Distribution of substantive UK gastroenterology consultants by region

Region (previously SHA)	Pop (1,000s) for 2011	No. cons 30/9/15	No. cons 30/9/16	% change	N (%) female	Population served by 1 consultant	Recommended no. (14% LTWT)
London	8173.900	237	247	4.2	48 (19)	33,093	208
North East	2596.900	78	78	0	14 (18)	33,294	66
Scotland	5295.000	128	127	-0.8	25 (20)	41,693	135
South West	5288.900	123	123	0	24 (19)	42,999	135
North West	7052.200	160	162	1.3	24 (15)	43,532	180
West Midlands	5601.800	122	128	4.9	23 (18)	43,764	143
Northern Ireland	1810.863	40	40	0	5 (13)	45,272	46
East of England	5847.000	118	126	6.8	25 (20)	46,405	149
Wales	3063.456	64	66	3.1	13 (20)	46,416	78
Yorkshire & the Humber	5283.700	107	112	4.7	27 (24)	47,176	135
East Midlands	4533.200	88	93	5.7	13 (14)	48,744	116
South East Coast / South Central	8634.800	149	153	2.7	39 (25)	56,437	220
UK	**63181.775**	**1414**	**1455**	**2.9**	**280 (19)**	**43,424**	**1610**

Population statistics 2011: Office for national statistics population census 2011 http://www.ons.gov.uk/ons/rel/census/2011-census/population-and-household-estimates-for-the-united-kingdom/stb-2011-census--population-estimates-for-the-united-kingdom.html (accessed Mar 2014).

There continues to be significant variation across England; South Coast/South Central having among the highest populations per gastroenterologist (56,437) and London the lowest (33,093) (table 6). Only the North East and London meet the RCP recommendation of number of gastroenterologists for the population served (adjusted for 14% working LTWT). However, as mentioned earlier, these figures do not take tertiary services into account.

There is also regional variation in the percentage of female gastroenterology consultants. The average for the UK is 19% but it is 20% in Wales, 19% in England, 20% in Scotland and 13% in Northern Ireland. In England the percentage of female consultants varies from 14% in the East Midlands to 25% in South East Coast/ South Central.

Single handed gastroenterologists

There are 15 consultants working alone (a significant reduction compared to 30 in 2014). 13 are in England, 1 in Wales and 1 is in Northern Ireland. 1 is working on an island.

Trainees in gastroenterology

Table 7: No. of LATs appointed by calendar year

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
No. LATs	58	57	64	59	45	65	58	59	30	4

The number of LATs appointed in 2016 was 4 (table 7). HEE reduced the number of LATs available for all medical specialties by 20% in 2015, and LATs were abolished in England in Jan 2016, the money saved was diverted to GP training. LATs are still permissible in Wales, Scotland & Northern Ireland.

In addition there are CMTs, clinical fellows and LASs in clinical posts, but numbers are insufficient to cover, leaving an unknown number of gaps in the service (on the 2nd Sept 2013 there were 28 unfilled posts in the UK (TPD census 2013).

Actual CCTs awarded

Table 8: No CCTs awarded by calendar year

	2007	2008	2009	2010	2011	2012	2013	2014	2015	*2016
No. CCTs	61	71	89	88	74	69	98	104	152	71

*1st Oct 2015 to 30th Sep 2016

71 UK gastroenterology CCTs were awarded from 1st Oct 2015 to 30th Sep 2016 (table 8). 46 of these were male (65%) and 25 female (35%) with an age range of 33-44 years. The mean duration of UK training was 6.8 years which is very similar to 2015 (range 4 to 12 years). Training time does not take into account absences due to, for example, parental leave and has not been adjusted for LTWT training. The average

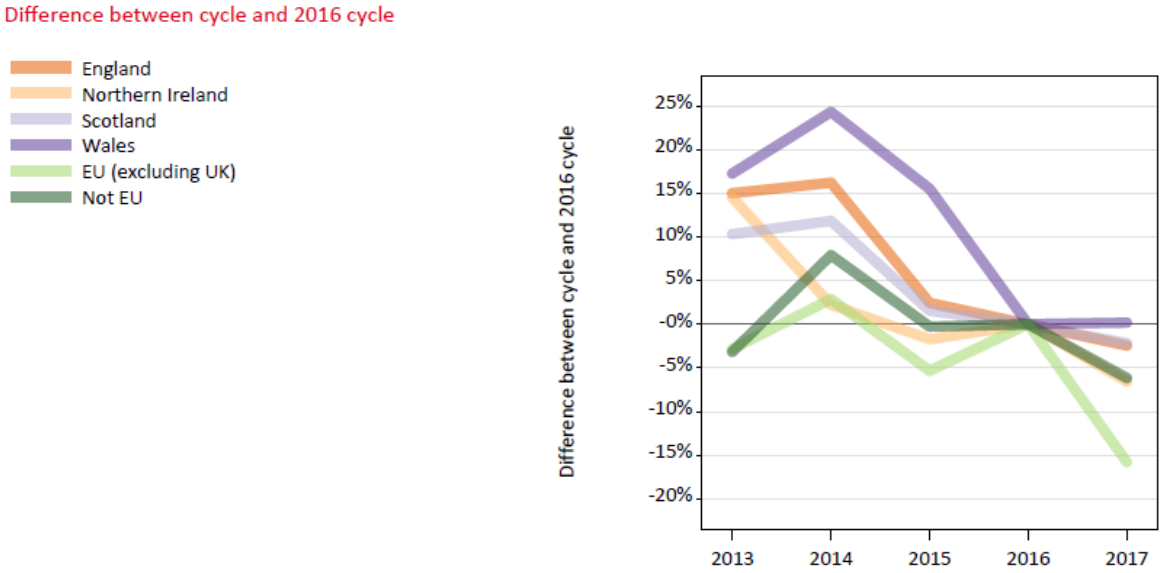
number of CCTs awarded has been 88 per year for the last 10 years. The average of 77 per year from 2007 to 2011 increased to 99 per year from 2012 to 2016.
12 Hepatology CCTs were awarded from 1st Oct 2015 to 30th Sep 2016. There were 8 male (67%) & 4 females (33%) with an age range of 35-43 years. The mean duration of UK training for those with a gastroenterology & hepatology CCT was 7 years (range 4 to 11 years).
There were 9 CESR applications for Gastroenterology from 1st Oct 2015 to 30th Sep 2016 of which 4 (44%) were successful. There were 0 hepatology CESR applications in this time period.

Recruitment

Medical Students

There were 19,210 applicants to study medicine in 2017, a fall of 890 (4%) on 2016 and a marked decline (16%) from the peak of 22,740 students applying to study medicine in 2014 (UCAS, 27th Oct 2016, figure 7). There were 40,078 medical students in the UK in 2015 taking 4-6 years to complete the course (GMC The state of medical education and practice in the UK report: 2016).
Health Secretary Jeremy Hunt has recently announced that there will be 1,500 more medical school places in 2018, in a bid to tackle the shortfall in junior doctor numbers and support a more sustainable workforce (which will help gastroenterology consultant recruitment, but not until 2032!). Once trained these doctors will have to work for the NHS for four years or pay back the cost of their training (estimated to be £220,000 according to the Government). How this will actually affect overall number of doctors in future remains to be seen.

