BMA

Northern Ireland

Championing patients, advancing healthcare, valuing colleagues

A strategy for consultants in Northern Ireland

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Introduction from NICC chair

The current picture of health and social care in Northern Ireland is one of a fragmented system with financial pressures, workforce gaps and long waiting lists resulting in an increasingly challenging environment for consultants and their patients.

'Delivering Together 2016-2026'[1] describes the Department of Health's (NI) vision of a greater range of services available to patients in community settings; unscheduled and elective care delivered in very different ways to how they are now; significantly reduced waiting times for patients; and a strategic approach to health and care workforce planning. Consultants in Northern Ireland believe they can and should play a leadership role in shaping and delivering its implementation.

Consultants make up two in five of Northern Ireland's medical workforce.[2] It is therefore essential that consultants are leaders in this evolving environment, shaping and resourcing the services necessary to ensure health and social care is better for patients.

This document outlines the issues affecting consultant-led care in Northern Ireland and the provision of the workforce necessary to deliver that strategy. It reviews the existing consultant workforce and the issues and concerns raised by consultants about the current system for delivering health and care. It sets out the developments and actions needed to deliver effective, efficient and high-quality healthcare for all patients-and a future vision for consultants that will allow them to provide best quality care for patients, advance healthcare and be valued as senior healthcare leaders and professionals.

It highlights the need for urgent action to:
- Progress the priority areas for service transformation to improve access to, and reduce waiting times for, health and care services.
- Support consultants to be leaders of service development and drive up the quality of patient care.
- Improve recruitment and retention of consultants in Northern Ireland to make the service better for patients.
- Deliver a manageable workload for consultants and shorter waits for patients by organising services more effectively.
- Staff services safely by filling vacancies and producing the right number of trainees in every specialty to ensure future service sustainability.
- Reverse the extremely low levels of morale in consultants with a series of measures to properly value them and their work.

Anne Carson
Chair, Northern Ireland
consultants committee

1 Department of Health (2016) Health and Wellbeing 2026: Delivering together.
2 Department of Health (2017) Northern Ireland Health and Social Care Workforce Census March 2017.

Vision

The vision for the BMA Northern Ireland consultants' strategy is that consultants lead and drive transformational change, improve quality, patient safety and excellence in medical care. It aspires that consultants in Northern Ireland are fully valued in their roles and can exercise autonomy and judgement in providing clinical care to deliver the best outcomes in the context of effective, population based, joined-up services for patients.

Who are consultants?

Consultants are senior doctors who typically spend nine or more years training and have specialised in a specific area of medicine. They have passed accredited specialist exams in their chosen specialty. Consultants are the most senior, expert doctors who have ultimate responsibility for patients who have been referred for specialist care. Most referrals from general practice for 'specialist' treatment places the patient to be cared for under the responsibility of a consultant and his or her team. Diagnostics and scans to ascertain treatment needs are also directed and reported by consultants. Patients can experience a one-off treatment interaction with a consultant or a treatment relationship lasting many years.

The work of the consultant goes beyond treating and caring for patients. They lead multidisciplinary teams; they teach and train medical students, doctors in training and other healthcare professionals, and lead on research and service development. Consultants practice independently, are highly regulated and undergo appraisal annually, with formal revalidation every five years.

Consultants in Northern Ireland

Health and social care in Northern Ireland employs around 64,000 people.[3] Doctors make up 8.2% of the health and social care workforce, and within that, consultants make up 3% of directly employed staff.[4] DoH (NI) figures as of March 2018 stated there were 1,693 WTE (whole time equivalent) consultants employed in the health and social care system in Northern Ireland.[5] This is 40% of the medical and dental workforce.

