

Consultant workforce shortages and solutions:

Now and in the future

Consultant workforce shortages and solutions: *Now and in the future*

On 22 July 2020 the BMA UK consultants committee hosted a roundtable event with representatives from medical royal colleges in order to discuss the future of the consultant workforce in England. The meeting gave particular consideration to short, medium and long-term staffing problems, their causes and potential amelioration strategies. This document summarises the outcomes from this meeting, is aimed at the Government, employers and arms-length bodies, and details how we can protect patients, consultants and the NHS from an emerging consultant workforce crisis.

Acknowledgements

We are grateful for the input of the following medical royal colleges into the development of this report:

- Faculty of Intensive Medicine
- Royal College of Anaesthetists
- Royal College of Obstetricians and Gynaecologists
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Royal College of Psychiatrists
- Royal College of Radiologists
- Royal College of Surgeons of England

Executive summary

Prior to the COVID-19 pandemic the NHS workforce faced a perfect storm of consultants choosing to retire earlier, a significant proportion approaching retirement age and a growing trend of younger doctors walking away from a career in the NHS. COVID-19 added significant additional pressure on the workforce with doctors working long hours, in new settings, sometimes whilst risking their own lives. Now the NHS is facing a growing backlog of unmet need on top of the existing staff and resource shortages. Every consultant has become more precious than ever; retention is crucial to the success of any plans for continuing to deliver safe patient care and catching up with existing and developing backlogs.

Projections of future demand indicate that the NHS needs to respond quickly to address the workforce crisis, both by increasing supply and improving retention. Vacancies reported nationally are high and are likely to represent a significant underestimate. Future consultant workforce gaps need to be filled by expanding medical student and FP (Foundation Programme) places now to meet current and future patient demand. At the same time, more staff/educators and supporting resources are required to deliver the increased educational workload. The Government is not on track to deliver the commitments set out in the [NHS Long Term Plan](#).

This report highlights some of the factors driving consultant retention problems and why retaining and growing the consultant workforce must be a top priority for the NHS:

The UK has a growing and ageing population

The IFS (Institute for Fiscal Studies) found that 'meeting the needs of a growing and ageing population would require hospital activity to increase by a projected almost 40% over the next 15 years'. The consultant workforce requires considerable further growth to keep up with this changing pace of demand.

The consultant workforce is ageing, and medical career paths are changing

24% of consultants are over the age of 55, and younger doctors are pursuing different career paths from their older colleagues – including taking breaks in training or leaving clinical work in the NHS.

Consultants are leaving the medical profession earlier than planned

A recent BMA survey found that 6 out of 10 consultants intend to retire before or at the age of 60, for reasons heavily linked to job satisfaction, wellbeing, workload, ill health, bureaucracy and pension taxation rules.

Working in systems under pressure bears a cost to staff

The number of doctors in the UK sits far below that of comparator countries in Europe. Inadequate staffing is leading to rising sickness absence, overworking and burnout, low morale and poor wellbeing, and doctors reducing their hours or outright leaving the medical profession.

The role of consultants in care delivery is increasing

There is an increasing expectation, both by the public and the medical royal colleges, of moving to a system of consultant-delivered care as a way of improving outcomes and making more efficient use of resources.

Consultant vacancies are likely higher than vacancy data suggests

At the end of June 2020 there were at least 8,278 secondary care FTE (full time equivalent) medical vacancies (10% of all current recorded NHS vacancies). However, persistent problems with – and varying policies on – how vacancies are advertised and recorded means vacancy data likely does not reflect the true number (and there is consistently a discrepancy between vacancies that are nationally reported and those captured in census data by the medical royal colleges).

The COVID-19 pandemic highlights the need to grow the consultant workforce

NHS performance measures have been progressively deteriorating over recent years, with record low performance becoming a monthly norm over the past few winters. COVID-19 has exacerbated this, creating a huge backlog of non-COVID care, which is likely to grow in the coming months. To overcome this backlog, reduce NHS waiting lists and waiting times and restore activity to previous levels, medical workforce numbers – which must include the consultant workforce – must increase.

Organisations will need to put in place immediate interventions to prevent erosion of the consultant workforce. Now is a critical time to understand the factors that motivate the workforce to leave or stay, and respond accordingly.

In the short to medium term, the Government and employers need to:

Reform the pensions taxation system

There are a number of issues with the NHS pension scheme that are forcing doctors to retire before they would otherwise choose, which need to be addressed.

Clarify and widen 'retire and return' arrangements

Trusts should have clear and transparent policies regarding 'retire and return' for consultants and ensure this is communicated to staff. This should of course be facilitated at a local level, but a national steer would help ensure this is universal.

Address the real terms pay erosion

Consultant pay in England has declined by over 30% in real terms over the last decade. Addressing this issue will improve retention, as well as make the career more attractive to new entrants.

Make the most effective use of retired doctors who would like to return to work

Despite many retired doctors being restored to the temporary medical register to support the COVID response, it has not been possible to provide them all with productive work. Ways need to be found to harness the skills of this workforce. As a minimum, returners should receive an induction, have access to a mentor and be able to have open conversations about how they are able to contribute. This could include taking roles in medical education. There also needs to be adequate funding in place to employ returning doctors.

Enable consultants to change parts of their role

Job planning conversations should be positive; staff must be listened to if they want to make changes to their role, including devoting more time to education and training, research, leadership and management. Employers should support older consultants who wish to withdraw from certain parts of their role, eg emergency/on-call work to improve retention.

