

## Biochemistry Laboratory Workforce Issues Scotland – Update April 2017

Last years report identified three key areas of concern –

1. Shortfall in consultant medical replacements due to poor recruitment to StR training nationally.
2. Ongoing retirement of Clinical Scientists with limited STP training despite large numbers of highly qualified and suitable applicants.
3. Specific need in Remote and Rural Laboratories to gain multidisciplinary skills and IBMS Fellowship no longer allowed from a small laboratory.

This short report will update on how these issues are progressing. There is no evidence of decline in testing volume only evidence of increasing demand and expectation that “Primary Care” will support the ongoing monitoring clinical burden. This will require more input helping them. The suggested “three Health Board model” may materialise but that major IT redesign, cross-reporting and support from afar will remain a problem. Laboratories will need individuals with strong IT skills and ideas to support the service as it changes. Some will come from the group which currently includes Clinical Scientists because they have the clinical knowledge and understanding of analytical issues to maximise the IT benefits.

Redefining what is included in core repertoire and what will need to be done at a central laboratory will need to take place. This will vary between rural/island based laboratories and those in larger conurbations. Because Scotland covers such a large land mass with distant laboratories, this will have impacts on the scales expected of those working in the more rural laboratories. Central laboratories will need to support them.

Both the Royal College of Pathologists and the Association for Clinical Biochemistry and Laboratory Medicine have been reviewing their workforce planning. The points they have raised are incorporated in the following sections.

**Current status** - Because of Agenda for Change and pay protection there are gaps within many senior BMS posts across the country. Recruitment of newly qualified BMS is usually possible but this temporary failure to recruit to higher bands as individuals do not want to lose their pay protection is causing an impact on the management and short-term leadership in this service.

Since last year, three medical consultant posts are unfilled in Edinburgh, Lanarkshire and in the Queen Elizabeth University Hospital in Glasgow. While there is a CCT holder who is expected to take one of these posts, another has already been advertised and had no applicants. This year we had seven StR's in post, one LAT and one out of programme research trainee. One current StR has decided to resign her post and go into general practice. In terms of Clinical Scientists, we currently have eight empty 7 and 8A posts with two empty in Edinburgh, Dundee, Glasgow Royal and one at RAH and a further post expected to be required in Forth Valley.

### **Current progress with recruitment –**

Medical Posts we were fortunate to recruit a LAT to a St2 post and two St3 posts in Chemical Pathology/Metabolic Medicine out of the four applicants appointed in the UK. We will therefore have eight trainees with one empty at each of the centres down the East Coast next year. It is anticipated that these individuals should reach CCT posts with three in 2018, two in 2020, two in 2021 and two in 2023. Against this the current estimate of medical retirement, particularly as individuals who are in the 1995 scheme retire early and those in the later scheme's will work on; we will likely to see a short-term gap. It can be anticipated in addition to the net of two empty posts we currently have, in the next two years we should lose another 3 posts, with 2-3 posts over next three years following that and up to eight years we will have lost a further additional 4-5 posts. Thus despite having eight trainees we will have twelve posts to fill. It is also fairly certain that not all trainees who currently are training in Scotland will remain in Scotland.

On top of this short-term gap, two-thirds of our trainees are female and many expressing the wish to work less than full-time as they do elsewhere in the UK. In the rest of the UK, 41% of all medically qualified Biochemists are over 55. While currently the College reckons that 51 are in training compared with 70 training posts, many are currently working part-time with 20 individuals starting before 2012. The numbers in training north of the Yorkshire/Lancashire boundary are our own plus 10 further individuals. It is anticipated that a large number of retirements will appear in these regions. In the previous generation, Scottish trainees filled many of these posts. While in UK terms there may be a small surplus of trainees achieving a CCT in 2018, for each subsequent year there'll be deficit to posts between 2019 to 2024. Those lucky enough to be in the 1995 section NHS pension may retire early while those reaching the age of 60 beyond about 2024 may be expected to remain in post for 5-6 more years.

**Clinical Scientists** - HEE has frozen the funding of training posts until 2020. There is even a current suggestion that trainees should self-fund their own training but grants would not be readily available to those currently recruited as many already have already obtained a PhD. Scotland has recruited two who are currently in Year 3 and both have moved on to a permanent appointment and are already included in above figures, three currently in Year 2 and four in Year 1. NSD suggest they are going to allow Recruitment to a further three this coming year. This is in spite, as above we have eight empty posts. Within the next, it is anticipated there will be within two years a further 5 retirements, within five years an additional 5 and within eight years 2 more (making a total of 12). Thus over the next eight years we require 20 posts to stand still and if replacing the gap in medical work or less than Whole Time Equivalent at least 22 will be required. This also assumes that our current new replacements do not work less than Whole Time ! Thus it would be prudent at the very least that over the next five years we appoint at least 3 a year from 2017 to 2021. Due to the time required to train and current gap, it would be wise to start with more training posts sooner rather than later.

## Remote and Rural Issues –

Recruitment for Rural and Remote laboratories remains difficult. The expertise required for the 4 main disciplines (Biochem, Haem, BTS and Micro) need to be augmented by multi-discipline experience. So the training period is much longer since any portfolio BMS would need to get to grips with work outside their comfort zone to cover on-call and weekends.

Thus the pool of people available for recruitment is very small. It's often a more mature age group so the retirement element always looms high. Whilst Health Science continues to "split" and "specialise" qualifications and course contents, the smaller this pool will become. There is no major role for multi-discipline BMS across the UK. This is in stark contrast to Australia, Canada, Scandanavia and the US

What we really need is a wider multi-discipline role within the larger laboratories.

Consolidation of Biochemistry and Haem into "core" laboratories for the large sites and the removal of non routine work in the intermediate sites to the large sites

(effectively making the smaller sites multi-discipline labs) would make that scenario possible. What we need is a move away from a departmental based lab to a core based lab with specialties attached.

Robert Wardrop has experience of workflows where staff move between the core and the speciality, so they are not mutually exclusive but the rule was core first on recruitment, specialty second. Associating the large labs with smaller labs and having all BMS employed by the same entity makes movement much easier. It will require a new way of looking at pathology. It does however fit with and indeed supports the disseminated model.

Most of R+R recruitment occur from outside Scotland. Requiring quite a lot of liaison with HCPC and the IBMS if from outside the UK. Given Brexit this will only get more complicated and recruitment more difficult.

Accreditation, in particular MHRA's rigid approach means that services for R+R hospitals are always on the edge of non-compliance. Accreditation agencies in general seem reluctant to view the total service rather than the compliant detail, though with ISO15189 this should improve for the other disciplines.

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