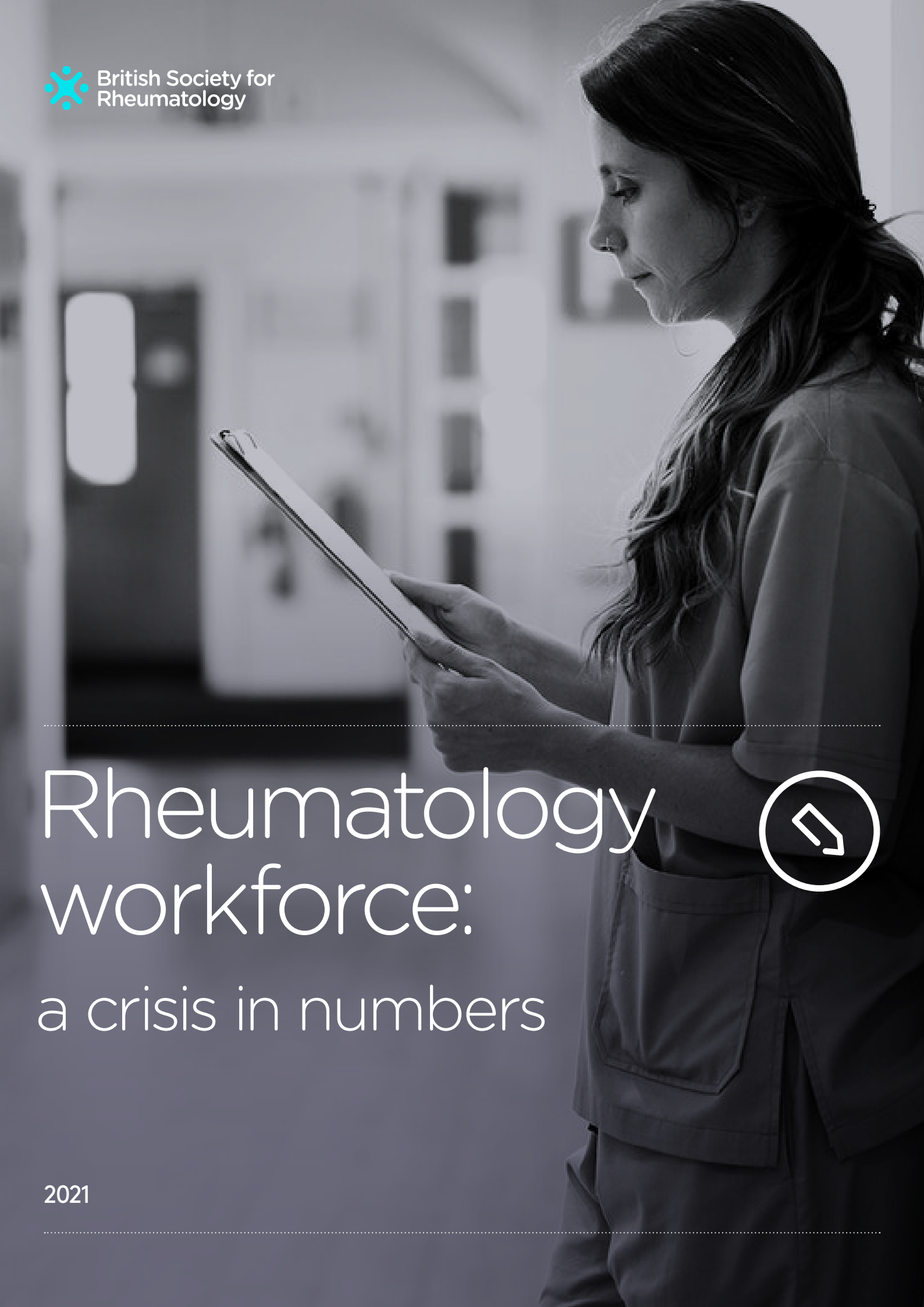
British Society for Rheumatology



Rheumatology workforce:

a crisis in numbers

2021

About BSR

British Society for Rheumatology is the UK's leading specialist medical society for rheumatology and musculoskeletal professionals. We support our members to help deliver the best care for their patients, in order to improve the lives of children, young people and adults with rheumatic and musculoskeletal disease.

Our members represent the entire profession – from those at the beginning of their career to the most senior consultants, researchers, academics and health professionals in the multi-disciplinary team.

Together, they form a powerful voice for paediatric, adolescent and adult rheumatology in the UK.

Contents

Rheumatology workforce

The adult, paediatric and adolescent rheumatology clinical workforce is composed of a multidisciplinary team (MDT) that provides holistic care to individuals with inflammatory, non-inflammatory and autoimmune diseases of the musculoskeletal (MSK) system, as well as metabolic bone disease.

These conditions are often chronic and complex, requiring treatment with advanced therapies and multidisciplinary management. This shared approach to patient care is one of the many things that attracts consultants, nurses, allied health professionals (AHPs), psychologists, physician associates and pharmacists to the specialty.

Around 10 million people across the UK are affected by arthritis, and the widespread impact of rheumatology conditions costs the NHS £10.2 billion every year.[i] The healthcare cost of these conditions is predicted to reach £118.6 billion over the next decade.[ii]

British Society for Rheumatology (BSR) calls on parliamentarians, policy-makers and national professional bodies to implement and support long-term sustainable rheumatology workforce solutions which adequately reflect the needs of the UK population.

Executive summary

This report presents for the first time a detailed analysis of the entire adult, paediatric and adolescent rheumatology workforce, including comprehensive UK-wide workforce data. Our findings provide robust evidence in areas that have traditionally relied on anecdote, such as chronic understaffing, persistent regional and national vacancies and lack of exposure to the specialty throughout training and early career.

Our analysis shows that the rheumatology workforce in both adult and paediatric and adolescent services lacks sufficient staff to provide the level of care recommended by NICE guidance and that regional and national variations in patient care persist. There are not enough consultants or specialist nurses in rheumatology and access to certain members of the MDT, including psychologists and pharmacists, is not sufficient. There is unacceptable variation in workforce provision, without adequate succession planning, which means that other clinicians must address these gaps, leading to long waiting times and delays in the care pathway and consequently, worse patient outcomes, more disability, and loss of work.

It also puts forward key recommendations on the expansion of the workforce to ensure the rheumatology workforce is sustainable, adequately staffed and reflective of population demands. These recommendations are based on clinical audit data, which shows more consultants, specialist nurses and access to the MDT leads to better outcomes for patients. For paediatric and adolescent rheumatology, more work is needed to provide this evidence base and determine the optimal workforce to best serve its patients.

In the remainder of the report, we make recommendations based on BSR-commissioned research interviews and a membership survey exploring people's experiences of training and working in the specialty. The recommendations in this section focus on how to increase exposure to rheumatology, and thus encourage more people to pursue a career in the specialty. People who work in rheumatology have high job satisfaction, and the specialty has high retention rates.

Recommendations

Our recommendations are targeted at national bodies throughout the UK, including the NHS and its national health education sub-bodies, the General Medical Council, the Joint Royal Colleges of Physicians Training Board (JRCPTB), as well as locally at Commissioners, Trusts and Health Boards.