Address the gender pay gap

A primary cause of the gender pay gap in medicine is because of the gender imbalance across the highest paid positions, grades and specialties. Career pathways and workplace environments must be designed to encourage retention of female consultants in addition to addressing issues that may encourage female staff to take on positions in lower-paid roles.

Allow consultants to work flexibly, including remotely where possible

Flexible and remote working, and other measures to improve work-life balance, should be encouraged. Employers should ensure that staff have access to necessary IT hardware, software and training to carry out their duties remotely. Consultants should have the right to work flexibly. Employers should ensure staff have suitable equipment to work from home.

Prioritise health and wellbeing of staff

Employers must prioritise doctors' health and wellbeing and ensure workplace risks are reduced; this will help to reduce sickness absence. Risk assessments need to be rolled out and staff need to have adequate access to PPE. Staff who are more at risk of COVID-19, including BAME staff, need to be better protected. Employers must ensure that staff know where they can access support if their mental or physical health deteriorates.

Offer sabbatical leave

Sabbatical leave, which is a norm for many modern employers, should be provided. Employees value sabbaticals as a chance to take time out from a stressful work environment, an opportunity to acquire new skills and knowledge or to study the operation of other healthcare systems or organisations. Sabbaticals will retain staff and help them bring new skills back to their workplaces.

Support staff going through the menopause

Employers should develop a culture where those experiencing physical and/or mental symptoms can speak openly and access the support they need. Employers should raise awareness about menopause and provide training for line managers.

Develop a supportive and inclusive workplace culture

Employers need to build a supportive, no-blame culture that values equality and diversity and addresses bullying, harassment and discrimination. Employers should improve access to workplace adjustments, invest in OH (occupational health) support and enable staff to self-refer to OH teams.

Provide opportunities for leadership, training, development and research

Barriers to undertaking research and/or training should be removed and the role of patient-facing research as part of direct clinical care needs to be recognised. Staff should be provided with opportunities to develop and become leaders. Workforce shortages should not prevent consultants from having defined job planned time for this. The opportunity to develop professionally ensures staff enjoy their role and are motivated to stay.

In the long term, Government and arms-length bodies must urgently take action to ensure that consultant supply closely matches patient demand.

Introduction

Consultant-led clinical teams play a pivotal role in planning and delivering safe patient care. However, they work in a system under pressure. Whilst numbers are increasing slightly each year, the overall number of FTE (full time equivalent) consultants continues to grow by approximately 4% per annum,¹ the demand for consultant care is growing at a faster rate. This means staff numbers lag behind what is required to undertake consultant activity within the health service. At the end of June 2020, there were at least 8,278 secondary care FTE medical vacancies (10% of all current recorded NHS vacancies).² However, NHS Digital data does not consider the 'aspirational gap'; the growing deficit between healthcare expectations and staff required for delivery of that standard of care.

Given the length of time it takes to train a consultant – 12 to 15 years depending on the speciality – immediate action needs to be taken now to grow the workforce. Delay now will impact the NHS and its ability to deliver timely access and effective services to patients in future.

The UK has a growing and ageing population

The drivers for an increased requirement for the consultant workforce are readily apparent. The UK has a growing and ageing population with a high probability of individual citizens developing complex comorbidities.³ The IFS (Institute for Fiscal Studies) found that 'meeting the needs of a growing and ageing population would require hospital activity to increase by a projected almost 40% over the next 15 years', ie by 2033. If this is correct, the consultant workforce requires considerable further growth to keep up with the pace of demand.

The consultant workforce itself is ageing and career paths are changing

There are other less apparent factors that drive the need to increase consultant numbers. A significant proportion of the workforce is approaching retirement – 24% of consultants are over the age of 55.⁴ There is also a growing trend of younger doctors pursuing different career paths from their older colleagues – including taking breaks in training or leaving clinical work in the NHS. For example, in 2018, only 37.7% of F2s continued directly into core or specialty training programmes.⁵

Consultants are leaving the medical profession earlier

The consultant workforce is not just ageing. Surveys from the BMA and medical royal colleges have also found that consultants are choosing to retire earlier than planned.⁶ This is for a variety of reasons linked to job satisfaction, wellbeing, workload, ill health, bureaucracy and pension taxation rules.⁷ A recent BMA survey found that 6 out of 10 consultants intend to retire before or at the age of 60, with important factors in decisions around retirement being health & wellbeing and pensions. Many of these factors could be resolved by Government and employers, given sufficient political will.

NHS work is seen as increasingly stressful and less adequately rewarded, lacking the flexibility to accommodate older doctors, and therefore less attractive. The Royal College of Physicians, for example, found that working on-call and the pressures of work were common drivers in considering retirement.⁸ An increasing loss of autonomy in consultant roles can also act as a powerful disincentive, as does inadequate resourcing.