The working life for consultants is set out in an annual job plan, agreed with his or her employer. The job plan summarises the consultant's main duties and responsibilities; scheduling of work commitments; professional and managerial accountability arrangements; and agreed service development objectives. Supporting professional activities (SPA) time is also written into consultant contracts to allow time for teaching, training, education, CPD, audit, appraisal, research, clinical governance, service development and related areas. Feedback from BMA members has indicated that the majority of consultants do not receive their allocated SPA time.[6]

3 Department of Health (2017) Northern Ireland Health and Social Care Workforce Census March 2017.
4 Department of Health (2017) Northern Ireland Health and Social Care Workforce Census March 2017.
5 Department of Health (2017) Northern Ireland Health and Social Care Workforce Census March 2017.
6 British Medical Association (2017) Survey of consultants in Northern Ireland.

The case for change – challenges for the consultant workforce in Northern Ireland

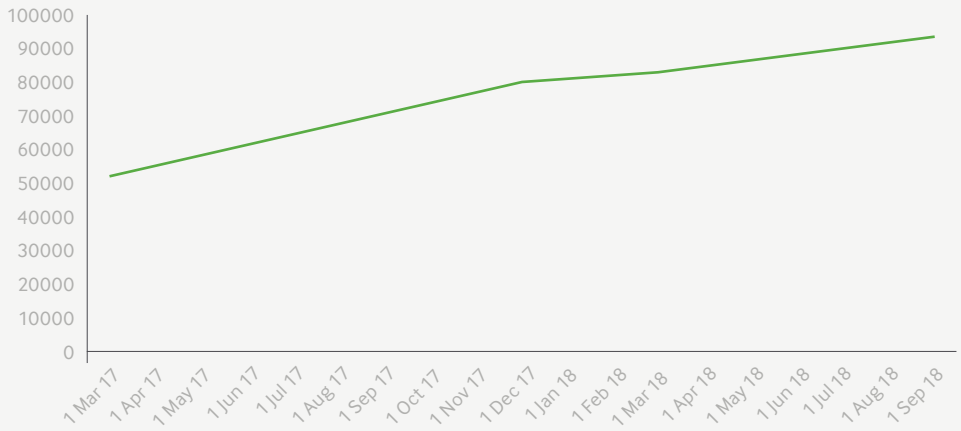
Meeting changing population needs

'Health and Wellbeing 2026: Delivering Together' sets out the evolving needs of our rapidly changing and ageing population.[7] Consultants are caring for an ever-growing number of people needing specialist assessment and care, with an inexorable increase in the volume and complexity of our population's needs. One in three of the population of Northern Ireland live with one or more long-term condition.[8] By 2021 it is predicted that more than one million people across the UK will be living with dementia and by 2030, three million people will be living with or beyond cancer[9]. This changing need has a substantial effect on the frequency with which patients access healthcare and the time it takes to care for them.

While consultants and their teams are caring for more people every year, this is not keeping pace with the rising need for care. The number of patients waiting and the length of waiting times continues to increase and Northern Ireland has the longest waiting times of the four UK nations.[10] At 31st December 2018, a total of 281,705 patients were waiting for a first consultant-led outpatient appointment.[11] The greatest impact is on patients who are waiting unacceptably long periods of time for treatment. At 31st December 2018, 33.7% (94,953) of patients were waiting more than 52 weeks for a first consultant-led outpatient appointment, compared with 29.7% (80,651) at 31st December 2017, an increase of over 14,000 patients waiting more than a year.[12]

It is unacceptable to all consultants that no waiting targets are currently being met and that patients in Northern Ireland are waiting significantly longer than in other parts of the UK.