Recommendations: 1-5

Expanding the rheumatology workforce

Recommendation

Adult rheumatology **consultant numbers must increase** to secure the long-term sustainability of the workforce.

Service needs and waiting times should be reviewed urgently to ensure the adult rheumatology workforce meets service demands (i.e. one consultant per 60,000–80,000 population).

01

02

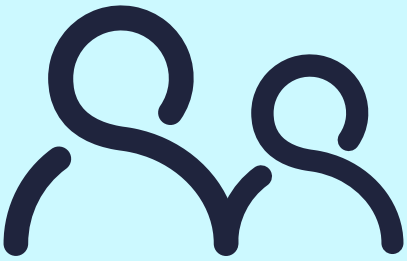
Recommendation

Adult rheumatology specialist nurse numbers **must increase** to ensure departments are adequately staffed, with a **specialist nurse to consultant ratio of at least 1:1.**

03

Recommendation

A children and young people's health workforce strategy **should be developed in the UK**, including recommendations for specialist services.



04

Recommendation

All adult and paediatric rheumatology departments **must have access to:**

A dedicated physiotherapy service with expertise in managing patients who have inflammatory MSK disease;

An occupational therapist with expertise in return-to-work/ school support and employment advice for patients;

Specialised psychologist support with expertise in managing chronic MSK conditions and other long-term conditions; this should be embedded in rheumatology services;

A pharmacist with specialist knowledge of biologics;

Podiatry within a hospital or community setting (adult services only).

05

Recommendation

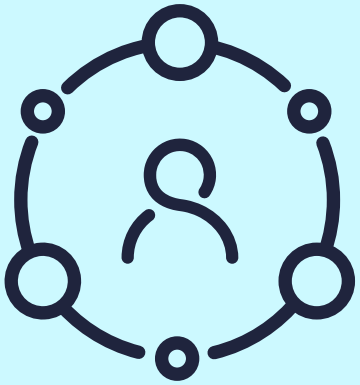
Enhanced roles for AHPs, pharmacists and nurses must be developed within adult and paediatric and adolescent rheumatology departments by providing opportunities to extend their scope of practice and meet increasing demands of services. **Roles should be recognised at appropriate Agenda for Change Bands 6, 7 and 8** to ensure the required level of skill is recognised and remunerated.

Recommendations: 6-8

Raising awareness of rheumatology in education and training

Recommendation

Exposure to rheumatology must increase in undergraduate and postgraduate curricula through teaching modules and clinic placement opportunities for all members of the MDT.



06

Recommendation

Rheumatology specialty training posts must increase to address current workforce shortages and meet future demands on the specialty.

This should include a review of rheumatology specialty training led by the Specialty Advisory Committee to ensure training meets the needs of the specialty, including whether experiences during training are valuable for trainees.

07

Recommendation

Rotational posts for AHPs and nurses should increase at Band 5/6 level to expose people to the specialty and encourage career progression in rheumatology.

08

Methodology

BSR collated existing sources of data, such as that in the National Inflammatory Arthritis Audit (NEIAA), the embargoed draft national rheumatology report from the Getting It Right First Time (GIRFT) programme, the Royal College of Physicians (RCP) census and the Royal College of Paediatrics and Child Health (RCPCH) census. As there are gaps, such as the lack of workforce data for paediatric rheumatology in all four nations, and inconsistencies within these data sources, we collected further data using our existing network, most notably our members. Through this exercise we now have comprehensive rheumatology workforce data for the UK for the first time. This resulted in data from 80% of departments across the UK, including data for 100% of local Health Boards in Wales and Northern Ireland.

We combined this quantitative data with qualitative research interviews, commissioning Shift Learning to research the career pathways of all members of the MDT. This took the form of telephone/video interviews with clinical staff working in rheumatology, as well as other specialties, to discuss the motivations of individuals to pursue or not to pursue a career in the specialty. These interviews were an opportunity to explore influences on career decisions and when these decisions are made.

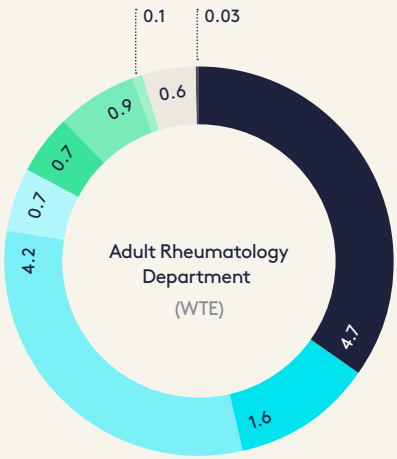
A total of 75 people were interviewed, who were broadly representative of the rheumatology community, including all members of the MDT, adult and paediatric and adolescent rheumatology specialties and from all four nations. Transcripts from interviews were coded and analysed using the qualitative data analysis software Atlas.ti, allowing researchers to draw out key themes.

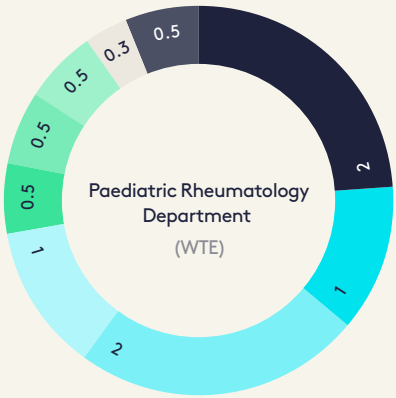
Findings from this qualitative research then informed the questions that were asked in a survey of BSR members. A total of 153 responses to our survey were received, with representation from all members of the MDT.

What the average rheumatology team looks like now

Based on the data we collected, we were able to determine the composition of the average rheumatology MDT. We also learned that there is no typical MDT, as the size of the workforce and population served varies across the UK. An adult rheumatology MDT will usually include a mixture of rheumatology consultants, trainees, specialist nurses, occupational therapists, physiotherapists, podiatrists, pharmacists and psychologists. Within paediatric rheumatology, there are often more AHPs and psychologists embedded in departments. It is difficult to generalise the average rheumatology MDT, as the make-up of departments varies considerably, in part due to variations in the clinics and services provided by departments.

Average UK rheumatology department whole time equivalent (WTE)





4.7	**Consultant**	●
1.6	**Trainee/registrar**	●
4.2	**Specialist nurse**	●
0.7	**Nurse**	●
0.7	**Occupational therapist**	●
0.9	**Physiotherapist**	●
0.1	**Podiatrist**	●
0.6	**Pharmacist**	●
0.03	**Psychologist**	●

2	**Consultant**	●
1	**Trainee/registrar**	●
2	**Specialist nurse**	●
1	**Nurse**	●
0.5	**Occupational therapist**	●
0.5	**Physiotherapist**	●
0.5	**Pharmacist**	●
0.3	**Psychologist**	●
0.5	**Social worker/Youth worker**	●

Note: Whole time equivalent (WTE) is that amount of time an employee works compared to a full-time role (i.e. 1 WTE = a full-time post). Using WTE allows us to account for employees who work reduced/part-time hours.