Figure 7: Applicants for medicine courses with 15 October deadline by domicile group (2017 cycle)



AM.2 Applicants for medicine courses with 15 October deadline by domicile group

Domicile of applicant	2013	2014	2015	2016	2017
England	14,520	14,670	12,930	12,620	12,320
Northern Ireland	660	590	570	580	540
Scotland	1,160	1,170	1,060	1,050	1,030
Wales	670	710	660	570	570
–UK	17,000	17,140	15,220	14,820	14,450
EU (excluding UK)	1,990	2,110	1,940	2,050	1,720
Not EU	3,130	3,490	3,230	3,240	3,040
–All	22,130	22,740	20,390	20,100	19,210

According to the Guardian newspaper who have obtained leaked figures from HEE in a report on Wed 10th Feb 2016, applications of F2 doctors who have applied to start training as a specialist in a branch of medicine in Aug 2016 (assumed to mean CMT) are falling (17,106 in 2013, 16,308 in 2015 and 15,855 in 2016, 7.3% lower than in 2013). The number of F2 doctors applying to become GPs has fallen even more sharply (6,447 in 2013 and 4,863 in 2016 a 25% reduction). The dispute with the Government over junior doctor contracts and the imposition of the new contract on junior doctors in England from Aug 2016 may have resulted in more doctors applying to the devolved nations, leaving the NHS to go abroad, taking non-training posts or leaving medicine altogether, at least in the short term. This is very concerning and will probably affect ST3 and consultant recruitment in the future.

The number of UK CMT/ACCS posts advertised in round 1 has increased from 1555 in 2013, to 1549 in 2015 and 1640 in 2016 (91 more posts in 2016 compared to 2015).

The overall CMT fill rates in round 1 were 100% in 2013, 97% in 2015 and 80% in 2016 (1308 posts).

Table 9: CT1 Recruitment 2016 round 1, round 2, combined – fill rates by region

Round 1	**Posts**		**Accepted**		**Fill rate (% posts filled)**		
	ACCS	CMT	ACCS	CMT	ACCS	CMT	**Overall**
HE East Midlands	3	85	3	64	100.0%	75.3%	**76.1%**
HE East of England	9	106	9	78	100.0%	73.6%	**75.7%**
HE Kent, Surrey & Sussex	4	97	4	83	100.0%	85.6%	**86.1%**
HE North East	6	75	6	33	100.0%	44.0%	**48.1%**
HE NW (Mersey)	0	75	0	67	n/a	89.3%	**89.3%**
HE NW (North Western)	5	96	5	83	100.0%	86.5%	**87.1%**
HE SW (Peninsula)	2	45	2	33	100.0%	73.3%	**74.5%**
HE SW (Severn)	7	51	7	51	100.0%	100.0%	**100.0%**
HE Thames Valley	3	37	3	37	100.0%	100.0%	**100.0%**
HE Wessex	2	58	2	54	100.0%	93.1%	**93.3%**
HE West Midlands	2	118	2	68	100.0%	57.6%	**58.3%**
HE Yorkshire & Humber	6	150	5	100	83.3%	66.7%	**67.3%**
London	12	280	12	279	100.0%	99.6%	**99.7%**
Northern Ireland	0	81	0	41	n/a	50.6%	**50.6%**
Scotland	13	121	13	117	100.0%	96.7%	**97.0%**
Wales	2	89	1	46	50.0%	51.7%	**51.6%**
Totals	**76**	**1564**	**74**	**1234**	**97.4%**	**78.9%**	**79.8%**

Round 2	**Posts**		**Accepted**		**Fill rate (% posts filled)**		
	ACCS	CMT	ACCS	CMT	ACCS	CMT	**Overall**
HE East Midlands	0	17	0	16	n/a	94%	**94%**
HE East of England	0	37	0	37	n/a	100%	**100%**
HE KSS	0	10	0	10	n/a	100%	**100%**
HE North East	0	40	0	32	n/a	80%	**80%**
HE NW (Mersey)	0	6	0	6	n/a	100%	**100%**
HE NW (North West)	0	18	0	18	n/a	100%	**100%**
HE SW (Peninsula)	0	13	0	5	n/a	38%	**38%**
HE SW (Severn)	0	2	0	2	n/a	100%	**100%**
HE Wessex	0	5	0	5	n/a	100%	**100%**
HE West Midlands	0	49	0	49	n/a	100%	**100%**
HE Yorkshire & Humber	1	69	1	34	100%	49%	**50%**
London	0	9	0	9	n/a	100%	**100%**
Northern Ireland	0	40	0	5	n/a	13%	**13%**
Scotland	0	3	0	3	n/a	100%	**100%**
Wales	1	56	1	27	100%	48%	**49%**
Totals	2	374	2	258	100%	69%	**69%**

Overall 2016	Posts		Accepted		Fill rate (% posts filled)		
	ACCS	CMT	ACCS	CMT	ACCS	CMT	**Overall**
HE East Midlands	3	85	3	80	100.0%	94.1%	**94.3%**
HE East of England	9	116	9	115	100.0%	99.1%	**99.2%**
HE KSS	4	97	4	93	100.0%	95.9%	**96.0%**
HE North East	6	75	6	65	100.0%	86.7%	**87.7%**
HE NW (Mersey)	0	76	0	73	n/a	96.1%	**96.1%**
HE NW (North Western)	5	101	5	101	100.0%	100.0%	**100.0%**
HE SW (Peninsula)	2	45	2	38	100.0%	84.4%	**85.1%**
HE SW (Severn)	7	53	7	53	100.0%	100.0%	**100.0%**
HE Thames Valley	3	37	3	37	100.0%	100.0%	**100.0%**
HE Wessex	2	60	2	59	100.0%	98.3%	**98.4%**
HE West Midlands	2	118	2	117	100.0%	99.2%	**99.2%**
HE Yorkshire & Humber	6	169	6	134	100.0%	79.3%	**80.0%**
London	12	288	12	288	100.0%	100.0%	**100.0%**
Northern Ireland	0	81	0	46	n/a	56.8%	**56.8%**
Scotland	13	122	13	120	100.0%	98.4%	**98.5%**
Wales	2	107	2	73	100.0%	68.2%	**68.8%**
Totals	**76**	**1630**	**76**	**1492**	**100.0%**	**91.5%**	**91.9%**

The overall CMT fill rates for rounds 1 and 2 in 2014 were 1539/1545 (99.6%), in 2015 were 1558/1609 (96.8%), and in 2016 were 1568/1706 (91.9%) (table 9). Therefore despite a difficult year for doctors in training the number of trainees in CMT posts has increased slightly.

Approximately 15% of CMT trainees choose to go into non-medical specialties such as general practice or clinical oncology and a proportion also choose to spend some time working abroad. The number of training posts in general practice increased from 3609 in 2015 to 3896 in 2016 (287 more posts). The overall fill rate for GP ST1 2016 after both recruitment rounds was 89.6% (3490 posts). This represents the highest number of GP trainees the NHS has ever seen recruited in ST1.

2016 ST3 recruitment

A total of 1299 medical ST3 posts were offered in round 1 2016 recruitment. 1059 were filled (82%). The overall fill rate across all medical specialties has remained fairly constant despite the significant rise in the number of GP ST1s.

In the 2016 ST3 recruitment round 1 94 NTNs and 4 LATs (LATs were abolished in England in Jan 2016) were advertised in gastroenterology, a total of 98 training posts

(table 10). At the interview 100% of the NTNs and LAT posts were filled, so 100% of posts overall, although one trainee in the North East failed to pass MRCP and was therefore unable to take up their post (hence 99% of NTN posts filled). This compares to 94 of 94 NTNs & 30 of 39 LAT posts which were filled in round 1 2015 (93% of advertised posts overall). This compares to fill rates for all medical specialties of 1022/1235 (83%) of NTN posts, 37/64 (58%) of LAT posts & 1059/1299 (82%) of posts overall. The specialties that filled 100% of training posts were dermatology, medical ophthalmology and palliative medicine (none of which dual train with GIM). Fill rates for other major medical specialties combined with GIM were: cardiology (99%), respiratory (81%), endocrinology & diabetes mellitus (68%), geriatric medicine (85%) and acute internal medicine (62%). Of the 91 posts filled in England, Wales & Scotland 44 (48%) trainees were female and 47 (52%) male.