1 [NHS Workforce Statistics – June 2020](#), NHS Digital (September 2020)

2 [NHS Vacancy Statistics England April 2015 – June 2020 Experimental Statistics](#), NHS Digital (August 2020)

3 [National population projections: 2018-based](#), Office for National Statistics (October 2019)

4 [NHS Workforce Statistics – June 2020](#), NHS Digital (September 2020)

5 [Number of FY2 doctors moving straight into specialty training falls again](#), British Medical Journal (January 2019)

6 [Thousands of NHS hospital consultants intend to quit years before retirement, survey finds](#), Independent (January 2019)

7 [Pension tax driving half of doctors to retire early](#), Royal College of Physicians (2020)

8 ['Later careers – stemming the drain of expertise and skills from the profession'](#), Royal College of Physicians (November 2017)

Working in systems under pressure bears a cost to the staff within them

The number of doctors in the UK is far below that of comparator countries in Europe.⁹ Rising pressure caused by workforce shortages is resulting in increased sickness absence, doctors reducing hours or people leaving the profession, adding further burden to the existing workforce.¹⁰ Inadequate staffing means that consultants are often pressured to cover rota gaps or even take on the work of more than one doctor.¹¹ Many consultants work significantly beyond their contracted hours in order to ensure patients get the care that they need; sometimes that work is unrecognised and, frequently, it is unrewarded.¹² Where that is the case this can cause a loss of goodwill amongst consultant staff, contributing to burnout, low morale and disengagement with the organisation, and leads to doctors leaving the medical profession.¹³

Consultants may also bear the brunt of systemic pressures. For instance, there is a growing willingness to assign problems arising from resourcing shortages to consultants to solve. Consultants are appointed as clinical leaders, of course, but intense pressure on the secondary care system has the effect of simply deferring issues, appropriate or otherwise, to the consultant within a team. The worsening NHS performance figures year on year are evidence of the extraordinary pressure within the system. The expectation for consultants to manage what is fundamentally a lack of resources becomes unbearable for many.

The good news is that many of these factors could be resolved by Government and employers, given sufficient political will (see solutions set out later in this paper).

The role of consultants in care delivery is increasing

There is also an increasing expectation, both by the public and the medical royal colleges, of consultant-delivered care. *The Benefits of Consultant-Delivered Care*, a report by the Academy of Medical Royal Colleges, sets out the case for, and the key benefits of, moving towards a model of consultant-delivered care in the NHS:¹⁴

- Rapid and appropriate decision making
- Improved patient outcomes
- More efficient use of resources
- GP access to the opinion of consultant specialists
- Patient expectation of access to appropriate and skilled clinicians and information
- Benefits for the training of junior doctors.

The report concluded that 'there are real evidence-based benefits to moving to a system of consultant-delivered care. Therefore, viewing the increased numbers of doctors coming out of training through a purely financial lens would be a significantly missed opportunity to improve the quality of care'.

9 The UK ranks second lowest in the EU with three doctors per 1000 inhabitants (by comparison, Denmark has 4.2, Germany has 4.3, and Austria has 5.2. [Doctors](#), OECD (Organisation for Economic Development) data (2019)

10 [The state of medical education and practice in the UK](#), General Medical Council (December 2019)

11 [Focus on physicians: 2018–19 census \(UK consultants and higher specialty trainees\)](#), Royal College of Physicians (October 2019)

12 The BMA's Quarterly Survey of March 2018 reported that 35.2% of doctors very often worked outside their regular hours and 17.6% of senior doctors undertook research activities in their own time and 21% undertook teaching or management activities in their own time. Nearly a third of senior doctors provided pastoral support and mentoring in their own time, rising to 34.7% of women doctors. Two-thirds of those who had taken on additional responsibilities reported that they did not receive additional pay for doing so.

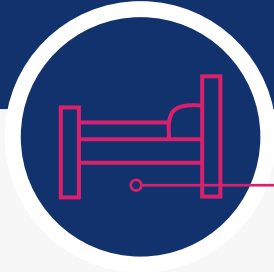
13 [The state of medical education and practice in the UK](#), General Medical Council (December 2019)

14 [The Benefits of Consultant Delivered Care](#), Academy of Medical Royal Colleges (January 2012)

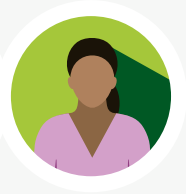
The number of doctors in the UK is far below that of comparator countries in Europe

United Kingdom

3 doctors per 1,000 inhabitants



2.5 hospital beds per 1,000 inhabitants



Europe

Denmark

4.2 doctors per 1,000 inhabitants



Germany

4.3 doctors per 1,000 inhabitants



Austria

5.2 doctors per 1,000 inhabitants



Changes to the way care is delivered mean additional consultants are required

Recent growth in the consultant workforce has focused on delivering more specialised consultant services in order to improve patient outcomes. While it is true that focusing some specialist work in the hands of a smaller number of consultants can improve patient outcomes, eg by increasing procedure numbers, such changes also drive the development of more specialised consultant on-call rotas. These rotas increase the contribution of out of hours working to the overall consultant job plan and help drive the increased requirement for more appointments.

Medical vacancies are likely higher than reported

Even when posts are advertised, a significant proportion – close to half – go unfilled.¹⁵ At the end of June 2020 there were at least 8,278 secondary care FTE medical vacancies (10% of all current recorded NHS vacancies). However, consultant vacancies are only considered to exist where a job plan has been approved by an employing trust, and has been advertised but not filled. In some parts of England, if such posts are re-advertised and remain unfilled those posts are no longer advertised and no longer recorded as vacancies. In other parts of the UK, varying policies for recording unfilled vacancies exist. It is therefore no surprise that there is a discrepancy between vacancies that are nationally reported and those captured in census data by the medical royal colleges, which suggest that vacancies are likely to be higher.¹⁶ In Scotland, the vacancy rate is twice as high as official workforce figures indicate.¹⁷

Current NHS service needs and COVID-19 illustrate the need to grow the workforce

The fact that current workforce numbers and service needs do not match up is abundantly clear when looking at recent NHS performance figures. In the 2019/20 winter, the NHS recorded its worst performance ever against multiple key metrics.¹⁸ These performance measures had been progressively deteriorating over recent years, with record low performance becoming a monthly norm over the past few winters. Pressure is now so significant, even during summer, which usually allowed an opportunity to tackle climbing waiting lists and improve waiting times, 2019 was the worst summer on record.