Patients waiting more than 52 weeks for first consultant-led outpatient appointment



7 Department of Health (2016) Health and Wellbeing 2026: Delivering together.
8 Long term Conditions Alliance Northern Ireland (2016) Response to Draft Programme for Government Framework 2016 – 2021, https://ltcani.org.uk/wp-content/uploads/2016/08/LTCANI-Response-to-draft-PFG-FINAL.pdf (accessed 13 March 2018).
9 See http://www.lse.ac.uk/website-archive/newsAndMedia/news/archives/2014/09/Dementia.aspx for the dementia figures. The cancer data are Macmillan Cancer Support estimates of prevalence at the end of 2012 and 2030 by nation in the UK, estimated using prevalence rates from Maddams, J., Utley, M. & Møller, H. Projections of cancer prevalence in the United Kingdom, 2010–2040. Br. J. Cancer 107, 1195–1202 (2012).
10 BMJ (2018) Longer waiting times in Northern Ireland than in rest of UK deemed 'unacceptable'.
11 DoH (NI) (2018) Northern Ireland Waiting Time Statistics.
12 DoH (NI) (2018) Northern Ireland Waiting Time Statistics.

The capacity of the consultant workforce to meet increasing need

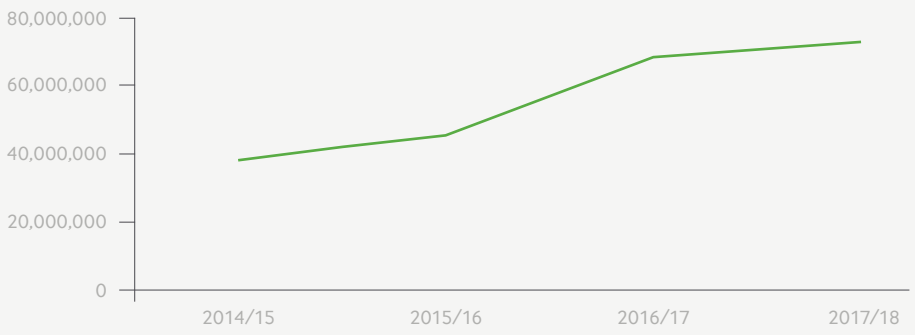
Between 2006 and 2016 there was an increase of 47% in the number of whole-time equivalent consultant posts.[13] However, in the current configuration of services this has not been sufficient to meet the increased volume and complexity of need and the advances in healthcare. Similarly, increases in the numbers of other health and care staff have also not kept pace with rising need, including general practice doctors (GPs), nurses, allied health professionals and social care staff.[14] Tasks other than direct patient care are also required of consultants which impact on the number of hours available in their job plan. The capacity, effectiveness and efficiency of the consultant workforce is negatively impacted by:

- **Consultant vacancies** – The official consultant vacancy rate increased from 6.2 per cent WTE to 9.3 per cent between March 2013 and March 2015.[15] DoH (NI) stated that there were 100 consultant vacancies being recruited to at the end of September 2018.[16] The DoH (NI) definition of a vacancy is a post that is activity being recruited to. This under-counts the remaining vacant posts leading to the official vacancy rates being lower than the actual number of empty posts. BMA Northern Ireland surveys have indicated a real-terms consultant vacancy rate of 13 per cent, equating to around 230 posts.[17]

- **More consultants leaving than new consultants joining** – In Northern Ireland, leaving rates for hospital medical staff have been higher than joining rates for three out of the four years reviewed by the Doctors and Dentist's Review Body (DDRB) in their 2018 report.[18] Between April 2016 and March 2017 there were 56 (3.2 per cent) consultants joining and 69 (4.0 per cent) consultants leaving the Health and Social Care system. In this year the leaving rate was above the joining rate by 0.5 percentage points and in 2015-16 the difference was 0.7 percentage points. This is in contrast with England and Scotland where joiner numbers have been consistently higher than leavers (no comparable data were available for Wales).[19]

- **Increase in number and cost of medical locums** – One key indicator of the impact of consultant vacancies in secondary care is the increased expenditure on medical locums which increased from £38.5 million in 2014-15 to £73 million in 2017-18.[20]