1.0 Section

Expanding the rheumatology workforce

Recommendations 1-5

1.1 Expanding the consultant and specialist nurse workforce in adult rheumatology services

Recommendation 1/8

Adult rheumatology **consultant numbers must increase** to secure the long-term sustainability of the workforce.

Service needs and waiting times should be reviewed urgently to ensure the adult rheumatology workforce meets service demands (i.e. one consultant per 60,000–80,000 population).

More adult rheumatology consultants reduce patient waiting times

The RCP has previously calculated that one WTE consultant is needed per 86,000 population.[iii] The original RCP figure was based on data from 2007–2009, and in subsequent years, demands on units have increased due to an ageing population with increasing rates of chronic illnesses. Using our methodology, this figure should be one WTE consultant per 60,000–80,000 population.

More consultants equates to better patient outcomes, which is evidenced by the National Early Inflammatory Arthritis Audit (NEIAA). More consultants lead to a higher likelihood of achieving the former Quality Statement 2 (QS2), which, while no longer used by NICE, remains a key metric in the NEIAA.[iv] It measures the delay between receiving a referral for suspected early inflammatory arthritis and the date of clinical assessment, with the aim of keeping the waiting time to three weeks after referral. This is a significant target for patients, as we know early detection and treatment leads to better health outcomes.

Currently in England and Wales, 48% of patients referred for suspected early inflammatory arthritis are seen within three weeks, meeting the QS2 target.[v] These numbers are improving year on year, as evidenced by the NEIAA, but substantial regional variations persist. Using the NEIAA QS2 target, we know that to meet 100% of patient demand (compared to 48% of patients currently being seen within three weeks), rheumatology workforce numbers must expand to replicate one consultant per 60,000–80,000. Ensuring every patient has timely access to a consultant rheumatologist will lead to better health outcomes and reduced risk of permanent disability caused by unacceptable referral waiting times.

One consultant per 60,000–80,000 population is needed at a minimum to meet service demands, maintain safe waiting times and ultimately improve health outcomes for patients across the UK.

This figure should be closer to one consultant per 60,000 population in some regions based on local service demands. Local service demands include regions sharing rheumatology services across high-density populations and large geographical Trust/Local Health Board boundaries. We know from the draft GIRFT report that there are significant variations across England in the services and clinics offered by rheumatology departments.[vi]

Departments in areas that lack tertiary care, community rheumatology services or supportive MSK physiotherapy services will have greater demands on their services. If services for non-inflammatory painful MSK conditions are provided in primary or community care, as recommended in the draft GIRFT report, rheumatology MDTs can focus on the patients that would benefit most from their care.[vii] Also, the growth of First Contact Practitioner roles in primary care in England should help with this shift, allowing patients to be seen closer to home, in line with the NHS Long Term Plan.

Regional consultant shortages

The recent RCP workforce census shows that the number of consultant rheumatologists in the UK is well below the recommendations per head of population recommended by the RCP and in this report. Many regions, such as London, do meet the provision requirement we are calling for, but there are wide regional variations. Within Scotland, Wales and Northern Ireland, consultant provision is unacceptably low, and far below our minimum recommendation of one consultant per 80,000.

For instance, in Scotland there is one consultant per 100,556 population, while in Northern Ireland there is one consultant per 106,165 population. England overall has better consultant provision, but there are some regions of concern, particularly the East of England (one consultant per 96,914) and the East Midlands (one consultant per 115,067).[viii] This variation is likely to persist due to the uneven distribution of trainees across the UK.[ix] The expansion of the consultant workforce must be targeted at the nations and regions that most need it.

Low levels of consultant provision lead to unacceptably high caseloads for the whole MDT and affect patient outcomes. A patient in Northern Ireland, where the waiting time for a first rheumatology appointment is six years, should not be waiting longer than someone in other parts of the UK. This raises issues of equitable access to care, creating a postcode lottery, resulting in many populations being underserved. This will not change without substantial investment and additional staffing.

Consultants per population

England	NI	Scotland	Wales
80,617	106,165	111,637	99,423

Recommendation 2/8

Adult rheumatology specialist nurse numbers **must increase** to ensure departments are adequately staffed, with a **specialist nurse to consultant ratio of at least 1:1.**

More specialist nurses in adult rheumatology services improves patient outcomes

Workforce expansion must not stop at consultants – more rheumatology specialist nurses are needed across the UK to improve patient outcomes. Nurses care for people at every stage of life and across every rheumatology setting. The specialist nurse role is crucial to rheumatology services, and we have previously highlighted in our Specialist Nursing in Rheumatology report the need for an expansion of the workforce. In that report, 83% of specialist nurse survey respondents reported that there were aspects of care that their team was either unable to provide, or that were regularly delayed because of excessive workload.[x]

Rheumatology specialist nurses are overworked because the current workforce is not sufficient to meet demands on services. The Royal College of Nursing (RCN) has highlighted that in England alone there is an **overall nurse shortage of 40,000**.[xi] Within Northern Ireland, there are almost 2000 nurse vacancies[xii] and a further 4000 nursing and midwifery vacancies in Scotland.[xiii] These vacancies do not account for the additional unfunded posts needed to address wider workforce shortages.

More specialist nurses are needed to address the disparities in patient outcomes. From the NEIAA data, we know that there is a positive relationship between the number of specialist nurses in a department and the likelihood of achieving Quality Statement 3 (QS3). QS3 measures the time in days to initiation of cDMARD therapy for those patients with a confirmed diagnosis of early inflammatory arthritis. Only 64% of units in England and Wales have achieved QS3 based on the results of the most recent NEIAA report.[xiv] Therefore, more specialist nurses mean patients get treatment earlier, and the irreversible effects of rheumatic diseases can be stopped sooner.

There is approximately one WTE specialist nurse per 100,000 population[xv] and most departments have fewer specialist nurses than consultants. To improve outcomes for all patients, the ratio of specialist nurses to consultants should be 1:1 within a department (i.e. one WTE specialist nurse per 60,000–80,000). This means all patients can start cDMARD therapy within six weeks of referral, receiving timely and needed care. Currently, 55% of departments in the UK do not meet this ratio, with fewer specialist nurses than consultants.[xvi]

Case study:

1/3

Bedfordshire Hospitals NHS Foundation Trust: clinical nurse specialist (CNS) osteoporosis service

Specialist services are often designed around in-demand consultant appointments, leading to significant delays in treatment pathways. Bedfordshire Hospitals NHS Foundation Trust designed an innovative osteoporosis service, where patients consulted with a metabolic bone CNS, with a consultant providing remote oversight.

Patients could then be treated earlier by a CNS, thereby reducing the need for consultant appointments and hospital visits. Beginning treatment sooner potentially reduces the risk of hospitalisation, emergency admissions and other complications for this patient group. In the trial period, 38 new patient consultant appointments were saved and median time from referral to start of treatment was reduced from 84 to 38 days, a 54% reduction.

In this new pathway, a consultant and CNS virtually triage women over 65 into the service. Using a dedicated proforma as a template, the CNS undertakes a telephone consultation with new patients to assess the suitability of parenteral treatment. Later, the consultant and CNS review all patients in a joint meeting. An appropriate parenteral treatment option is agreed, and the CNS provides individualised advice and support to patients, guided by a safety checklist. If checks are satisfactory, then treatment begins and patients are advised to use the advice line for any concerns.