To improve NHS performance, and to sustain that performance into the future commensurate to population requirements, medical workforce numbers, including consultants, must increase. This is particularly pressing now given the huge backlog of non-COVID care created as a result of the pandemic, which is only likely to grow in the coming months. To tackle this backlog, reduce NHS waiting lists and times and restore activity to previous levels, an extraordinary effort will be necessary over a sustained period of time. Clinical care continues to be impacted by staff absences, with many staff having to isolate or shield to protect their own wellbeing. It is now more important than ever to maximise consultant numbers.

At the end of June 2020 there were at least 8,278 secondary care FTE medical vacancies (10% of all current recorded NHS vacancies)

¹⁵ ['RCP publishes census of consultant physicians and higher specialty trainees 2018'](#), Royal College of Physicians (October 2019)

¹⁶ The Royal College of Anaesthetists census indicates there were 680 funded consultant posts that were vacant. However, clinical directors reported that they needed another 374 consultants to meet demand. If there's a similar error in all other specialities, then the 8,278 FTE gap is likely to be more like 15,000 FTE.

¹⁷ ['Scotland's consultant vacancies are double official tally, BMA finds'](#), British Medical Journal (December 2018)

¹⁸ December 2019 saw the percentage of patients being admitted, transferred or discharged from A&E within four hours, reaching an all-time low at 79.8%. The number of patients waiting over 12 hours in corridor trolley beds also skyrocketed to over 2,800 in January 2020. In February 2020, the proportion of patients on the waiting list treated within 18 weeks of referral was at its lowest level since September 2008 at 83.2%, and over winter the waiting list size fluctuated between 4.42 and 4.45 million. January 2020's average treatment wait time of 8.4 weeks (almost 2 months) was the longest monthly wait time on record since April 2008.

Timescales and Solutions

As set out above, the consultant workforce needs to grow to address patient need. Moreover, it is imperative that the NHS retains its existing consultants.

Now is a critical time to understand the factors that motivate the present workforce to leave or stay and respond accordingly. Health service leaders, including employers, must engage with consultants proactively to help understand why they choose to leave the NHS. Other bodies, including the BMA and medical royal colleges, also hold valuable data that may help inform employers as they develop retention strategies.

This section sets out the different solutions needed and divides them into short, medium and long-term solutions.

Short-term solutions

During the first peak of the COVID-19 pandemic, 28,000 doctors made themselves available in response to COVID-19

Short-term solutions should focus on ensuring NHS services are able to respond to patient demand in the face of subsequent waves of COVID-19 as best as possible. All available and willing consultants should be recruited and deployed to assist that effort in whatever way they can contribute; there is no shortage of work for them to undertake.

Make the most effective use of retired doctors who would like to return to work

During the first peak of the COVID-19 pandemic, 28,000 doctors made themselves available to return to work, but only a small proportion of them were eventually deployed.¹⁹ Many of the doctors that applied reported encountering difficulties when trying to return. While many staff were restored to the temporary medical register, it has not been possible to provide all of them with productive work:²⁰ this is a serious shortcoming. Ways must be found in order to harness the skills of a willing and available workforce at a time when they are so obviously needed.

Employers must also provide an effective return to work offer to both attract consultants and harness the value they bring. Such offers should also include supervision plans to ensure a smooth return to clinical activity, and detailed consideration must be given to whether an individual consultant could work on site or remotely. Trusts also need adequate funding to ensure returning doctors are supported.

While many consultants returning to the workforce will be in an older age group, and may consequently need to be shielded themselves, this should not preclude the possibility of them undertaking useful productive work on behalf of the NHS and its patients. Much of this may well be remote working or using technology to support clinical and other work. Clearly, secondary care NHS IT facilities need to be adequate in all locations in order to support such work. Further consideration should be given to developing additional proposals for remote working to allow this group of staff to be used to their full potential.

Appendix 1 provides examples of work doctors can undertake remotely.

¹⁹ [Doctors returning to the workforce: guidance for hospitals](#), Royal College of Physicians (July 2020)

²⁰ [Doctors returning to the workforce: guidance for hospitals](#), Royal College of Physicians (July 2020)

NHS Digital reports that 39,911 FTE consultant days were lost due to sickness absence related to COVID-19 between March and May

Prioritise health and wellbeing

Health systems should use all measures to protect their workforce from the impacts of infection. NHS Digital reports that 39,911 FTE consultant days were lost due to sickness absence related to COVID-19 between March and May 2020.²¹ The lack of provision of PPE during the first wave of COVID-19 put many doctors – and their patients – at risk of serious illness or even death.

A significant proportion of doctors who contracted COVID-19, having recovered, are also now experiencing long-term sequelae of infection, including fatigue, concentration difficulties and physical weakness, delaying their return to work.²²

Evidence also indicates that doctors from BAME backgrounds are more susceptible to severe and life-threatening COVID-19 infections.²³ Great care needs to be taken to ensure that this vital group of staff are fully reassured that measures have been put in place to protect their health, including avoiding unreasonable risk. BAME doctors are more likely to be pressured to work with inadequate PPE, still be experiencing ongoing health issues following COVID-19 infection and are likely to have taken sick leave.²⁴ In response to the pandemic, the Royal College of Psychiatrists developed guidance on risk mitigation for BAME staff.²⁵ Alongside immediate action to protect the health of BAME staff, longer term and broader action is needed to address the deeper causes of inequality within the healthcare system.