Northern Ireland spending on medical locums



13 Department of Health (2016) Northern Ireland Health & Personal Social Services Workforce Census March 2016
14 BMA (2016) General Practice in Northern Ireland: The Case for Change.
15 DOH (2015) Northern Ireland Health and Social Care Workforce Vacancies as at 31 March 2015.
16 Department of Health (2018) NI Evidence to the Review Body on Doctors' and Dentists' Remuneration 2019/20 – Annex A (Workforce Information).
17 BMA (2016) Recruitment and retention: Challenges facing the consultant workforce.
18 DDRB (2018) Review Body on Doctors' and Dentists' Remuneration 46th Report: 2018.
19 DDRB (2018) Review Body on Doctors' and Dentists' Remuneration 46th Report: 2018.
20 BBC (2018) Western Trust spends £27m on locum and agency staff.

– **Increasing workload of the consultant workforce** – The economic, workload and quality costs of vacant posts goes beyond the cost of locum doctors. A recent BMA Northern Ireland survey of consultants reported that only half of consultants said their job plan reflected their actual hours of work. Consultants reported working an additional 6.3 hours per week on average in addition to their job plan, with some consultants reporting working as many as 20 additional hours a week.[21] If the average additional 6.3 hours per week worked by consultants on direct patient care are extrapolated across the working consultant population in Northern Ireland, this equates to approximately 11,000 additional hours being worked by existing consultants on top of their 40-hour week.

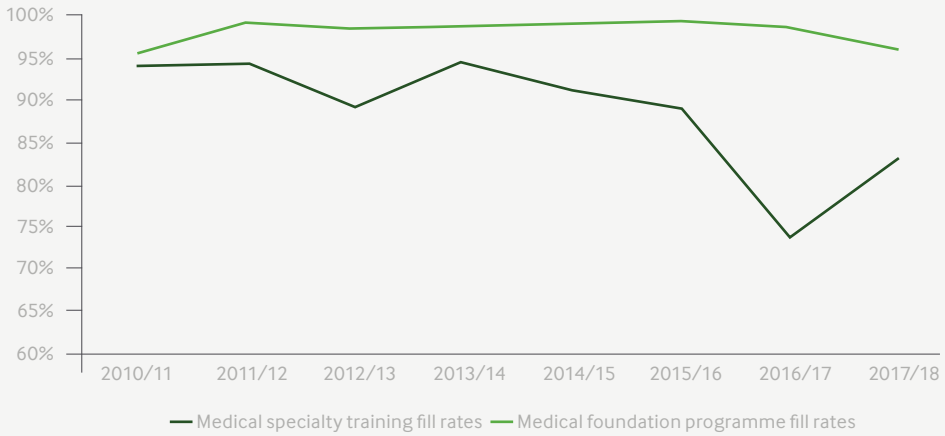
Other factors that need to be considered in relation to the consultant workforce are:

– **The changing needs of the future workforce** – In 2018, 609 consultants in Northern Ireland were women and 1083 were men (WTE).[22] Of all medical branches of practice in the Northern Ireland Health and Social Care service, consultants currently have the lowest percentage of women practising. With the increase in the number of women who are medical students (61% women entering Queen's University Belfast medical school in 2016[23]), the proportion of consultants who are women is likely to rise significantly in the future. This is further evidenced by the increasing number of women doctors who are registered with the GMC, between 2012 and 2017 there has been a 11.2% rise in the number GMC registered women doctors compared to a 1.6% reduction for men doctors.[24] The route to a consultant role needs to be flexible to accommodate the changing demographic needs of doctors. Training routes and employment must reflect these needs. Feedback from women consultants in Northern Ireland stated that job plans were often not flexible enough to allow them to continue working in the pattern that would best meet their needs. The system must support women to aspire to be a consultant.