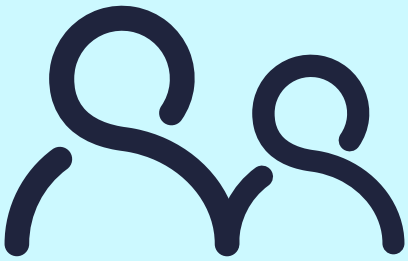
This new model of care is also an opportunity for professional development, improved wellbeing and increased job satisfaction for the CNS:

“Personally, I've really enjoyed this new clinic. I've had the opportunity to extend my clinical knowledge by working closely with one of our rheumatology consultants. My work is more varied and has incorporated some of the skills and knowledge my degree was based upon, for example assessing patients, investigative work, managing my own workload and auditing.”

1.2 Determining paediatric and adolescent rheumatology MDT provision

Recommendation 3/8

A children and young people's health workforce strategy **should be developed in the UK**, including recommendations for specialist services.



More work is needed to understand the population demands for paediatric and adolescent rheumatology services and the optimal make-up of the workforce to meet these demands. Unlike adult services, we do not have an audit to provide evidence of service demands and clinical performance to determine the necessary paediatric and adolescent workforce. This is particularly challenging for adolescent and young people services, as dedicated services are sparse and there is no national mechanism for data collection in this respect.

In 2010, the then-British Society for Paediatric and Adolescent Rheumatology (BSPAR), alongside the Arthritis and Musculoskeletal Alliance (ARMA), published the UK Standards of Care for young people diagnosed with rheumatological conditions. This sets out the need for children and young people to have equity of access to gold standard care. The understanding at that time was that one paediatric rheumatology consultant is needed per 200,000 child/young person population.[xvii] This was based on past service specifications regarding children with inflammatory disease, but this figure should be updated, because it does not account for non-inflammatory MSK conditions, which make up a significant portion of paediatric rheumatology workload.

Further data collection will allow BSR to explore what a paediatric rheumatology MDT must look like to address service demands, build a long-term sustainable workforce and deliver equitable access to care to improve patient outcomes.

Despite it being 10+ years since the publication of this figure, many nations and regions fall short of this conservative estimate of need. In Wales, the recent Welsh Health Specialised Services Committee draft service specification included only one paediatric rheumatologist for a population of over 3 million. There are many caveats to this figure depending on how services are delivered (i.e. clinical networks, time of transition to adult services and prevalence of outreach services), highlighting the need for a comprehensive review of service demand and clinical provision.

CNSs are essential in providing and ensuring continuity of care for young people with rheumatological conditions, therefore a 1:1 ratio of CNS to paediatric rheumatology consultant is needed.

The RCPCH workforce census has highlighted significant gaps in the child health workforce, which are threatening the ability to improve health outcomes for children and young people. We support the RCPCH's call for a significant expansion of the paediatric workforce and a child health workforce plan for all four nations. The RCPCH estimate that an increase of approximately 850 WTE paediatric consultants (in total for all specialties) is required to meet service demands.[xviii]

To ascertain how many are needed specifically within paediatric rheumatology, more robust evidence is currently being collected.

It is important to acknowledge that with health care divided into paediatric and adult specialties, adolescent and young people with rheumatic disease (AYA-RMD) are relatively invisible in both settings and a priority in neither. Some regions, such as London, Oxford, Sheffield and Newcastle, have long-established adolescent and young adult clinics, but these are the exception and not the rule. To ensure equity in access to AYA-RMD services, the rheumatology workforce must be able to confidently deliver developmentally appropriate care across paediatric and adult settings. This will be a challenge for future workforce planning and any national workforce strategy.

Case study:

2/3

Alder Hey Children's Hospital: development and implementation of a rheumatology pain multidisciplinary clinic

(shortlisted for BSR's Best Practice Awards)

The rheumatology therapist team at Alder Hey Children's Hospital established an MDT clinic, bringing together a clinical psychologist, physiotherapist and occupational therapist into the same appointment for a single and holistic assessment for children with chronic pain. The aim was to reduce the duplicative nature of appointments, while 'de-medicalising' a child's condition and reducing the number of inpatient rehabilitation admissions. Previously, the three therapist appointments may have been based in different departments at the hospital, which could have resulted in conflicting guidance and mixed messages.

Following introduction of the MDT clinic, appointment wait times have improved, with a reduction in the number of inpatient hospital admissions and high levels of patient and parent/carer satisfaction.

- **Waiting times for pain assessment via the clinic reduced from 19 to 12 weeks, an improvement of seven weeks from the previous staggered approach of three separate appointments**
- **Substantially reduced the number of patients requiring hospital admission following their therapist appointment, with the majority of children entering the service now managed as outpatients**

The service is a cost saving compared to consultant-led services. Also, substantial cost savings have been largely due to reduced bed-days as a result of decreased hospital admissions.

1.3 Enhanced provision of the rheumatology MDT: AHPs, pharmacists and psychologists in adult, paediatric and adolescent services