The new junior doctor's contract from Aug 2016 gives a pay premium in addition to nodal pay values for academia, emergency medicine, general practice, oral & maxillofacial surgery, and psychiatry training programmes. This may have an effect on recruitment to other specialties in 2017.

In the 2016 ST3 recruitment round 2 18 NTNs and 0 LATs were advertised in gastroenterology, a total of 18 training posts. 100% of the NTN posts were filled so 100% of posts overall. This compares to fill rates for all medical specialties of 190/358 (53%) of NTN posts, 2/9 (22%) of LAT posts & 192/367 (52%) of posts overall. Gastroenterology was the only medical specialty to fill 100% of training posts in R2.

Table 10: 2016 ST3 recruitment for gastroenterology by deanery/HEE local team

HEE Local team/Deanery	Round 1			Round 2		
	NTNs	LATs	**Total**	NTNs	LATs	**Total**
East Midlands	7/7 (100%)	0/0 (N/A)	**7/7 (100%)**	2/2 (100%)	0/0 (N/A)	**2/2 (100%)**
East of England	12/12 (100%)	0/0 (N/A)	**12/12 (100%)**	2/2 (100%)	0/0 (N/A)	**2/2 (100%)**
Kent, Surrey & Sussex	8/8 (100%)	0/0 (N/A)	**8/8 (100%)**	0/0 (N/A)	0/0 (N/A)	**0/0 (N/A)**
North East	7/8 (88%)	0/0 (N/A)	**7/8 (88%)**	2/2 (100%)	0/0 (N/A)	**2/2 (100%)**
NW Mersey	6/6 (100%)	0/0 (N/A)	**6/6 (100%)**	0/0 (N/A)	0/0 (N/A)	**0/0 (N/A)**
NW North Western	8/8 (100%)	0/0 (N/A)	**8/8 (100%)**	0/0 (N/A)	0/0 (N/A)	**0/0 (N/A)**
SW Peninsula	1/1 (100%)	0/0 (N/A)	**1/1 (100%)**	0/0 (N/A)	0/0 (N/A)	**0/0 (N/A)**
SW Severn	5/5 (100%)	0/0 (N/A)	**5/5 (100%)**	0/0 (N/A)	0/0 (N/A)	**0/0 (N/A)**
Thames Valley	2/2 (100%)	0/0 (N/A)	**2/2 (100%)**	0/0 (N/A)	0/0 (N/A)	**0/0 (N/A)**
Wessex	3/3 (100%)	0/0 (N/A)	**3/3 (100%)**	2/2 (100%)	0/0 (N/A)	**2/2 (100%)**
West Midlands	7/7 (100%)	0/0 (N/A)	**7/7 (100%)**	0/0 (N/A)	0/0 (N/A)	**0/0 (N/A)**
Yorkshire & Humber	9/9 (100%)	0/0 (N/A)	**9/9 (100%)**	4/4 (100%)	0/0 (N/A)	**4/4 (100%)**
London recruitment	6/6 (100%)	0/0 (N/A)	**6/6 (100%)**	5/5 (100%)	0/0 (N/A)	**5/5 (100%)**
Scotland	7/7 (100%)	0/0 (N/A)	**7/7 (100%)**	0/0 (N/A)	0/0 (N/A)	**0/0 (N/A)**
Wales	3/3 (100%)	0/0 (N/A)	**3/3 (100%)**	1/1 (100%)	0/0 (N/A)	**1/1 (100%)**
Northern Ireland	2/2 (100%)	4/4 (100%)	**6/6 (100%)**	0/0 (N/A)	0/0 (N/A)	**0/0 (N/A)**
Total	**93/94 (99%)**	**4/4 (100%)**	**97/98 (99%)**	**18/18 (100%)**	**0/0 (N/A)**	**18/18 (100%)**

Table 11: The "NTN weave"

Deanery/LETB	No. clinical training posts (CTP)	CTP x 1.36 (NTN weave)
East Midlands LETB	33	45
East of England LETB	39	53
*Kent, Surrey & Sussex LETB	18	24
North East LETB	29	39
NW – Mersey LETB	24	33
NW - North Western LETB	32	44
SW Peninsula LETB	11	15
SW Severn LETB	16	22
Thames Valley LETB	14	19
Wessex LETB	24	33
West Midlands LETB	46	63
Yorkshire & Humber LETB	44	60
*London S LETB	36	49
London NW LETB	37	50
London NC & E LETB	48	65
Scotland	37	50
Wales	21	29
Northern Ireland	14	19
Total	**523**	**711**

**A large proportion of KSS trainees have clinical posts in London and other regions (mainly London south).*

Table 11 looks at the number of numbered clinical training posts and estimates the total number of NTNs required in each deanery/LETB to avoid rota gaps for the average number of trainees going out of program ("the NTN weave"). This number is an estimate and should be determined by the training programme director for each deanery/LETB at each recruitment round.

2017 ST3 recruitment

Round 1 2017 recruitment will follow the same process as in 2016: single transferrable score recruitment model with interviews held at 3 centres (London, Birmingham and Edinburgh). The adverts will be published by Wed 25th Jan 2017 (www.jobs.nhs.uk), interviews will be held between Mon 6th Mar to Wed 26th April 2017 and the process will complete by Fri 5th May 2017.

Round 2 2017 recruitment will also follow the same process as in 2016: single transferrable score recruitment model with interviews held at 1 centre (Edinburgh).

National Advanced Training Programme Posts (ATPs)

Hepatology

In 2016/17 there were 15 English & 1 Scottish hepatology ATP posts. 14 English posts were recruited nationally for the third time in Jan 2016 (1 post was filled by a trainee returning from maternity leave). Scotland joined the national recruitment process for the first time this year. 24 candidates were interviewed, 23 were deemed appointable and all offers of posts were accepted by the trainees. 1 trainee subsequently pulled out, but the post was refilled by a trainee from the North East. 12 trainees will complete the hepatology ATP year before (11 trainees) or at the same time (1 trainee) as obtaining their gastroenterology & GIM CCT (i.e. within the training programme), 2 trainees have a CCT date before completion of the hepatology ATP post (although will complete the ATP within their 6 month grace period) and will therefore extend their training time.

In 2017/18 there will be an additional hepatology ATP post in Leeds (17 posts in total). Scotland will take part in the national recruitment process again next year. The posts will be advertised in November 2016 with a proposed date for interview of Wed 25 Jan 2017 in London.

There may be a second Scottish ATP post in the future if funding can be secured.

Nutrition

4 nutrition ATP posts were offered for 2016/17 (2 St Mark's/Addenbrookes, John Radcliffe Hospital/Hope Hospital). 3 candidates were interviewed in Jan 2016 and accepted posts. 1 candidate will finish the post 1 month after their 6 month grace period post-CCT, the other two candidates will complete their ATP post before the end of their grace period. The Salford/Oxford post was not filled during the national process but was filled subsequently after a second interview by a local trainee. The large geographical split between the Salford/Oxford posts in particular appears to be putting trainees off applying and a 3/9month split may work better. The posts will be advertised in November 2016 with a proposed date for interview of Tues 24th Jan 2017. There does not appear to be the demand from trainees to create more nutrition ATP posts.

Consultants

British Medical Journal (BMJ) Advertisements

There were 119 substantive gastroenterology or hepatology consultant jobs advertised in the BMJ between 1st Oct 2015 & 30th Sep 2016 (114 in England, 4 in Scotland, 1 in Northern Ireland and 0 in Wales) (figure 8). 117 of these posts were whole time and 2 were less than whole time (1 gastroenterology and 1 hepatology post). The three regions with the largest number of posts were North West, London and East of England. 42 (35%) were new posts, 7 (6%) replacement posts, 2 (2%) retirement posts and 68 (57%) were unclassified. Some of the posts were not filled and were therefore advertised more than once. Some posts would have been advertised on NHS jobs but not in the BMJ and are not shown here.