The decline in junior doctors applying for specialty training posts – The junior doctors of today are the consultants of tomorrow. The chart below illustrates the decline in junior doctors applying for the speciality training posts that are the route to qualification as a new consultant. Posts for foundation training are still being filled, yet in 2016/17 only around 73% of the specialty training posts needed to supply trained consultants in the future were filled.[25] Furthermore, the proportion of doctors completing the Foundation Programme in Northern Ireland and entering directly into GP or specialty training has fallen progressively from 68.4% in 2012 to 34% in 2017.[26] GMC data from across the UK has shown that doctors are taking on average 6 years to reach the end of ST3 rather than the minimum of 5 years, and trainees could take 12 years or more to fully complete training after registration in 8-year specialty programmes.[27] Without junior doctors applying for specialty posts, training and staying in Northern Ireland, there will be even fewer consultants to provide a service here in the future.

21 British Medical Association (2017) Survey of consultants in Northern Ireland.
22 Department of Health (2018) Northern Ireland Health and Social Care Workforce Census March 2018.
23 Gardiner, K (2018) Medical school places review.
24 Gardiner, K (2018) Medical school places review.
25 NIMDTA (2017) Annual Report.
26 Gardiner, K (2018) Medical school places review.
27 Gardiner, K (2018) Medical school places review.

Foundation and specialty fill rates



The reasons for this decline include the fact that Northern Ireland has not remained as attractive as a place for doctors to train to become consultants. The medical job market has become increasingly international and opportunities exist to work outside the UK. This has further impacted on the number of consultants working and training in Northern Ireland. Unlike the rest of the UK, DoH (NI) stopped the award of new clinical excellence awards in 2010. This has had a direct impact on the amount of funding available for consultant remuneration in Northern Ireland and has resulted in a less attractive environment compared with other jurisdictions.

The Medical School Places Review (2018) highlights that Northern Ireland needs to be attractive to doctors to both remain here and to return to work from elsewhere.

The Review also states that the average number of doctors completing their consultant training in Northern Ireland is likely to just meet local requirements. However, not all doctors who complete through a Northern Ireland training programme will stay here. The rate at which consultants are leaving has been between 62 and 71 doctors/year with an average of 66.8. If it is assumed that the age at appointment as a consultant, duration of working life as a specialist and the age of retirement stays the same, then the number of doctors completing training in a specialty would need to increase to 106.8/year.[28]

The DoH (NI) has taken the initiative to fund some international recruitment projects to attract doctors to work here, however, to date they have not had a significant impact and BMA believes that this is not the long-term answer to the recruitment and retention problem.

Action is needed to improve flexible working and workload management so that becoming a consultant in Northern Ireland remains attractive to doctors in training, with initiatives targeted at preventing a further decline in the number of specialty trainees, addressing the gaps that previous reduction in numbers will leave in the consultant workforce and ensuring new consultants are coming in to our system ready to sustain and develop the transformed services needed by patients in Northern Ireland.

28 Gardiner, K (2018) Medical school places review.

In summary, the consultant workforce challenges in Northern Ireland are driven by:
- inadequate medical workforce planning to ensure vacant posts can be filled through permanent employment of consultants.
- underinvestment in the consultant workforce relative to other jurisdictions (including in consultant pay).
- job plans that do not reflect the time commitments of the job (with an expectation that additional work is completed without remuneration).
- lack of flexible working and training arrangements.
- junior doctors not taking up specialty training posts in Northern Ireland.

Vision for change

The ambition set out in the ministerial vision 'Delivering Together – Health and Wellbeing 2016-2026' is to improve the health of people, improve the quality and experience of care, ensure sustainable services and support and empower the workforce.[29] These aims are shared by consultants in Northern Ireland. Consultants have a unique and critical role to play in shaping, supporting, developing and leading the implementation of these changes, in particular:
- The priorities and plans to transform hospital services and develop new and additional out of hospital services to improve the quality, effectiveness and timeliness of care.
- The development of the consultant workforce to lead and deliver these changes, ensuring Northern Ireland can attract and retain the numbers of skilled and specialist staff needed to provide new models of high quality and sustainable care.
- Consultants who work in a system where they have a meaningful say in planning their own work and a lead role in driving change. Systems must be agreed which allow consultants to work flexibly in a variety of settings, with the aim of providing the highest quality care for patients.
- Current barriers between primary and secondary care are viewed by doctors as introducing unnecessary costs and often compromise quality of care. Current systems are too fragmented and create greater waiting times and access barriers for patients. Effective partnership working across current primary and secondary care boundaries, for the benefit of patient services is urgently required.
- A greater role for consultants in front line triage, and in early intervention and prevention of conditions.