Helpfully, trusts are being urged to deploy risk assessments for vulnerable staff, including those from BAME backgrounds, with organisations being encouraged to prioritise the safety and wellbeing of the workforce by rolling risk assessments out to *all* staff.²⁶ Such systems are essential not only to protect staff from infections acquired in the workplace but also to maintain confidence.

The mental health of doctors has been a particular focus for the BMA and medical royal colleges who have engaged with their members to understand the challenges they face at work.²⁷ This research highlights concerns about the long-term impacts of COVID-19 on staff mental health. There is potential for colleagues to experience anxiety, grief, depression, moral injury and even post-traumatic stress disorder as a result of their experiences. Our findings illustrate the variety of challenges that doctors experience and the diversity of responses that are needed to ensure that they are supported.²⁸ Supporting staff will be important in helping them avoid ill health and reducing time away from work.

The NHS People Plan 2020/21 sets a clear expectation for employers to focus on health and wellbeing, eg through the appointment of wellbeing guardians, providing access to psychological services and ensuring a healthier workplace. Early implementation of these measures is essential in order to retain staff confidence.

21 13,346 (March 2020), 19,922 (April 2020), and 6,643 (May 2020) – [NHS Sickness Absence Rates May 2020, Provisional Statistics](#), NHS Digital (September 2020)

22 [COVID-19: analysing the impact of coronavirus on doctors](#), BMA (September 2020)

23 [COVID-19: the risk to BAME doctors](#), BMA (September 2020)

24 [The mental health and wellbeing of the medical workforce – now and beyond COVID-19](#), BMA (May 2020)

25 [COVID-19: Guidance on risk mitigation for BAME staff in mental healthcare settings](#), Royal College of Psychiatrists (June 2020)

26 [People Plan 2020/21](#), English NHS (July 2020)

27 For example, the BMA runs a regular tracker survey to measure staff wellbeing – [COVID-19: analysing the impact of coronavirus on doctors](#), BMA (September 2020)

28 [The mental health and wellbeing of the medical workforce – now and beyond COVID-19](#), BMA (May 2020)

Box 1: Good practice examples of investing in staff wellbeing:

Invest in facilities

The BMA [Fatigue and Facilities charter](#) outlines simple steps that can be taken by trusts and health boards to improve facilities and reduce fatigue.

Offer opportunities to relax:

“My hospital has set up an all-professions chill-out space. A mess, I suppose, not that I’ve ever worked in a hospital that has one. It is so nice to have a centrally located space where staff can relax together.” RCPCH member, May 2020.²⁹

Offer return to work support:

The RCOG Return to Work Toolkit is a good example of measures designed to support doctors back into the workplace, after a period of absence, as a way to retain staff and reduce attrition.³⁰

Medium-term solutions

Medium-term solutions encourage existing staff to remain in the workforce rather than retire, decrease their working hours or leave their current employer to work somewhere else.

Retention of staff is beneficial to employers because existing staff know the organisation and work effectively within it. High staff turnover leads to decreased efficiency and productivity, which, in turn, affects patient care.³¹ It is both more costly and time consuming to recruit a new employee than it is to retain one. The recently released NHS People Plan helpfully recognises this.³² Staff retention should not solely focus on those nearing retirement, although those staff are a large and important group. Rather, efforts should be directed at consultants across the breadth of their careers: organisationally, all groups are of equal importance.

Retaining consultants in the workforce is largely dependent on organisations taking active steps – warm words alone do not suffice. Doctors who have taken ‘hard steps’ towards leaving the profession feel unable to cope with workload, find it difficult to provide sufficient patient care and experience high levels of burnout and dissatisfaction.³³ Addressing these issues requires commitment and practical steps by employers.

Appendix 2 sets out principles that should underpin retention policies.

a) Clarify and widen ‘retire and return’ arrangements

Many employers offer “retire and return” arrangements. This involves consultants retiring from their full or part-time roles and returning to work post-retirement, usually with a reduction in delivered clinical sessions. They are able to access pension payments and take up paid employment alongside that. Despite those arrangements being long-established, there is great variability in how they are interpreted and applied. Such a lack of visibility and clarity regarding the nature of the offer means that some employees do not seek out or access such an alternative. Their clinical skills and contribution to the provider’s output are lost as a result. It is vital that trusts have clear policies in place around ‘retire and return’ and that these are clearly communicated to consultants.

Appendix 2 includes further information on how employers should develop ‘retire and return’ policies and areas they need to clarify.

29 [Reimagining the future of paediatric care post-COVID-19](#), Royal College of Paediatrics and Child Health (June 2020)

30 [Return to Work Toolkit](#), Royal College of Obstetricians and Gynaecologists (2020)

31 [Reviewing the Benefits of Health Workforce Stability](#), National Centre for Biotechnical Information (December 2010)

32 [People Plan 2020/21](#), English NHS (July 2020)

33 [The state of medical education and practice in the UK](#), General Medical Council (December 2019)

b) Reform the pensions taxation system

The 2020 budget announced significant pension taxation reforms, which are a welcome step towards resolving the ongoing crisis. Nevertheless, a number of issues still exist that are forcing doctors to retire before they would otherwise choose. These must be addressed in the next budget.

As part of the 2020 reforms, both the threshold and adjusted income limits were raised by £90,000. This means that individuals with a 'threshold income' (net income before tax excluding pensions) of £200,000 in the 2020/21 tax year and an 'adjusted income' (net income plus pension accrual) below £240,000 will no longer be impacted by the tapered AA (annual allowance). The AA will begin to taper down for individuals who have an 'adjusted income' above £240,000 (down to a minimum of £4,000).