Recommendation 4/8

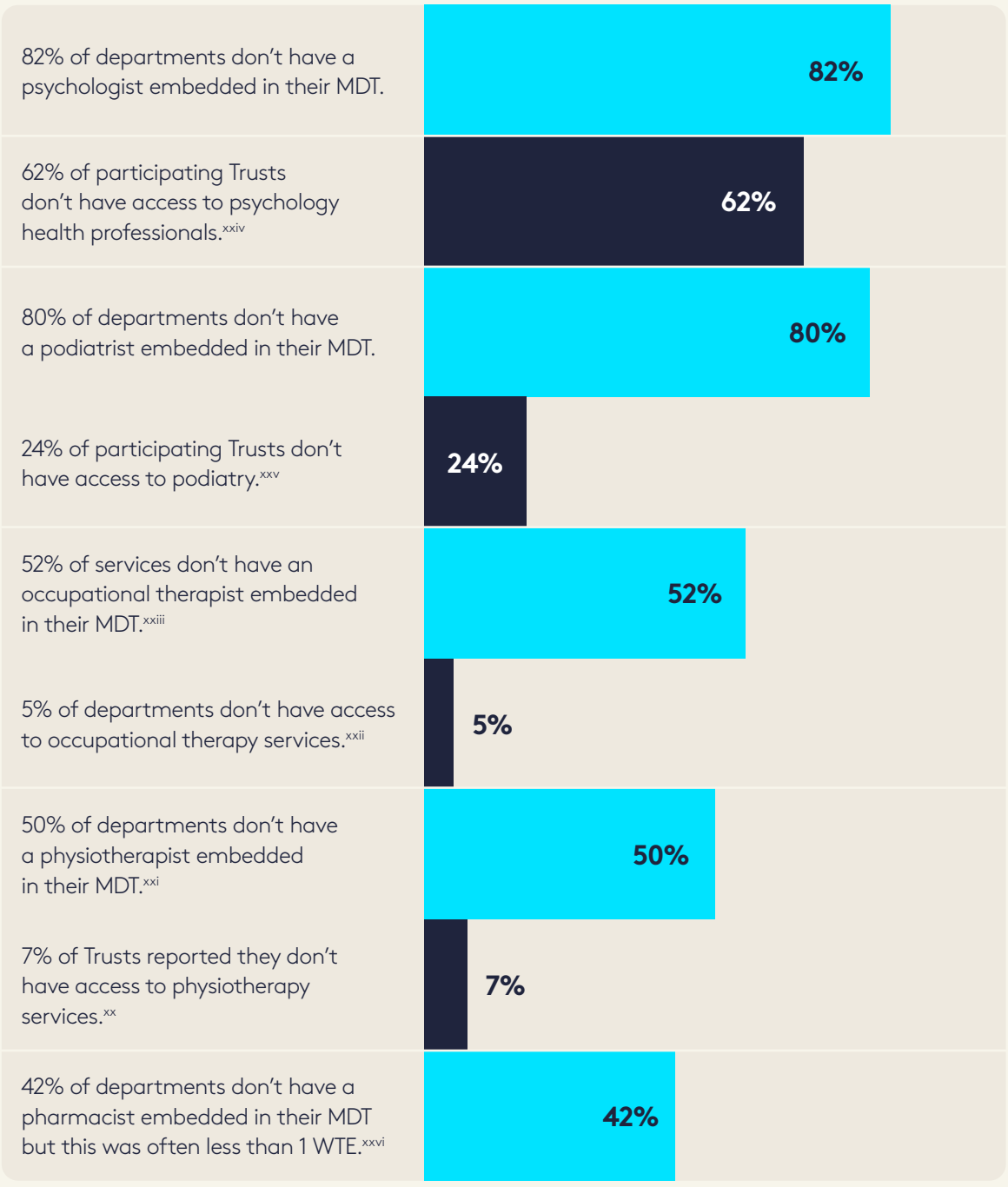
All adult and paediatric rheumatology departments **must have access to:**

- A dedicated physiotherapy service with expertise in managing patients who have inflammatory MSK disease;
- An occupational therapist with expertise in return-to-work/ school support and employment advice for patients;
- Specialised psychologist support with expertise in managing chronic MSK conditions and other long-term conditions; this should be embedded in rheumatology services;
- A pharmacist with specialist knowledge of biologics;
- Podiatry within a hospital or community setting (adult services only).

Rheumatology is a specialty characterised by MDT working, due to the complexity of rheumatic disorders, which require multidisciplinary management. At a minimum, it is essential that all rheumatology services have access to occupational therapy, physiotherapy, podiatry, psychology and pharmacy services, in line with NICE guidance.[xix]

Staffing levels of nurses and other members of the MDT vary within rheumatology departments and often these services can only be accessed via a Trust's or Health Board's core services, within dedicated MSK services or general paediatrics. They are also likely to divide their time between rheumatology and other specialties. However, this is not always sufficient, and some patients will benefit from more specialist services.

Access to minimum standards of care in rheumatology adult services



Note on graph: The figure on numbers within departments is based on BSR-collected data in all four nations. The data on access is based on findings from the NEIAA and only include services in England and Wales. A small number of Trusts and Health Boards report no access to specialist AHP services.[xxvii] Anything below 100% access to AHP, pharmacy and psychology services is not acceptable. The data on access is self-reported by units in the NEIAA, which also shows that staffing and structural factors are linked to performance against NICE quality statements.[xxviii] Some patients are not receiving optimal care.

In general, AHP, pharmacy and psychology services tend to be more integrated within general paediatric and adolescent departments, and therefore they are not exclusively attached to paediatric rheumatology departments. The numbers indicate some dedicated time for the rheumatology department within a position.

Access to integrated mental health support

While improvements are needed in accessing all these services, equally concerning is the lack of integrated support for mental health. Psychology access remains limited across all regions and is a priority concern given the established relationship between chronic illnesses and mental health.

While only 8% of rheumatology departments have a psychologist embedded in the team, only 38% of Trusts and Health Boards in the NEIAA reported they have access to psychology health professionals.

This figure has not changed in **7 years**, when in 2014 a survey of nurses found **only 8% of departments in England had a psychologist.**[xxx] This is despite increasing demands on mental health services and longer waiting times in subsequent years.

This is particularly important in paediatric and adolescent services because children and young people have unique psychosocial needs at this stage of their development. Rheumatological conditions such as juvenile idiopathic arthritis affect the mental and emotional health of children and young people, causing stress, anxiety and depression. While **68% of paediatric rheumatology departments** have integrated psychology services, this does include departments that have only a **0.1 WTE psychologist.** We know this is not sufficient to meet the needs of children and young people, and that waiting times are unacceptably long.

In a survey of the paediatric rheumatology workforce, **38% reported** their patients did not have access to a psychologist.[xxxi]

We do not know how often rheumatology patients are seeking mental health support through their GPs, paediatricians or by self-referring to services. For instance, adults and young people have access to the Improving Access to Psychology Therapies (IAPT) programme in England and children have access to the Children and Adolescent's Mental Health Service (CAMHS) across the UK.

The Five Year Forward View for Mental Health and the NHS Long Term Plan set out the intention to extend IAPT services with a focus on people with long-term conditions.[xxxii] Many departments may be opting to signpost their patients to these and equivalent services where available. However, access to these services is still limited, and while this may be sufficient for some patients, others will need services that are more specialised, with expertise in rheumatological and MSK diseases. This is why it is important that departments have access to dedicated psychology support beyond IAPT, CAMHS and equivalent services, ensuring patients receive support that is most suited to their needs.

Recommendation 5/8

Enhanced roles for AHPs, pharmacists and nurses must be developed within adult and paediatric and adolescent rheumatology departments by providing opportunities to extend their scope of practice and meet increasing demands of services. **Roles should be recognised at appropriate Agenda for Change Bands 6, 7 and 8** to ensure the required level of skill is recognised and remunerated.

Developing enhanced roles for AHPs, pharmacists and nurses to increase service capacity

There is an opportunity to develop enhanced roles for AHPs, pharmacists and nurses, allowing them to extend their scope of practice within departments and meet increasing service demands. AHP, pharmacist and nurse-led care is safe and effective, while also providing significant cost savings to Trusts and Health Boards. This is already being done in many departments, and we have included some case studies in this report. For example, extended prescribing roles for pharmacists have been shown to reduce patient waiting times and provide cost savings to the Trust by reducing consultant time.[xxxiii] Freed-up consultant time can then be spent on the patients who would benefit most from their care.

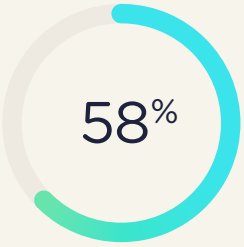
This is in line with the draft GIRFT report recommendation on developing enhanced roles for nurses, pharmacists and AHPs. GIRFT found that departments in England were not making best use of the multidisciplinary skills mix of the team, and that this could be harnessed to address capacity challenges, optimise services and increase their resilience and sustainability.[xxxiv] The draft GIRFT report also found significant variation in the skillset of members of the MDT between departments.[xxxv] There is no standardisation among roles between Trusts, including with respect to the banding of roles. The RCN has begun to address standardisation through the publication of the RCN competency framework, but this needs to be more widely adopted and replicated across the MDT.

