

BGCS Workforce Summary 2022

Situation

There was evidence from the Scottish Ovarian Cancer Survival Analysis and the English Ovarian Cancer Outcomes audit to indicate regional variation in outcomes. The precise reasons for regional variation were not clear but workforce assessment was felt to be an important area to assess. Further, there was data from the International benchmarking Studies on ovarian cancer to highlight the need for the UK to assess where improvements can be made.

Nationally there has also been a subjective feeling that there are significant differences in the composition of the surgical workforce in gynaecological oncology. Extending this subjective assessment to the wider workforce delivering gynaecology cancer care through the MDT, there are also concerns that this may impact across all workforce groups.

The BGCS set up a short life working group as a cancer society to assess the minimal data set required to answer basic workforce questions. As a society for all groups we attempted to answer questions all groups delivering gynaecological cancer care.

Background

Initial discussions took place with the RCOG as they were also undertaking a national workforce assessment under the direction of Jo Mountfield. This led to some discussions (and potential future work) with Health Education England (HEE) representatives. Additionally, discussions took place with Mr Bill Allum, Vice President of the Royal College of Surgeons, to determine if similar work was underway in other surgical specialties. The RCOG were primarily assessing future workforce requirements with respect to the needs in 2030 with an ageing population across NHS England. The RCOG were planning to use this data to determine how many specialty and subspecialty training posts would be required and where these posts should be delivered to match regional training requirements. The RCS have no projects underway and the only similar project was in paediatric cardiac surgery.

Regional representatives came together to discuss the potential question set. The question sets were debated on a number of occasions, discussed at council and sent out to individuals in each region who we felt were the most likely to respond. We devised question sets for Gynaecology oncologists, medical oncologists, clinical oncologists, radiologists, pathologists and clinical Nurse Specialists.

The questions tried to determine the current workforce complement, workforce vacancies, perceived ideal workforce complement. We used the terminology Wholetime equivalent due to the split responsibilities associated with most specialties involved in our MDT.

The question sets were sent as a survey to try and help with the collation of the results. Where individuals had difficulty in accessing or completing the survey we sent out an excel sheet with the same questions and manually collated the results.

Des Barton was also very interested in assessing the exenteration workload between centres and additional questions on this were also included with the survey. This was felt to be appropriate as it would allow distinctions between centres with respect to the volume of complex exenteration procedures. However, it was not the primary focus of the survey.

The denominator for regional catchment area size was taken from work completed by Anil Tailor in 2012 and 2014. Current catchment area sizes are very difficult to determine and this was felt to be an initial pragmatic approach until an alternative approach could be completed. Tom Clayton, HEE representative leading on RCOG workforce modelling, has described a number of possible methods for this work and has offered to complete this free of charge for the society.

Assessment

The survey was completed by 81% of centres due to a combination of diligent completion and gentle nudging from regional representatives. The most reliable data was from the gynaecological oncology responses and the clinical nurse specialist responses. The difficulty with responses from the other specialties was the issue where they undertake work in areas other than gynaecological cancer. Due to the complex composition of job plans and the fluid nature of work it was difficult to identify clear data to allow comparison between centres.

The assessment will therefore focus of the Gynaecological Oncology and Nurse specialists findings. The range of hours operating by consultants was from 5-18 hours each week. The Median number of consultants was 3 with a range of 2-10 consultants per centre. The range of consultant per Million population was 1.25 to 5. The range of vacancies was from 0-3 with a median of 1 vacancy per centre.

The figures for the surgical group were influenced by the size of a centre in that some centres with the highest number of consultants/ million population were in actual fact smaller centres where a minimum number is required to maintain a service. It was also difficult to devise a question or assessment method to determine on each centre how much work was traditional 'centre' work and how much was 'unit' work.

However, the figures do highlight significant regional variation. There were 140 consultants in post from the responses received. The current vacancies were 15.5 and the perceived need for additional posts were 24.5, giving a total of 40 potential vacancies. The findings do not account for any future population demographic changes with our aging population, rise in endometrial cancers due to obesity or evidence based changes in clinical practice (e.g. secondary cytoreductive surgery).

Assessment of the clinical nurse specialist data also revealed regional variation with a range of between 1 to 8 per centre with a median of 3.8. The banding for nurse specialists also highlights variation with most being a band 7 but ranging from 6-8 across surgery, medical oncology and clinical oncology. The number of vacancies currently stands at 20 with a perceived need for additional posts being 52, giving an overall total 72.

Recommendations

1. Work to be undertaken with HEE to develop best for catchment population
2. Work is required to determine the potential vacancies in line with future demands
3. Strategy required to raise awareness of vacancies in surgical staff
4. Strategy required to determine training models and trainee numbers to meet future demand
5. Strategy required to raise awareness of vacancies in Nursing staff
6. Work to be undertaken to better understand job descriptions that determine CNS banding across the UK.
7. Is a 'training course/new start Syllabus' required for Nurse Specialists?
8. A sustainable model for keeping abreast of surgical workforce requirements needs to be developed.