29 Department of Health (2016) Health and Wellbeing 2026: Delivering together.

Priorities for transformation of consultant led care

Consultants want to deliver high quality, population-based services, with elective and unscheduled care services which do not impact negatively on each other. Where most appropriate, a greater number of interactions with patients should happen outside hospital settings, there should be increased levels of social care and community-based support, and more specialist mental health services.

The current model of access to planned consultant expertise and treatment is no longer fit for purpose in managing the presenting need, as evidenced by the increasing need and lengthening waiting times. A key step to improving service provision is a focus on using hospitals for complex planned surgery and emergency care of patients needing an acute inpatient setting. Evidence supports concentrating specialist procedures and services in a smaller number of sites to produce better outcomes for patients.

Aspirations for consultants include:
- Patient access to consultant led services without having to attend hospital, particularly for frail elderly and people with long-term conditions.
- Designing services around the needs of the patient, rather than around the needs of the service structure.
- Consultants playing a part in reducing the waiting times for patients who have been referred for treatment by working with primary care colleagues to assess who requires urgent care.
- Investment to allow patients to receive timely consultant-led care within the NHS.

Clinical networks

The development of region-wide (and cross-border) networks for highly specialist services is referenced in 'Delivering Together – Health and Wellbeing 2016-2026' with the ambition to deliver more services on a larger geographic footprint where this is clinically appropriate.

A clinical networks model has the benefit of achieving the economy of scale required by Northern Ireland services while allowing the sharing of high-level expertise across geographies and health and care teams. With autonomy to innovate and collaborate across organisational boundaries, networks can provide a clinically led organisational model that would drive achievement of quality standards of care and lead the transformation of services. They would involve doctors and other front-line clinicians from secondary and primary care who would develop joint care pathways. Alongside the development of elective care centres, clinical networks allow concentration of more specialist expertise and procedures on a smaller number of acute hospital sites.

Priorities for transforming the consultant workforce

Investment in the optimum number of permanently employed consultants and in the non-consultant medical workforce that forms their clinical teams is critical to the successful delivery of the transformation of care set out in 'Delivering Together – Health and Wellbeing 2016-2026'.

Addressing the workforce challenges set out in the Case for Change section of this document will require a combination of immediate, short term and longer-term actions.

Immediate action is required on:

- **Incentivising recruitment and retention –** The Health and Social Care Workforce Strategy 2026 'Delivering for Our People' sets out actions to attract, recruit and retain the future workforce needed to deliver the aspirations of 'Delivering Together – Health and Wellbeing 2016-2026'. Urgent action is needed on this to have a package of incentives to attract and retain high quality candidates, particularly for specialities with significant gaps in the permanent workforce. The right incentives will help to keep both consultant and doctors in training within Northern Ireland. This will contribute to a reduction in the spend on locum consultants to fill vacant posts and will have significant benefits in improving the safety and quality of care and addressing some of the workload pressures BMA members have reported as driving the rate of consultant leavers.

- **Local training schemes must produce the right number of consultants in all specialties for services in Northern Ireland** – Immediate action must be taken to deliver this priority action and to reverse the decline in junior doctors taking up specialty training posts that produce the consultants of the future. Action must be taken to address the concerns of doctors in training to ensure Northern Ireland is an attractive place to live, train and work. It is essential that medical and wider Health and Social Care workforce planning is done effectively by the Department of Health (NI) and that it models against both population need and new models of service delivery.