Figure 9 shows the type of jobs advertised in the BMJ. 103 of the 119 advertised posts (87%) were after a pure gastroenterologist, 8 (7%) a physician & gastroenterologist, 7 (6%) a hepatologist, 1 (1%) a physician & hepatologist.

Figure 8: Number of substantive consultant advertisements in the British Medical Journal by region 1st Oct 2015-30th Sep 2016

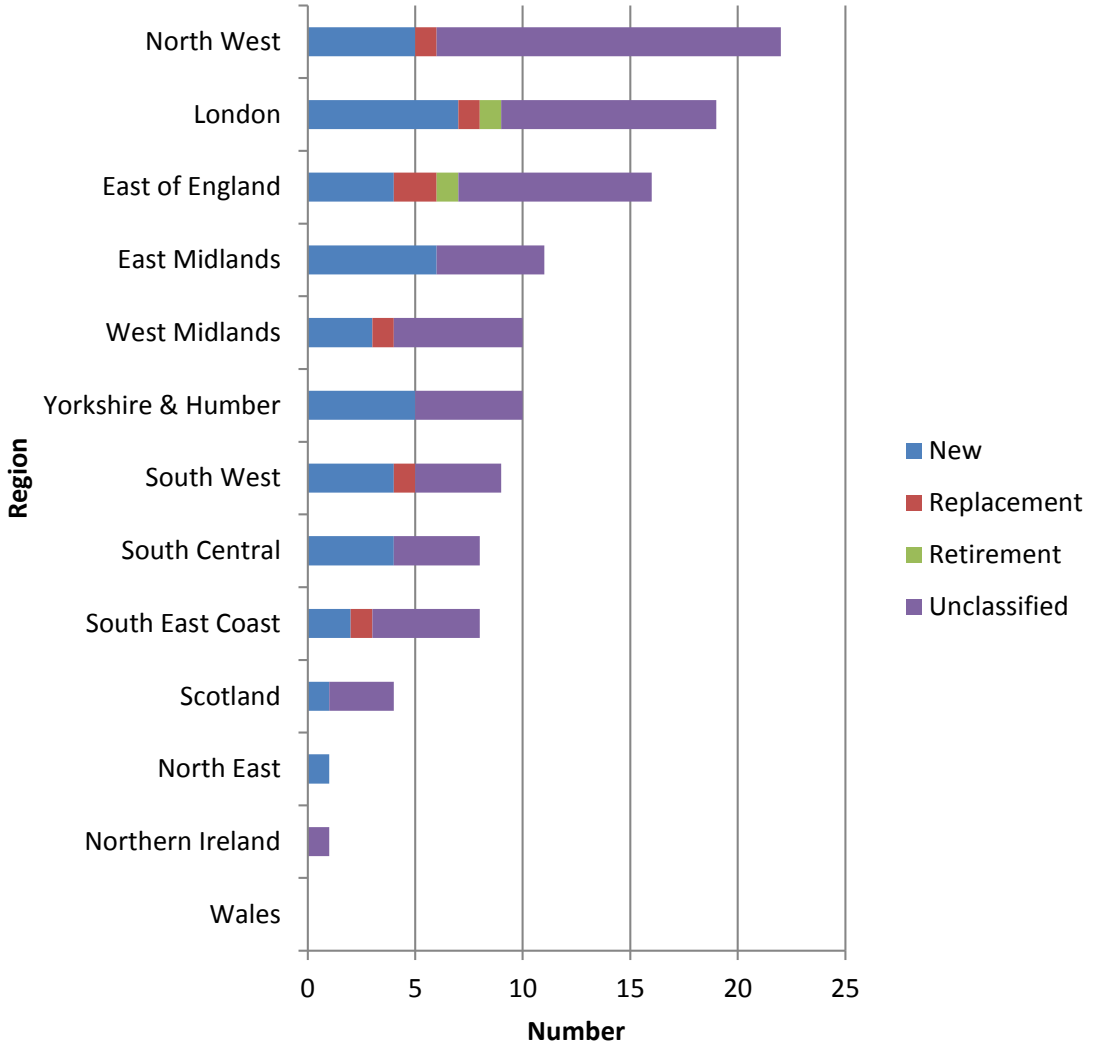
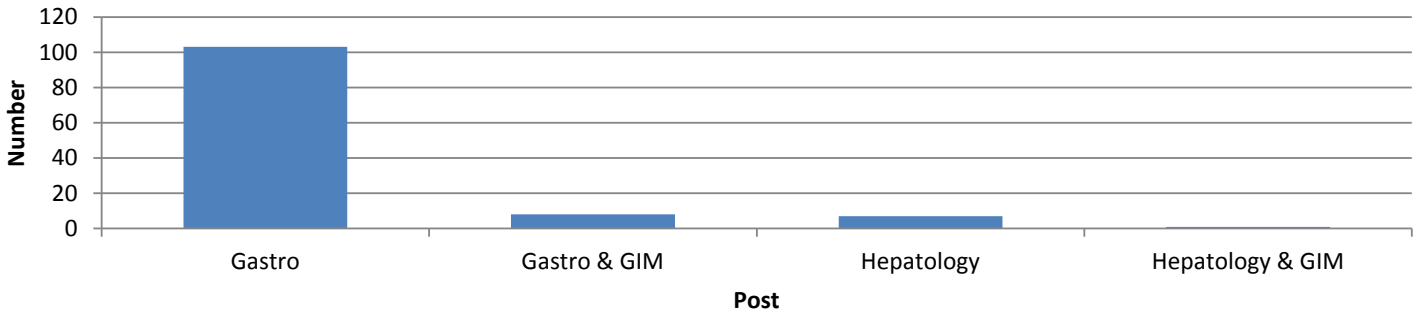


Figure 9: Type of consultant posts advertised



Appointments

Table 12: Outcome of substantive gastroenterology & hepatology consultant appointment advisory committees (AACs) by LETB 1st Sep 2015- 31st Aug 2016 AAC data (No data for Scotland and Northern Ireland)

LETB / deanery	No. appointments attempted	Appointed N (%)	Not appointed	No applicants	No suitable applicants	Withdrawn	Unknown	Total no. unfilled
Scotland	?	?	?	?	?	?	?	?
Northern Ireland	?	?	?	?	?	?	?	?
Wales	4	2	1	1	0	0	0	2
North East LETB	2	0	0	2	0	0	0	2
North Western LETB	22	11	0	4	2	5	0	11
Y & H LETB	18	10	1	4	1	2	0	8
E Midlands LETB	15	8	0	6	0	1	0	7
W Midlands LETB	24	10	5	3	3	3	0	14
E of E LETB	21	11	4	6	0	0	0	10
NW Lon LETB	2	2	0	0	0	0	0	0
NC & E Lon LETB	15	11	3	1	0	0	0	4
S Lon LETB	14	9	0	2	2	1	0	5
KSS LETB	8	6	0	1	0	0	1	2
Thames Valley LETB	6	3	0	2	1	0	0	3
Wessex LETB	9	0	0	2	5	2	0	9
South West LETB	11	6	0	5	0	0	0	5
Guernsey	1	0	0	1	0	0	0	1
Total	**172**	**89 (52%)**	**14 (8%)**	**40 (23%)**	**14 (8%)**	**14 (8%)**	**1 (1%)**	**83 (48%)**

We have data from the RCP Appointments Advisory Committee (AAC) from 1st Sep 2015 to 31st Aug 2016 for 172 attempted appointments in gastroenterology & hepatology combined (no data for Scotland or Northern Ireland) (table 12 & figure 10-12). Of these posts 89 (52%) were filled but 83 (48%) were unfilled. There were no applicants for 40 appointments (23%) and no suitable applicants for 14 appointments (8%). No appointments were made in 14 cases (8%) and in one of these cases the appointed consultant was appointed to another consultant post less than 3 months after the original consultant appointment. 16 of the 89 appointments (18%) were filled by existing consultants in a substantive post who would leave a vacancy and would not lead to an increase in the number of consultants. In addition to this I am aware that some Trusts are not advertising posts as they are waiting for a suitable trainee to get CCT prior to advertisement.