BSR is calling for Trusts and Health Boards to establish more enhanced roles for AHPs, pharmacists and nurses within rheumatology departments. Departments should be open to reviewing who does what within their team and whether there are better ways to make use of the multidisciplinary skill mix of the MDT. Staff should be encouraged to develop their specialist skills and extend their scope of practice with departments providing the opportunities to do so. These roles must be recognised with appropriate Agenda for Change (AfC) banding in line with the specialist skills required and to ensure that they attract qualified candidates.

From our interviews, we know that opportunities for career progression attract people to the specialty. Most AHPs and nurses make the decision to specialise when they apply for Band 6 or 7 roles. The decision over what specialism they pursue is often determined more by which specialties offer grade progression and future career advancement up the NHS banding system. Applying to a specialism is perceived as rewarding in terms of job satisfaction and progression goals. Developing enhanced roles for AHPs, pharmacists and nurses will attract people to the specialty and provide job satisfaction by way of career progression.

Barriers to entering the specialty

58% of AHPs, pharmacists and nurses quoted lack of posts and opportunities for career progression.[xxxvi]



Case study:

3/3

Queen Elizabeth Hospital: improved medicines optimisation through the use of digital technology and a specialist pharmacist

The rheumatology department at the Queen Elizabeth (QE) Hospital in Gateshead has improved patient safety and standards of care through improved medicines optimisation. The service adopted a digital DMARD monitoring system known as TAMONITOR® and introduced a prescribing specialist rheumatology pharmacist to the team.

As a result, there have been fewer 'did not attend' (DNA) appointments and prescription errors, as well as increased exceptions addressed and increased cost savings. This optimisation also improved patient care and increased service capacity from reduced consultant time needed.

The system generates a list of patient blood results that have deviated from set norms, which are then processed digitally by a consultant. The prescribing specialist pharmacist can contact the patient and create an electronic prescription using the information provided by the patient and information recorded in the system.

— **Rheumatology teams had manageable workloads that facilitate home working and fewer interruptions for clinical staff, improved health and wellbeing for the team and higher productivity across the team**

— **The service led to significant cost savings by utilising specialist rheumatology pharmacists to prescribe medicines, which is less costly than consultants and requires less administrative support**

1.4 Vacancies in adult rheumatology

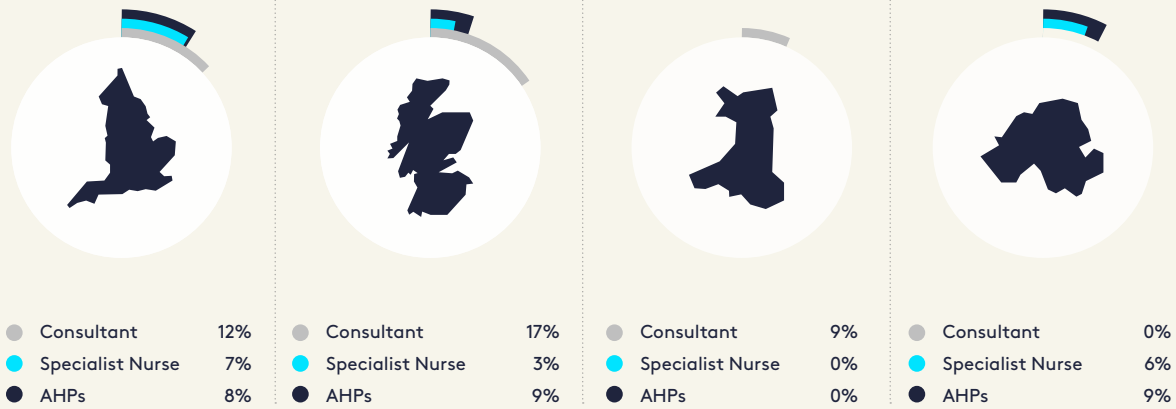
Workforce shortages are common in the NHS and Health and Social Care Northern Ireland (HSCNI), which has insufficient employees to meet demand across specialties, with a shortfall of 8% and 1 in 12 posts vacant.[xxxvii] The vacancy data in this section is based on responses to our workforce data requests, in which we received responses from 80% of departments, presenting a comprehensive picture of the UK workforce. Our data did not show there was an issue with high vacancy rates in paediatric rheumatology, and due to the small size of the paediatric rheumatology workforce, vacancy rates can overstate the problem of vacancies.

BSR members report that many vacancies remain open long term. The Care Quality Commission recognises that workforce shortages have a direct impact on the quality of people's care and must be addressed.[xxxviii] The most difficult-to-fill vacancies are often in departments based in rural areas, which struggle to attract the same number of applicants as positions in regional hubs. Departments must often resort to using locums to fill vacancies or other temporary staff via an agency or the Trust bank; a temporary and expensive solution. This can also be disruptive to services and hinder the ability to deliver continuity of care to patients.

Vacancies arise for a number of reasons – relocation, reducing hours or retirement. Based on our data, retirements will have significant impacts on workforce numbers in the coming years. The RCP estimates that 360 WTE rheumatology consultants are likely to retire in the next five years across the UK, which will exacerbate existing vacancy problems.[xxxix] In our previous Specialist Nursing in Rheumatology report, we found that that retirements are high among specialist nurses, with 1 in 4 (25%) survey respondents reporting recent specialist nurse retirements in their department.[x1]

There has been no national NHS workforce strategy in 18 years. The 2019 Interim NHS People Plan prioritises urgent action on work shortages. Health Boards and Trusts must prioritise rheumatology MDT vacancies. A sustainable workforce strategy with succession planning and an expansion of workforce numbers will also be required to address the impact of retirements, reduced hours and more flexible working requirements.

National and regional vacancies in adult rheumatology departments



Vacancies are high across the rheumatology MDT and are greatest among consultants, particularly in regions in Wales and Scotland. The average vacancy rate was 17% in Scotland, but in many regions, such as NHS Fife, NHS Highlands, NHS Grampian, NHS Orkney and NHS Shetland, vacancy rates exceeded 30%. Similarly, in Wales, the overall vacancy rate is 9%, but in Betsi Cadwaladr University Health Board the consultant vacancy rate is 49%. These high vacancy rates are in small departments with low consultant numbers to begin with, and therefore any one vacancy has a huge impact on staffing levels.

Consultant vacancies also have a long-term impact on the workforce, as they can lead to gaps on rotas, impacting the quality of training for trainees. One NHS-wide survey found that two-fifths (40%) of consultants and almost two-thirds (63%) of senior trainees reported daily or weekly gaps in hospital medical cover. This means there aren't sufficient numbers of senior medical staff to assure the quality and safety of training.[x1i]

2.0 Section

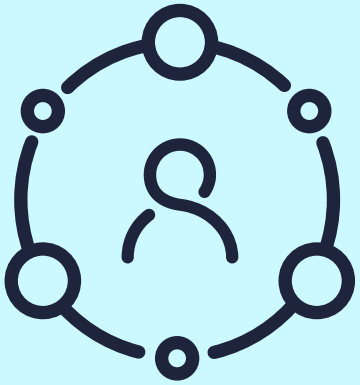
Why specialise in rheumatology?