- **Increasing consultant autonomy** – Consultants lead teams and drive initiatives to improve patient care and continually increase quality. A view of consultants in the past has been of senior doctors with high levels of leadership and autonomy over their own work, that of their immediate team and for the leadership of patient care. Feedback from consultants over recent years has indicated that there has been a significant diminution of their autonomy and control over their clinical decision making.

- Over half the BMA Northern Ireland consultant survey respondents said their control over their own work had decreased or significantly decreased in the last five years. Reasons given for this view included: increased decisions made by management and not consultants; additional administration; lack of control over patient lists; management targets having priority over clinical care; and changes made to job plans and rotas without prior agreement. It was reported that consultants were obliged by managers to see new patients within a management timeframe rather than who they see as a clinical priority.

- Consultants must have autonomy to practice, make clinical decisions, lead teams and improve the service experience for patients. Consultants must also be able to participate in meaningful research.

- New models of working including clinical networks, working across boundaries with primary care colleagues and consultants agreeing referral pathways for patients have potential to increase autonomy while improving care of patients.

- **Parity of consultant remuneration** – All doctors have experienced a significant fall in real income since 2008 of around 20 per cent. Pay review data for consultants in England includes the excellence and distinction awards available to recognise excellent work in that jurisdiction. These awards have not been available for new applicants in Northern Ireland since 2010. Their removal from consultant pay here has resulted in the removal of the opportunity for consultants to apply for this recognition and a consequent reduction in pay for the Northern Ireland consultant workforce. Further, the suspension of this scheme removes the ability to recognise excellent work by consultants in the same way as in the rest of the UK.

- Consultants in Northern Ireland must have parity of pay and reward with consultants in other jurisdictions in the UK. The immediate reinstatement of these awards, tailored if necessary to recognise excellence in the delivery of the transformation of care in Northern Ireland, is a critical action to address pay parity, reversing the recruitment crisis in the consultant workforce and improving the morale in a workforce that feels undervalued.

Recommendations

There is significant potential for consultants to move service transformation forward if the following are implemented:

- Consultants having support to use their autonomy to shape services, including across traditional primary and secondary care boundaries.
- Consultant job plans to deliver new services that are agreed and reflect the needs of a flexible service.
- All care providers have the same incentive to treat patients appropriately and in the community, if possible.
- Appropriate resources in community settings, particularly those which enable a person to recover in their own home if appropriate.
- Specialist hospital services become centralised on the appropriate number of sites to provide best, high quality care for patients.
- Clinical networks with the right care pathways are established to provide specialist care across Northern Ireland.
- Direct communication between doctors in primary and secondary care, and multidisciplinary colleagues as part of day to day work.
- Pre-referral discussions between consultants and GPs to consider best treatment plan for patients becoming the norm and prevent unnecessary waiting times.
- An over-arching goal to ensure the right patient is in the right place, with the right health and care staff in the right place.

To support the long-term future of consultant-led services in Northern Ireland, action is immediately required on the following areas:

- Full implementation of the recommendations of medical workforce plans to ensure Northern Ireland has the appropriate number of consultants to provide quality patient care.
- Full recognition of consultants as service leaders with full involvement and engagement in service change.
- A comprehensive plan to value and recognise the consultant workforce so that Northern Ireland becomes an attractive place for recruitment and retention of consultants.
- Consultant remuneration at least equal to consultants in other UK nations.
- Work-life balance as integral to consultant employment to ensure the workforce remains sustainable for Northern Ireland.
- Adherence to agreed, fully funded prospective job plans.
- Fully functioning administration support to enable consultants to spend their time working at the top end of their skill set to deliver care for patients.
- An effective strategy for full engagement with consultants in leadership activities within their workplace, including development opportunities.
- A comprehensive, fully funded occupational health and wellbeing service for health and care staff in Northern Ireland.

British Medical Association
BMA House, Tavistock Square,
London WC1H 9JP
bma.org.uk

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