The fact that we are unable to fill substantive consultant posts suggests that trainees

are prepared to wait for the right job for them (be it job plan, sub-specialty or location) rather than move for any job. In order to attract candidates Trusts need to advertise attractive job plans for example minimisation of cross-site working, >1.5 SPAs, research sessions, flexibility, an opportunity to sub-specialise etc.

Of the 89 successful appointments 31% were female and 69% male. The age range of successful appointments is illustrated in the bar chart below. The majority of consultants were age 35-39 years, however 7 were more than 50 years of age at appointment.

Figure 10: Age group of successful substantive gastroenterology & hepatology consultants 1st Sep 2015 to 31st Aug 2016 AAC data (no data for Scotland or Northern Ireland).

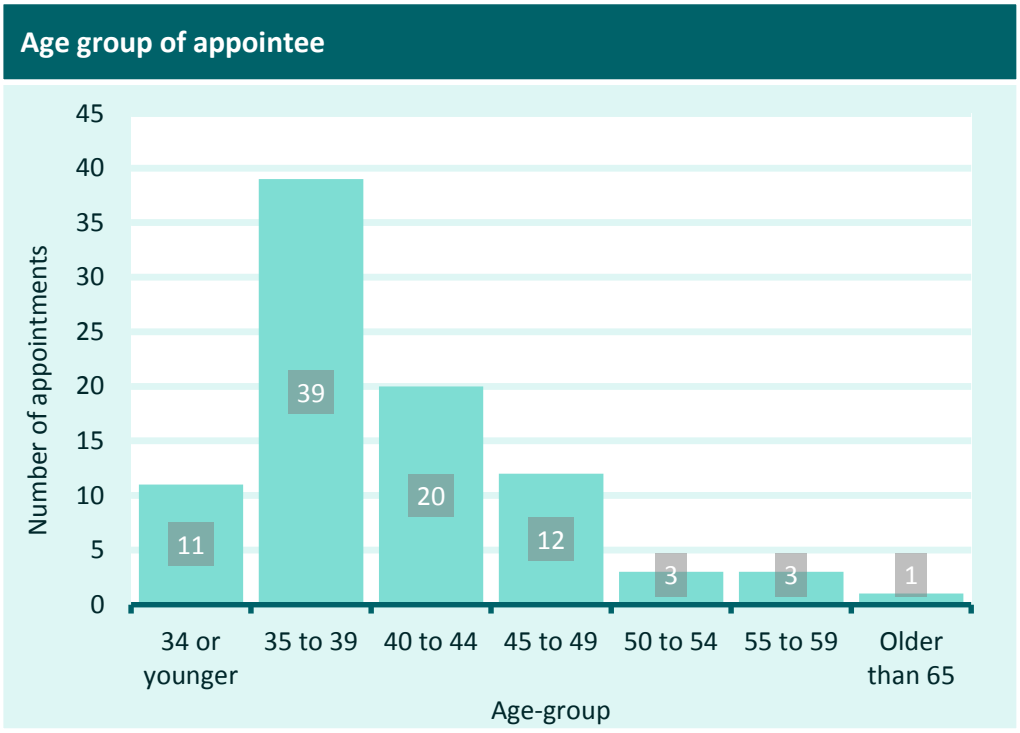


Figure 11: Outcome of substantive gastroenterology & hepatology consultant AACs by LETB or region 1st Sep 2015 to 31st Aug 2016 AAC data (no data for Scotland or Northern Ireland)

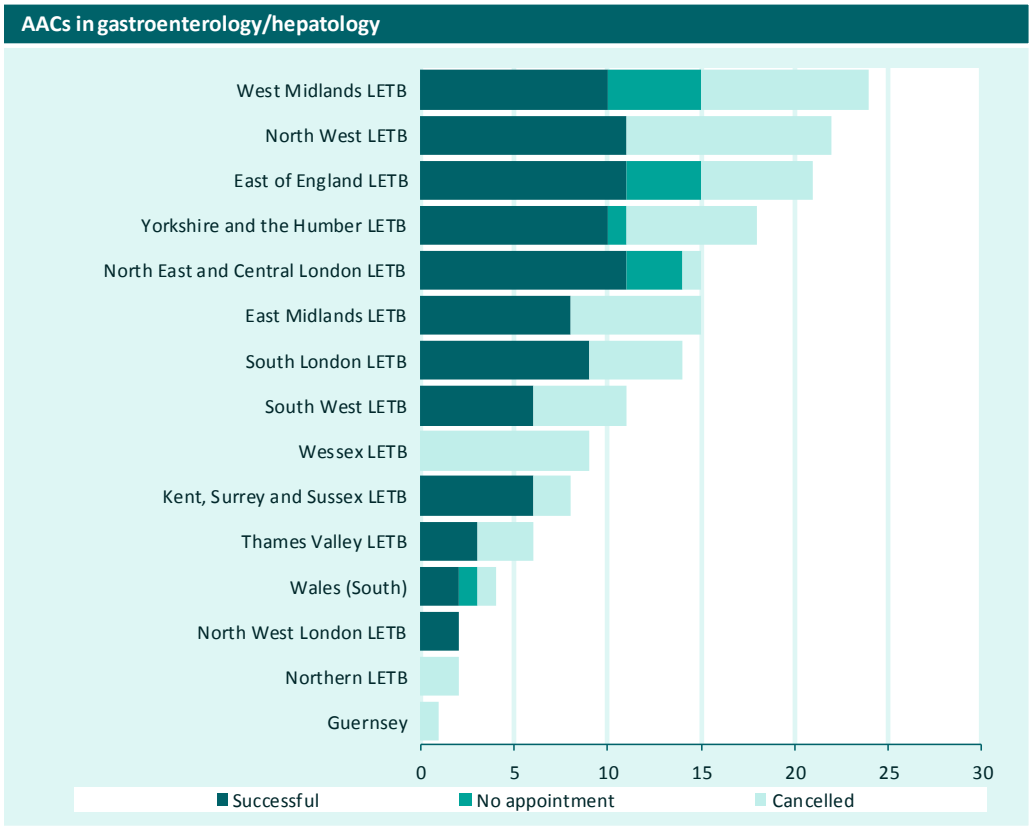


Figure 12: Appointment cancellations of substantive gastroenterology & hepatology consultant AACs by LETB or region 1st Jan to 31st Dec 2015 AAC data (no data for Scotland or Northern Ireland)