Recommendations 6-8

2.1 Consultants, trainees and students

Recommendation 6/8

Exposure to rheumatology must increase in undergraduate and postgraduate curricula through teaching modules and clinic placement opportunities for all members of the MDT.



Exposure during undergraduate and postgraduate training

Unlike other more prominent specialties, medical students often begin their degree with very little awareness of rheumatology, and in medical school exposure to rheumatology is often very limited. Rheumatology is often taught with other specialisms as either part of a musculoskeletal module, part of pathology or grouped with 'niche' specialisms such as dermatology.

One in five consultant and trainee respondents to our survey reported that poor exposure to rheumatology in medical school acted as a barrier preventing people from pursuing a career in rheumatology. At Keele University, which uses a spiral curriculum[x1ii] with problem-based learning elements, clinical placements were much stronger. This is a rare example within our study of an undergraduate experience creating sufficient engagement and clinical experience to create a commitment to rheumatology even at this early career stage.

Rheumatology trainee
ST4, male, West Midlands

At Keele, the rheumatology placements were always good... They do things like teaching clinics which give you a good experience, they bring in real patients for you to take a history from and examine – that would be a dedicated time period, the patients would know they were coming for a prolonged period and know what to expect and it was really well organised. When you go to clinic in some other specialties, it's just, the patients are coming in, and it's all ad hoc so you don't really get the time to focus. Keele also allows you to basically do your own clinic: they organise for you to see patients, do a history, examine them and behave like a real doctor would. Experiential learning if you will.

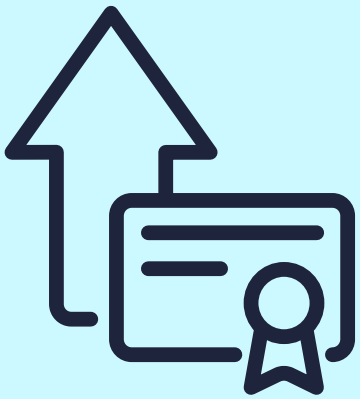
Opportunities for clinical exposure to rheumatology during undergraduate and postgraduate studies are also inconsistent across the UK. Many of the individuals in our interviews could not remember having any rheumatology placements in undergraduate studies. This was particularly pronounced in paediatric rheumatology. Some who did want foundation positions with rheumatology rotations found these were not always available. Also, with less rheumatology taking place on wards, there are fewer informal opportunities for trainees to encounter rheumatological conditions. Among paediatric rheumatology consultants, most had largely gained exposure to paediatric rheumatology on clinical placements during their foundation years or subsequently.

Increasing exposure to rheumatology in undergraduate and postgraduate studies will encourage more medical students to consider a career in the specialty. Without this exposure, people lack the confidence to seek out rheumatology placements later in foundation and specialty training. Rheumatology is perceived as a complex specialty requiring a wide breadth of knowledge, but this is often not reflected in curricula and training.

Recommendation 7/8

Rheumatology specialty training posts must increase to address current workforce shortages and meet future demands on the specialty.

This should include a review of rheumatology specialty training led by the Specialty Advisory Committee to ensure training meets the needs of the specialty, including whether experiences during training are valuable for trainees.



Specialty training for adult rheumatology

All trainees pursuing a career in adult rheumatology must now undertake a programme to dual accredit with general internal medicine (GIM). These changes were precipitated by a push for more generalists to respond to the needs of the UK's ageing population, with many more patients with chronic illnesses and multi-comorbidities. The GMC published The Shape of Training report,[xliii] setting out the need for a growing generalist consultant workforce with more training in generalist subjects (i.e. internal medicine training [IMT]) beyond foundation years. This shift will ensure that the consultant workforce is responsive to the changing demands of the UK population, but it should not be at the expense of rheumatology specialty training posts, which are desperately needed.

From August 2021, a third year is being added to IMT, and some specialties, rheumatology included, will have no or limited recruitment in 2021 as posts are being used for the third year IMT.[xliv] The addition of IMT3 was done without additional funding from Health Education England, meaning specialty training posts across other specialties had to be reduced to allow for the development of IMT3 posts. A total of 23 rheumatology specialty training posts were lost to IMT3, with an additional four expected to be lost in the next two years.

In Scotland, four rheumatology specialty training posts have been lost to IMT3, despite there being seven unfilled consultant posts and an additional five pending retirements in the next five years.

This is all despite no known increases in rheumatology specialty training posts in recent years to match the expansion of rheumatology as a specialty. More specialty training posts are desperately needed to address high consultant vacancy rates in rheumatology, but beyond that to meet our call to expand rheumatology consultant numbers. Over 20% of trainees are working LTFT (less than full time) with working patterns ranging from 60% to 80% LTFT. It is expected that these work patterns will continue throughout their careers, thereby strengthening the need for more rheumatology specialty trainees. On top of that, the UK had record numbers of medical school applicants this year due to removal of the cap on places. We need to ensure that this demand is met with increases in specialty training posts (and prior to that foundation posts) to ensure they are not overprescribed as a result.

The draft GIRFT report has highlighted several concerns with regards to training, and it has called for a review of rheumatology speciality training to be led by the Special Advisory Committee. Due to the introduction of the IMT programme in August 2020, it is estimated there will be a 15–20% reduction of trainee time in rheumatology.[xlv] There are also significant variations between Trusts in the amount of time trainees spend in rheumatology compared to acute GIM and some trainees spend a significant portion of their time doing tasks that had a low educational value.[xlvi] Trainees with dual accreditation are more likely to split their time between rheumatology and GIM throughout their careers, reducing dedicated time for rheumatology care. We support the draft GIRFT report's call for a review of specialty training to ensure that trainees receive valuable and diverse training experience.

Patients will be better served by a more robust acute medical service, through the introduction of dual accreditation in GIM. However, we must also recognise that the medical registrar role is very demanding, with large workloads and high levels of stress reported. Many foundation year doctors choose not to continue training in the medical specialties for this reason. In our interviews, the experience of working as a medical registrar was often contrary to the reasons someone may choose a career in rheumatology (i.e. advanced treatment options and work/life balance). Medical registrar roles were viewed as stressful, requiring long hours, fast-paced and consisting of mostly short-term patient interactions. These are challenges to which we do not currently have solutions.

2.2 The MDT: AHPs, psychologists, pharmacists and nurses

Exposure during undergraduate and postgraduate training

AHPs, pharmacists, psychologists and nurses also receive minimal exposure to rheumatology during their degrees. With the exception of physiotherapy and podiatry students, who come to understand rheumatology as a sub-specialism of musculoskeletal during their studies, our respondents had little to no exposure to rheumatology during their undergraduate degree. If any exposure, it was often due to chance encounter on placements with a rheumatology patient.