However, the standard annual allowance remained at £40,000. This means many doctors, with incomes far below the new threshold income, still face additional tax bills as a result of exceeding the standard annual allowance. The AA is unsuited for defined benefit pension schemes such as the one offered by the NHS. Even the most modest pay rises in pensionable pay can therefore result in a tax bill.

The budget also made no change to the LTA (lifetime allowance). Many doctors will still need to consider taking early retirement as a result of this. For those NHS staff consequently forced to leave the pension scheme, employer contributions must be recycled.

The sheer complexity of the NHS pension scheme also continues to be an issue for doctors; their financial and retirement planning is challenging. It is a contributing factor towards early retirement, as members are taking a risk adverse approach and leaving the pension scheme to avoid punitive taxation charges.

Furthermore, those doctors who are members of the 1995 legacy scheme and the 2015 reformed scheme are unable to draw their 1995 pension whilst continuing to pay contributions into the 2015 scheme. This puts pressure on members in the 1995 scheme to retire at the age of 60 rather than continuing to work longer.

We also believe that the strict abatement rules that then limit the amount of work doctors can do when they return to NHS employment after retirement should be reviewed.

Part-time consultants must not pay pension contributions at the FTE rate either.

Many consultants have received huge additional taxation charges as a result of AA and LTA breaches. There are sound reasons, however, for offering full employer contributions to employees who are forced to either leave the NHS pension scheme or face very large additional tax bills. A large proportion of the likely recipients of additional charges are older consultants. These older consultants are also at risk of breaching the LTA. For many, they may be able to choose between staying in employment or retirement. Even where they opt to retire and return to work, it is likely that the employer would have been able to access a greater amount of working time from that consultant if they could have been persuaded not to retire.

When consultants are forced to leave the pension scheme and continue to work, they are effectively doing the same work when compared to a colleague who has been able to remain in the scheme but for 20.6% less reward, ie a reduction in the Total Reward Package equivalent to the value of the employer pension contribution. There is currently no clarity as to whether this breaches Equal Pay legislation.

Paying the employer contributions to the employee would help to retain valuable consultants, as full or part-time employees, by removing the financial disbenefit otherwise incurred when leaving the pension scheme and by avoiding the financial incentive to retire and return. Scrapping or increasing the LTA would also remove the huge incentive for senior consultants to retire earlier than intended.

Box 2: Early retirement

A 2019 survey by the Royal College of Physicians³⁴ found that:

- **Nearly half** of the 2,800 doctors surveyed decided to **retire at a younger age than previously planned** – with eight in ten of those citing pension concerns as one of the reasons for this decision.
- **62% of senior clinicians said they avoid extra paid work** (such as covering for colleagues), and a quarter have reduced the number of programmed activities they work.
- **One in five report having stepped down from a leadership role** or other role with extra remuneration.

Similarly, in its annual census of the registered consultant workforce, the Faculty of Intensive Care Medicine³⁵ found that 20% of consultants in ICM were planning to leave critical care ahead of retirement.

A 2019 BMA survey found that more than 6 in every 10 (62%) doctors had retired and returned, or planned to return, with reduced clinical commitments due to actual or potential annual allowance taxation charges.³⁶

c) Allow consultants to work flexibly, including remotely, where possible

Enabling doctors to work flexibly will help improve work-life balance and staff retention. Full-time consultant staff have the right to request to work part-time but there is no contractual right. At various times of life, all doctors may have difficulty balancing working lives alongside other responsibilities. This is disproportionately the case for women who continue to take on more childcare responsibilities than men. At such times, it may be more practical for consultant staff to work part-time rather than withdraw from the workforce altogether. Junior doctors have rightly been given the entitlement to work part-time; this entitlement should now be extended to the consultant workforce too.

We welcome the commitment in the NHS People Plan to ensure employers are open to all clinical and non-clinical permanent roles becoming flexible. Employers should consider implementing the RCP toolkit on working flexibly to help them make this change.³⁷

We also welcome the commitment to ensure that staff who are mid-career or approaching retirement have a career conversation with their employer to discuss any adjustments.

Mirroring changes that have been taking place in primary care throughout 2020, it is vital that employers ensure staff have access to the necessary IT hardware, software and training to carry out their duties remotely. Although secondary care is, in some respects, more restricted to face-to-face consultations, remote consulting has the potential to open up opportunities for new innovative ways of working, eg by replacing some outpatient visits that currently require both patient and clinicians to travel.

At the moment, however, secondary care staff are reporting instances of being unable to deliver productive clinical work from home as a consequence of inadequate IT equipment.

34 ['Pension tax driving half of doctors to retire early'](#), Royal College of Physicians (October 2019)

35 [Census](#), Faculty of Intensive Care Medicine

36 BMA survey (June 2019)

37 [Working flexibly: A toolkit](#), Royal College of Physicians (2020)

The ability to conduct such appointments remotely could reduce footfall in outpatient departments, increase the availability of appointments for patients and enable clinicians to work in a way that suits them best. Those with disabilities or long-term conditions may also need specific or additional provision.

The technology to work remotely and effectively is well within our reach but requires dedicated funding from both employers and national bodies to be fully realised.

Employers should also ensure that staff have the right office equipment in order to do their role from home. Those with disabilities may need extra equipment.

Box 3: Covid-19 has accelerated innovation in flexible working

A recent report by the RCPCH highlights how Covid-19 has forced services to innovate rapidly and introduce new forms of working, including home working and remote consultations.