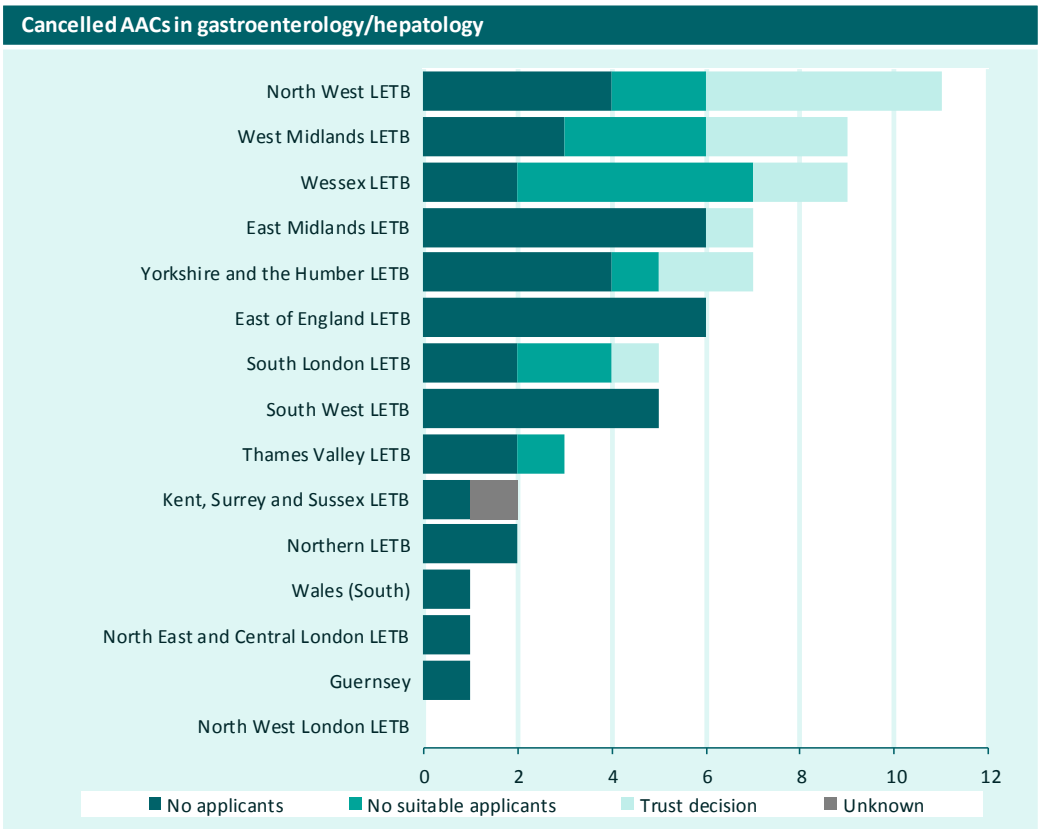


Figure 13 shows the trend in successful, no appointment, cancelled and total number of AACs for gastroenterology & hepatology from 2008 to 2015 calendar years in the UK (excluding Scotland). The number of attempted appointments started to increase in 2012 from an average of 92 (2008-2011) to 172 in 2015 (87% increase). There has been a 22% increase in successful appointments (89 in 2015 versus an average of 73 for 2008-2012) reflecting the increase in average CCT output which was 77 from 2007 – 2011 and increased to 99 from 2012 – 2016. The number of unfilled posts has risen dramatically from an average of 19 between 2008 - 2011 to 83 in 2015 (437% increase) as despite an increase in CCT output, this has not been sufficient to meet the unprecedented demand for new posts. This trend has been seen in the other specialties that dual accredit with GIM.

Figure 13: Trend in successful, no appointment & cancelled AACs 2008-2015 (no data for Scotland)

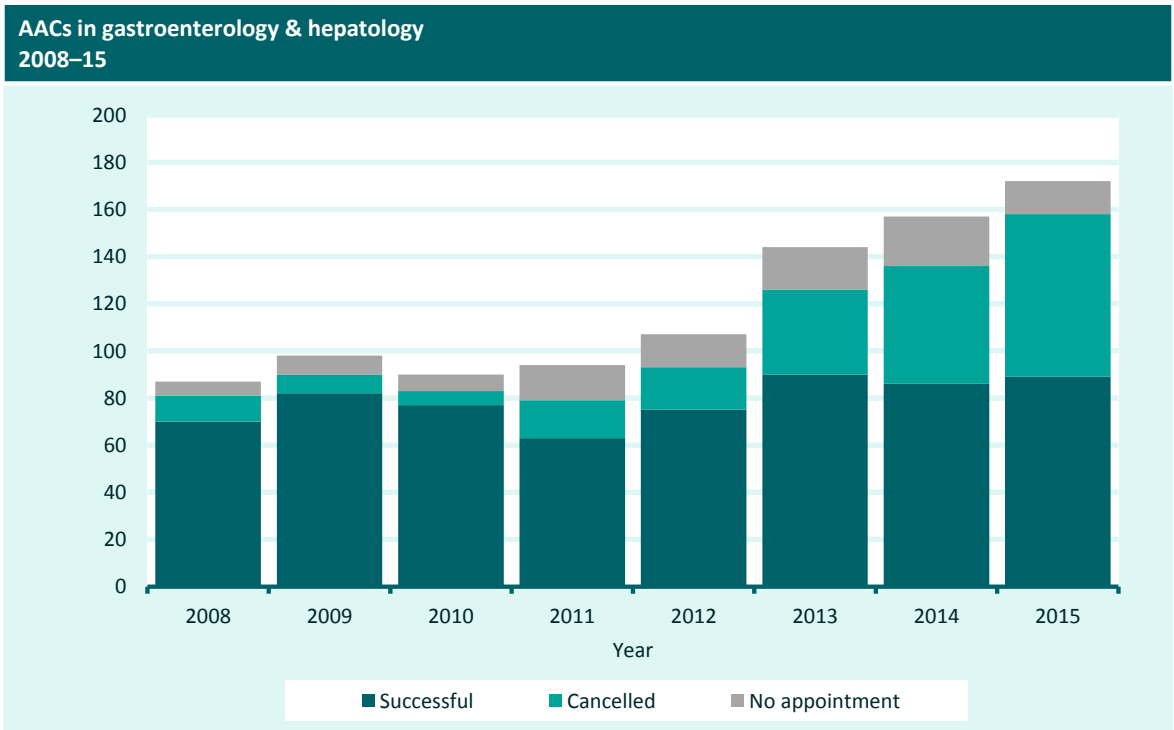
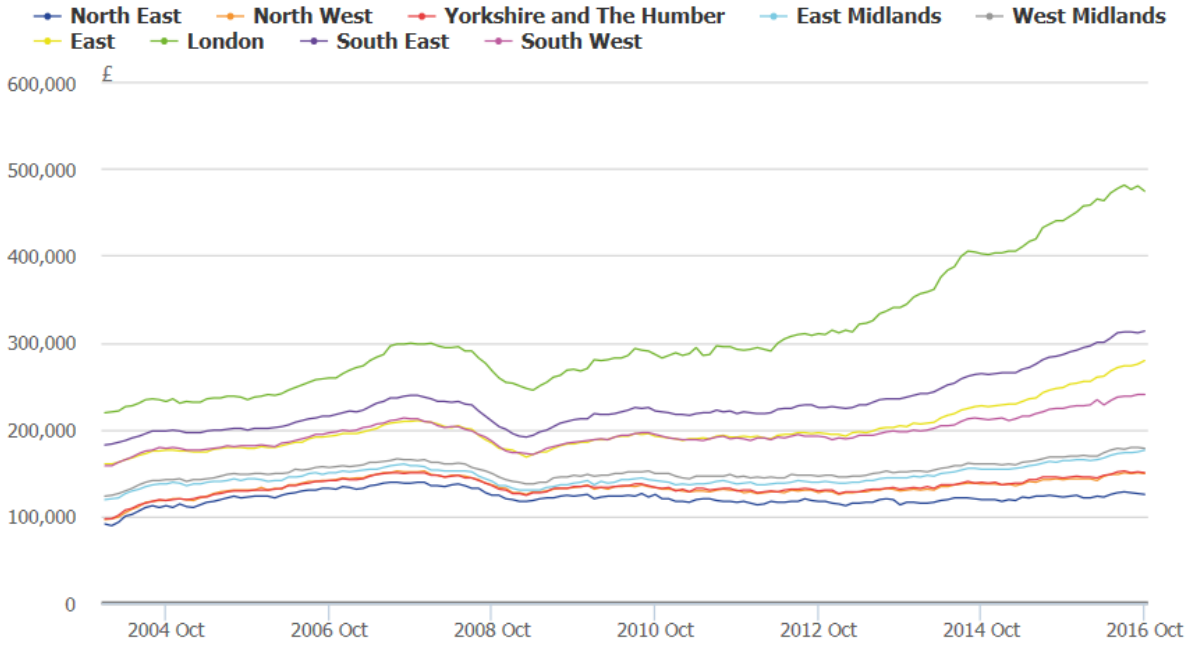


Figure 14: average house price by English region Jan 2004 to Oct 2016: (ONS



On a regional basis, London continues to be the region with the highest average house price at £474,000, followed by the South East and the East of England, which stand at £313,000 and £279,000 respectively. The lowest average price continues to be in the North East at £125,000. It is perhaps a little surprising that it is so difficult to fill substantive posts outside of London when you consider London house prices are so high (figure 14) and we have a national contract. However the majority of trainees are trained in London and we know that only a third will move regions for their substantive post. Health Education England should therefore consider moving NTN posts away from areas that have reached recommended consultant numbers to areas which have a shortage of consultants and / or recruitment difficulties.