This lack of exposure to rheumatology in course content and placement opportunities means that students are unlikely to explore rheumatology as a specialism option during their undergraduate degree. The undergraduate degree was seen as a key time for building theory-based knowledge of different specialisms and the medical conditions they address. Theory-based learning on rheumatological conditions should be included in the undergraduate degree curriculum in order for nurses, AHPs and pharmacists to build knowledge and gain early exposure to the specialism. Furthermore, our respondents reported that opportunities for clinical experience would provide them with a greater degree of confidence when applying to Band 6 and 7 roles in rheumatology, as reported by our respondents.

Rheumatology nurse
6–10 years, female, South East

I think that [placements] can define a career for nurses. There are lots of specialisms that I never did, like neurology, I had a very small placement in accident and emergency but not an extensive or long-term one, so that can define where you end up. The other thing that defines it is the team that you work with. I chose my first job based on the fact that I had a good experience on placement, and I had a supportive team to do my first role in nursing. That can define your career choices.

Recommendation 8/8

Rotational posts for AHPs and nurses should increase at Band 5/6 level to expose people to the specialty and encourage career progression in rheumatology.

Rotational posts

Many nurses were not aware of rheumatology as a specialist option until they came across rheumatology specialists during rotational posts. Rheumatology wards used to attract nurses into the specialty, but today, rotational posts are the best way to offer this exposure in an outpatient setting. Rotational posts are attractive to those early in their careers seeking a wide range of experiences and those later in their careers seeking to move into a specialism. They provide an opportunity to develop clinical skills and gain experience of different specialisms. We know one of the key motivations for nurses who choose to specialise in rheumatology is the promise of development opportunities and career advancement.

Rotational posts have been shown to improve staff retention for newly qualified clinicians and those more established in their careers. Where turnover for newly qualified nurses is high, rotational posts have helped organisations support, develop and retain their staff.[xlvii] These posts provide an opportunity for early-career AHPs, pharmacists, psychologists and nurses to gain clinical experience in rheumatology, while also exposing them to possible careers within the specialism.

Advanced nurse practitioner
Rheumatology, 6–10 years, female, South East England

I think try and be a part of the nursing curricular, because rheumatology really isn't on there. The more you flag it up to people... there's still this perception of rheumatology as purely being rheumatoid arthritis which is an old person's disease. And none of all the other strange and wonderful things that we treat. If you're never exposed to that then you would never know how interesting it is. So that needs to be right at the beginning; for nurses it needs to be on the curriculum and then the junior staff doing their ward rotations need to be exposed to it a bit more as well.

Why specialise in rheumatology?

Among those who choose a career in rheumatology, there is a great deal of job satisfaction and enthusiasm for their work, and many feel impassioned about rheumatology due to a sense that it is somewhat overlooked by the medical profession as a whole. The specialism is dynamic with ongoing research opportunities and new developments in drugs and patient care. Individuals also expressed a sense of gratification from establishing long-term patient relationships, and complexity of multi-system care and diagnostic problem-solving.

Our interviews and survey found that trainees are motivated to choose rheumatology for one or many of the following reasons: research opportunities, long-term patient relationships, variety and the multi-system nature of the specialism and work/life balance. For consultants working in paediatric rheumatology, in addition to these motivations people also chose the specialism due to the team working environment and limited exposure to terminal patients.

Rheumatology and general internal medicine
(GIM) Trainee ST3, female, South Wales

I started realising how many problems and how many organ systems can be involved under one condition. I remember seeing patients with scleroderma and being told to look at their hands and their skin. You'd listen to their chest and heart, and they'd have problems and clinical features in every single system. As a brand-new medical school student, I thought that was amazing.

Top reasons AHP, pharmacist, nurse and psychologist respondents identified for choosing a career in rheumatology:

- Interest in multi-system disease and conditions
- Interactions with patients and long-term patient relationships
- Colleagues and MDT working
- Work/life balance
- Advanced treatment options and ability to see impact on patients
- Interest in research

Among AHPs, pharmacists, nurses and psychologists many of the same motivations for choosing rheumatology persisted as in consultants, however they were also influenced by the availability of Band 6, 7 and 8 roles and CPD training. Rheumatology was perceived as a specialty that promised more senior roles, and scope for future career progression up the NHS banding system.

Specialist rheumatology pharmacist
1–2 years, female, North West

I completed my course on pharmacy prescribing in 2013. When I was first employed at that hospital, I was employed as a hospital discharge planner, and before I knew it my job was solely computers, which isn't really where I wanted to go because I really enjoy the clinical side of everything. And then slowly I became a specialist pharmacist for rheumatology, because I was looking for something more clinical.

Top reasons consultants and trainee respondents identified for choosing a career in rheumatology:

- Career opportunities
- Interest in multi-system disease and conditions
- Interactions with patients and long-term patient relationships
- Advanced treatment options and ability to see impact on patients

In this next section, we review the career pathways into adult and paediatric rheumatology for all members of the MDT. Time and again in our interviews and our membership survey, we learned that the biggest barrier to joining rheumatology was poor exposure to, and insufficient understanding of, specialty opportunities.

Barriers to entering the specialty

2/3 of consultants and trainees quoted poor specialty exposure

Rheumatology workforce problems will not simply be solved by creating more posts. Using findings from our commissioned interviews and survey, we've identified key opportunities to increase exposure to rheumatology and attract more people to the specialty. This help expand the rheumatology workforce, a key campaigning priority for BSR.

This relies on improving exposure to rheumatology within undergraduate and postgraduate training, as well as creating opportunities for clinical experience in the specialty via training placements and rotational posts for early-career AHPs and nurses.

Time to end the crisis in numbers: What's next?

There's a workforce crisis in rheumatology. Our report shows that the rheumatology workforce is understaffed and under-resourced, with high-vacancy rates across the UK. While clinicians are working exceptionally hard to surmount these challenges, we must build a long-term sustainable workforce. These issues are prevalent across the NHS, but BSR now has robust evidence to support our recommendations.

For the first time, we have comprehensive UK-wide workforce data for paediatric, adolescent and adult services, showing unacceptable regional and national variations in workforce provision with too few consultants and specialist nurses to deliver the level of care recommended by NICE guidance. It's patients – more than 10 million people living with rheumatic disease in the UK – who face these consequences. Longer waiting times and delays in assessment and treatment can lead to worse patient outcomes, delayed return into education and work, and more disability.

BSR has identified what the UK's medical bodies, governments, NHS, parliamentarians and local decision-makers must do to affect the change that our rheumatology specialty urgently needs in order to recover post-pandemic and build service capacity. Our new rheumatology team model and ratios will lead to better health outcomes and reduced risk of permanent disability caused by unacceptable referral waiting times and delayed treatment.

To secure the long-term sustainable workforce the specialty needs, we'll engage with stakeholders at the highest levels to:

— Advocate for our new BSR model of what a rheumatology MDT must look like
— Expand consultant and specialist nurse numbers using BSR's new ratios
— Develop enhanced roles for AHPs, pharmacists and nurses
— Increase exposure to rheumatology career pathways

To play your part in putting an end to the rheumatology workforce crisis, please email policy@rheumatology.org.uk to discuss your first steps. You can also share your support on Twitter with us @RheumatologyUK.

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