“In my department, having been told tele clinics could never happen, people could never work from home, and department teaching and meetings couldn’t be done remotely, we are now doing all those things – almost overnight.”

RCPCH member, May 2020

One of the benefits of this necessary reconfiguration is the opportunity for increased flexibility, which can support a better work-life balance, reduce travel time and increase wellbeing. Going forward post-COVID, employers should continue to build on the changes we have seen in this period by investing in at-home IT provision for staff and offering more opportunities for remote and flexible working. This will, in turn, support greater staff retention. As one RCPCH member says:

“I’d like to preserve the little things that make a difference to our day – like not having to worry about where to park your car, or whether there will be something available to eat if you are working late.”

RCPCH member, May 2020³⁸

d) Enable consultants to change parts of their role

Being a doctor is both physically and mentally demanding. An individual’s age can affect how well they manage fatigue, stress and cope with different working patterns. The BMA’s [fatigue and sleep deprivation report](#) found that older people typically have poorer quality sleep and are less likely to adapt to shift work, particularly night shift work, without adverse consequences.³⁹ As doctors age, they may be able to adapt less quickly and experience higher stress levels when covering unexpected situations, including those encountered during urgent and emergency/on-call work. Such work may generate stresses in those consultants – anxious that they may no longer be able to accomplish those duties with the same facility as they once did and that their colleagues still exhibit. Those stresses may encourage consultants to consider retirement, particularly if this is the only available route that would allow the stressors to be avoided. It seems more sensible to seek solutions that allow the consultant to escape from a stressor, while maintaining a similar time commitment for their employer. The RCP have recommended that, past the age of 60, and following discussion with the clinical lead, a consultant should only opt into on-call work if they wish to.⁴⁰ It is vital that this is not perceived as a weakness. Line managers should understand the normal effects of aging.

38 [Reimagining the future of paediatric care post-COVID-19 – a reflective report of rapid learning](#), Royal College of Paediatrics and Child Health (June 2020)

39 [Fatigue and sleep deprivation](#), BMA (September 2020)

40 [Later careers: Stemming the drain of expertise and skills from the profession](#), Royal College of Physicians (April 2018)



2020 | **36%**
of consultants are women



2009 | **30%**
of consultants are women



50%
of medical students
are women



Older staff can still contribute to out of hours work within their departments, even where this work is no longer on-call work. For example, rapid access clinics provide a valuable contribution to urgent care, while also providing good teaching and clinical mentoring opportunities, suitable for senior consultants wishing to contribute but not via out of hours on call. Such a quid-pro-quo may help reassure younger colleagues that older consultants continue to support the efforts of their departments, particularly where this is in expectation that younger consultants will be offered similar support later in their working lives.⁴¹

e) Offer sabbatical Leave

Sabbatical leave should be offered as an incentive for established consultants across all stages of their careers. Employees value sabbaticals as a chance to take time out from a stressful work environment, an opportunity to acquire new skills, to study the operation of other healthcare systems or organisations or to acquire new knowledge. They have been difficult to access within the NHS for many reasons, including cost and potential loss of service provision. Organisations offering sabbatical leave, particularly where such offers are facilitated by active assistance in setting up the sabbatical, may more easily retain staff who would otherwise have considered leaving. Those returning are also likely to come back refreshed, with new ideas, perspectives and skills.

⁴¹ ['Academic factors in medical recruitment: evidence to support improvements in medical recruitment and retention by improving the academic content in medical posts On behalf of Medical Academic Staff Committee of the British Medical Association'](#), Research Gate (June 2019)

The BMA estimates that a consultant's average take-home pay in 2019/20 represents a 31.2% real-decline in value from 2008/09 to 2019/20, taking into account the RPI measure of inflation

f) Support staff going through menopause

The proportion of NHS doctors who are women has grown every year since 2009 and this trend is expected to continue. Nearly 4 in every 10 (36%) of consultants were women in 2018 compared with only 3 in every 10 (30%) in 2009.⁴² Every specialty group has seen an increase in the proportion of women; in some specialities, eg psychiatry, there are now more women than men. Women also make up more than half of all medical students, meaning the proportion of women in the workforce is likely to grow going forward.⁴³

The female workforce may face additional challenges around their wellbeing, which employers need to address. A BMA survey of doctors found that over 90% of respondents reported that menopause symptoms impacted their working lives and 38% said these changes were significant.⁴⁴ Over 65% said that the menopause impacts both their physical and mental health. Worryingly, almost half (48%) of respondents said they had not sought support and would not feel comfortable discussing their menopausal symptoms with their managers. This failure to support doctors is leading to doctors stepping down from senior positions or leaving medicine earlier than intended.

Focus is needed on effective organisational interventions to support employees going through the menopause. Such measures might include allowing doctors experiencing these symptoms to work flexibly and placing an equal focus on supporting employees with the mental, as well as the physical, symptoms of menopause. Line managers and staff undergoing menopause should seek advice from occupational health teams as necessary.