Future changes to consultant numbers

Increased need for gastroenterologists:

- **National screening programmes**. The national flexible sigmoidoscopy screening programme for the population between 55-64 years of age – "Bowel Scope" was piloted in March 2013 and was rolled out nationally from 2014 to 2016 with £60 million pounds investment from the Department of Health. The BSG has estimated that the extra work for FSig will require 93 WTE individuals, not necessarily doctors, divided across the 59 screening

centres. This additional requirement has not been included in the RCP workforce estimates. There are plans to replace FOB testing with faecal immunochemical testing (FIT). Initially the sensitivity will be set to generate 2% positive tests (the same as FOBt) to avoid placing too much demand on the endoscopy service, but there are plans to gradually increase the sensitivity of FIT with time & hence the number of colonoscopies that will be required.

- **Increasing endoscopy demand**. Results of a detailed modelling exercise by the Department of Health has suggested that the demand for colonoscopy, flexible sigmoidoscopy and gastroscopy needs to rise by 27%, 127% and 15% per month on average respectively by 2019 to meet the 6-week wait standard and meet the projected demand for screening tests using historical trends since 2008 to predict future demand. This is equivalent to a need to deliver an extra 400,000 colonoscopies, 1 million flexible sigmoidoscopies and 300,000 gastroscopies over next 5 years. Even if capacity continues to increase at the rate it has been doing so since 2008, there will still be a major shortfall. Already, endoscopy activity in the UK is less than in comparable nations and there is significant variation, in particular relating to % of patients waiting more than 6 weeks for a procedure. The document includes an action plan calling for national workforce planning for endoscopy (already underway), improving productivity of existing workforce & endoscopy units and a major expansion of Non-Medical Endoscopist (NME) posts. As we already have nurse endoscopists and there is also a limited supply of these, a pilot of training other NMEs such as allied health professionals and Physicians Associates to endoscope is underway.
- **Recent BSG Barrett's oesophagus guidelines (Oct 2013)** have recommended considering endoscopic screening in patients with chronic GORD symptoms and multiple risk factors (at least three of age 50 years or older, white race, male sex, obesity), with a lower threshold in the presence of a family history.
- **Hepatology**. Increased hepatology requirements from a change in population behaviour, i.e. increase in obesity, diabetes and alcohol misuse. The National Liver Plan asks for a trained Hepatologist in every trust.
- **The future hospital commission proposals (March 2012):** continuous 7-day

care, holistic inpatient care by a single team with specialist input, specialist medical care in the community

- **Management of UGI bleeding.** NICE (June 2012) and NCEPOD (July 2015) recommend that unstable patients should have an OGD immediately after or within 2 hours of resuscitation and everyone else within 24 hours. Units seeing more than 330 cases per year should offer daily endoscopy lists.
- **7 day consultant present care (Dec 2012).** Increasing requirement for 7 day consultant present care, necessitating increased consultant gastroenterologist time at weekends in most acute settings. Estimating that weekend working comprises a ward round and an endoscopy list on each weekend day/ bank holiday, then in 52 weeks there will need to be 104 weekend days work, plus 8 bank holidays, making 112 days per year. These could be taken as 'days in lieu', often targeting Mondays/Tuesdays after a weekend, or taken as annual leave (Wirral model currently used successfully). If taken as annual leave then 112 days equates to 22 weeks leave, or almost 0.5 WTE. With approximately 220 Trusts across the UK, this would need about 110 new consultants. Other services may choose to take gastroenterologists off GIM on call to compensate for specialty work at the weekend and increase the number of acute physicians and geriatricians instead to cope with the larger number of acute medical admissions over the age of 65 years.
- ***Be clear on cancer*** **symptom awareness campaigns.** These started in 2010 and are activity to promote diagnosis of symptomatic cancers. For GI cancers there have been campaigns for symptoms of dyspepsia, dysphagia, change in bowel habit & PR bleeding. These have resulted in large increases in 2 week wait, outpatient & endoscopy demand.
- **The launch of a major early-diagnosis programme.** Part of the vision set out in the NHS Five Year Forward View (Oct 2014), which calls for action on three fronts: better prevention; swifter diagnosis; and better treatment, care and aftercare for all those diagnosed with cancer. Several new approaches have been suggested by the independent cancer taskforce report "achieving world-class cancer outcomes a strategy for England 2015-2020". The aim is to identify cancer more quickly and the suggestions are currently being

evaluated and may be implemented from 2016/17. Initiatives include: offering patients the option to self-refer for diagnostic tests; lowering referral thresholds for GPs; and multi-disciplinary diagnostic centres where patients can have several tests in the same place on the same day. All of these would create more endoscopy demand.

- **Increase in the number of consultants working LTWT** due to larger number of female gastroenterologists and retirements brought forward by the lower pension lifetime allowance (LTA).
- **Changes to the NHS pension**. The pension LTA fell from 1.8 million to 1.5 million on 06.04.12, to 1.25 million on 06.04.2014 and to 1 million from 06.04.16. This resulted in some consultants taking their pensions and coming back to work on a LTWT contract on their terms (often no ward commitment or on call). This does increase new appointments but probably at a lower rate than predicted.
- **An expanding and aging population.** The ONS predicts that the UK population will grow by 1% per year to reach 68 million by 2020 however the elderly population, who are high users of Gastroenterology services, will grow more than this, by approximately 3% per year.
- **Consultant contract negotiations** (in progress). A truly seven day service without a reduction in output Mon to Fri can only be achieved with more staff which will presumably only be possible if the existing staff are paid less (achieved with a lower starting salary & a lower top point of scale, redefining unsocial hours and the removal of all local clinical excellence awards (which are pensionable) and their replacement with a local performance award scheme (which is likely to be non-pensionable). Final contract proposals were expected in 2016 but are still being negotiated. The outcome could result in mass early retirement or a two tier pay system.
- **Brexit.** 1 in 10 of the UK's registered doctors is an EU national The Brexit result has left the future status of 3 million EU citizens living in Britain uncertain. While the Institute of Public Policy Research (IPPR) says their deportation is ultimately unlikely, the lack of official reassurance is already having a chilling effect on those seeking jobs, housing, bank loans or making other long-term commitments. The IPPR also suggests that any EU nationals

who have lived in Britain for more than six years should be automatically entitled to British citizenship, as well as all children of EU nationals who have been educated in the UK. Automatic indefinite leave to remain should be offered to all other EU migrants currently in Britain.

The majority of the gastroenterology consultant workforce is contracted for a for 12 or more PAs, and most work more than this (2015 BSG Workforce survey). There would appear to be saturation of available resources to enact the increased demands, necessitating an increase in the number of WTE gastroenterologists to meet needs.

Reduced need for gastroenterologists:

- **If gastroenterologists withdraw from GIM rotas** (although not if this is to compensate for 7 day gastroenterology services).
- **If others take on traditional gastroenterology roles**, e.g. radiology replaces endoscopy (e.g. prepless x-ray imaging capsule for colon cancer screening), non-medical endoscopist numbers increase.
- **If curative treatments are found**, e.g. new treatments for hepatitis C.
- **Changes to commissioning to a "1 year of care" model rather than payment by results.** This would drive secondary care to be more efficient to preserve profit, for example by screening out unnecessary referrals.
- **Changes to the NHS pension**. Changes to the NHS pension scheme in April 2015 linked usual retirement age (currently 60 for most) to State Pension age (increasing to 66 in 2018-2020). This may result in a 6 year retirement vacuum leading to an excess of CCT holders over jobs in April 2026 when protection arrangements cease.

Future changes in trainee numbers

- **Shape of training review (Oct 2013).** The JRCPTB is developing a new internal medicine curriculum, designed in part in response to the Shape of Training report. The proposed outline model for physician training is illustrated in figure 15. The JRCPTB plan to make a curriculum submission to the GMC in Spring 2017. To increase the number of general medical registrars there will

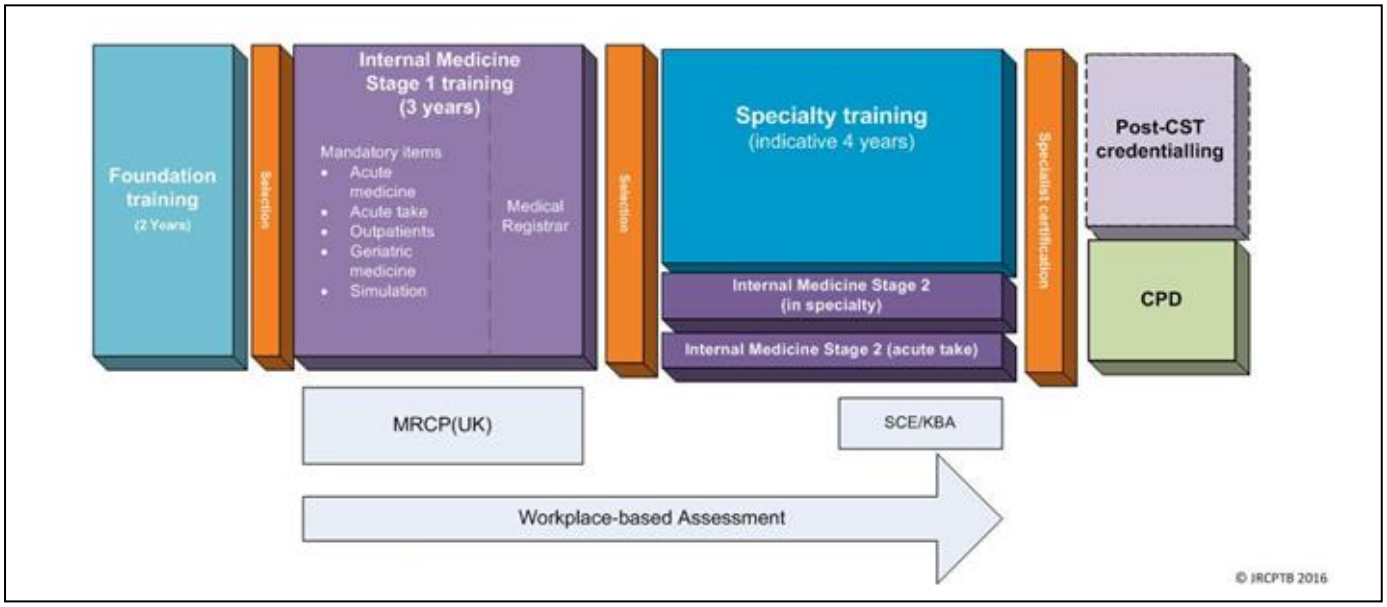
be an additional year after completion of 2 years of CMT and passing MRCP (termed the “medical registrar” year) prior to selection for specialty training. All physicians will undertake these 3 years termed Internal Medicine (IM) stage 1 training. It is not yet clear where the medical registrar year posts will come from. We should argue strongly that these should not come from existing gastroenterology NTN posts as this may reduce eventual CCT output (as not all trainees doing a gastroenterology medical registrar year post will go on to specialty training in gastroenterology). The best solution would be to use our clinical fellow posts. This would have at least two probable advantages: it would be likely to increase the fill rates of these posts as they would be converted to numbered training posts, it would also probably lead to an increase in the total number of gastroenterology trainees, hopefully increasing CCT output.

Following successful appointment to a specialty training programme, trainees will undertake one of the following routes:

- Completion of specialty training + IM stage 2 (in specialty) = CST in specialty
  Or
- Completion of specialty training + IM stage 2 (in specialty) + IM stage2 (acute take) = CST in specialty AND CST in IM.

  Specialty training has been reduced from 5 to 4 years. For gastroenterology to be able to train a trainee in this time, subsequent years could only have a maximum of 25% IM & preferably at least one year would be without IM. The first year would probably be the best time for this to allow maximum exposure to endoscopy training (SPRINT endoscopy training is a good model). A small proportion would also go on to credential in sub-specialty areas in gastroenterology post CCT, driven by workforce & patient needs. It has been proposed that funding for national credentialing would come from the removal of funding for the 6 months period of grace post CCT although as there are gaps in rotations due to inadequate numbers of CMTs to fill posts & trainees OOP there should be adequate employment opportunities for post CCT trainees while looking for a substantive consultant post.

Figure 15: JRCPTB proposed outline model for physician training



- **Junior doctor contract negotiations** (in progress). The imposition of a new contract on junior doctors in England from Aug 2016 may lead to a further drop in CMT & ST3 recruitment in England in 2016 with some trainees choosing to apply for posts in devolved nations or abroad, take a non-training post or leave the NHS altogether, at least in the short term.
- **Brexit** (see above).

Surrogate markers for pressure on jobs:

83 (48%) of advertised substantive gastroenterology consultant posts were not filled in 2016 and 23% had no applicants. There appears to be regional variation in consultant recruitment success. London & adjacent regions are usually able to successfully recruit, although even in London, there are posts that do not appear to be popular.

Conclusions

Consultant expansion is lower than it could be as 48% of advertised consultant posts have not been filled. In addition, Trusts are holding back posts until there is a suitable applicant available. Gastroenterology is predicted to have an excess of substantive consultant jobs compared to CCT output in the next five years, due to unplanned demand for gastroenterology services (especially endoscopy). However, trainees should not be complacent, as competition for popular posts remains high.

Gastroenterology remains a popular specialty with all training posts filled in 2016. However, due to the abolition of LAT posts in England, there are still unfilled gaps in training rotations due to for example: a LTWT trainee in a whole time post, parental leave, going out of programme or leaving post CCT. Attempts are made to fill gaps with service posts (LAS or clinical fellow posts). However, they are often difficult to fill due to an overall deficit of 300 CMT posts. Therefore there is no push, by training programme directors, of CCT holders to get a consultant job.

It is likely that the need for gastroenterologists will continue to increase dramatically in the coming few years due to expansion of screening programmes, population demographic changes, out of hours bleed rotas, the requirement for the service to cover evenings, weekends & bank holidays and the Governments strategy to improve outcomes the NHS delivers for people affected by cancer. This should provide more employment opportunities for CCT holders as increased income from tariffs (not applicable everywhere) should fund the posts.

HEE have agreed that the number of NTNs in a region/LETB should be approximately 36% higher that the number of clinical training posts to allow for trainees going out of program ("the NTN weave"). The exact number at any one time should be determined by the training programme director in consultation with the LETB as small rotations have less flexibility than large rotations.

NTN posts should be moved from areas of CCT overproduction to areas with consultant under-provision & recruitment difficulty.