Attention should also be given to developing cultures where those experiencing symptoms can speak openly and access the support they need. Employers should raise awareness about menopause and provide training for line managers. Ways should also be explored to bring staff together in an informal setting to share their thoughts, eg through a "Menopause Cafe".⁴⁵

g) Address the real terms pay erosion

Over the past 10 years, pay increases for consultant staff have either been subject to a public sector pay freeze or any offer has been sub-inflationary. Consequently, consultant pay in England has declined in real terms over time. The BMA estimates that a consultant's average take-home pay in 2019/20 represents a 31.2% real-terms decline in value from 2008/09, measuring inflation with the RPI (retail prices index). When taken together with multiple other financial penalties, such as AA and LTA taxation charges on pension growth, increased pension contributions and the recent reduction in clinical excellence award spending, the stark nature of the reduction in consultants' incomes becomes all too apparent. Pay cuts have had a damaging effect on consultant morale, spilling over into recruitment and retention.

h) Develop a supportive and inclusive workplace culture

Creating a supportive and inclusive workplace represents a key aspect of improving staff retention. Many doctors feel that they are working in a culture of blame that discourages learning and reflection.⁴⁶ A change is needed to replace a culture of blame with a culture of learning. There should also be an emphasis on making the process around job planning and appraisal as friendly as possible to ensure staff feel valued.

The medical profession and wider NHS workforce are increasingly diverse, but the experiences of staff and opportunities for development are not equal. Environments that are diverse and inclusive have greater professional satisfaction among staff and better outcomes for patients⁴⁷.

42 ['Narrowing of NHS gender divide but men still the majority in senior roles'](#), NHS Digital (March 2018)

43 ['The state of medical education and practice in the UK'](#), General Medical Council (December 2019)

44 ['Challenging the culture on menopause for working doctors'](#), BMA (2020)

45 ['Menopause at work'](#), NHS Staff Council (March 2020)

46 ['Caring, supportive, collaborative? Doctors' views on working in the NHS'](#), BMA (September 2018)

47 ['Diversity in the NHS is everyone's business'](#), NHS England (April 2018)

Unfortunately, bullying and harassment continues to be an issue in healthcare, particularly for BAME staff.⁴⁸ There are significant costs for organisations resulting from bullying and harassment; these mainly arise from higher staff turnover and increased sickness absence.⁴⁹ Positive action to tackle discrimination, harassment and victimisation, and the effective implementation of appropriate policies, must be taken by all employers. We welcome the emphasis in the NHS People Plan to tackle this issue. The BMA has also produced guidance for employers to improve equality and diversity in the workplace.⁵⁰ Scrupulous care should be taken to both ensure and, importantly, demonstrate that all staff policies are free from bias of any kind and will properly protect all staff groups. This is especially important where, as with COVID-19, there are real threats to life and health for staff.

Up to now, workplaces have paid insufficient regard to the realities of living and working with a disability or health condition. This has, in some instances, made it difficult for those doctors to work as effectively as they could.⁵¹ This is unwise, as it may lessen the ability of those staff to deliver their best. Employers could improve access to workplace adjustments, strengthen OH support (Occupational Health), enable staff to self-refer to OH teams and raise awareness within the NHS of the essential need to support workers with hidden/invisible and fluctuating disabilities and long-term health conditions. Line managers and supervisors should also have training and access to advice so they can handle conversations about disability sensitively, constructively and appropriately.

If unable to work as a result of ill health in their current or any other similar alternative employment role, the NHS pensions scheme does currently give members the ability to retire early and take their pension benefits without actuarial reduction and with enhancement. This is known as a tier 2 award. However, if the member subsequently decides to restart work, they are limited in the amount of money they can earn. If their earnings exceed the LEL (lower earnings limit) for National Insurance contributions, which is currently £120 per week for 2020/21 (this equates to £6,240 per annum), they will lose this benefit. This does not take account of fluctuating illness/disability and therefore needs to be reformed so members are not penalised for returning to work when they feel able to do so.

i) Close the gender pay gap

A primary cause of the gender pay gap in medicine is the gender imbalance across the highest paid positions, grades and specialties. Greater numbers of female consultants should be reflected by a similar increase in women in higher paid roles. Career pathways and workplace environments must be designed to encourage retention of female consultants, in addition to addressing issues that may encourage female staff to take on positions in lower-paid roles.

Female staff still take on a greater proportion of caring responsibilities than their male counterparts. That may be difficult to accommodate within traditional consultant working patterns and must be addressed. Flexibility regarding working patterns can be a key component in maximising participation in the workplace and addressing the career barriers that develop for women when they have children. Steps should be taken to normalise men taking an equal role in caring responsibilities; this should include consultants getting access to enhanced shared parental leave.

We are waiting for the publication of the Department of Health and Social Care's Independent Review into the Gender Pay Gap in Medicine. It is expected that the review recommendations will include measures to:

- address the short and long-term career and pay penalties of less than full time doctors and doctors with caring responsibilities

48 [NHS Staff Survey Results](#), England NHS (2019)

49 [The price of fear: Estimating the financial cost of bullying and harassment to the NHS in England](#), Taylor & Francis Online (October 2018)

50 [Are you a good employer?](#), BMA (September 2020)

51 [Disability in the medical profession](#), BMA (September 2020)

- review pay structures and additional payments, ensuring they are fair and transparent, and
- ensure senior jobs are accessible to improve retention and greatly increase promotions amongst women in the medical profession.

j) **Provide opportunities for leadership, training, development and research**

Consultants, like all staff, value opportunities to innovate and acquire new skills and abilities. Expanding the range of clinical services that an individual, a department or an organisation can offer benefits both the individual and the provider, particularly if tailored towards services that have not formerly been offered before. The available training and development should be widely known, and there should be an expectation for staff to make use of such offers. Staff should also be supported to undertake leadership training courses, eg those offered by the BMA and medical royal colleges, and university diplomas and degrees, as well as certificates from or membership of organisations.

Many consultants would also welcome the opportunity to renew or develop their research interests.⁵² Such activity rewards the individual conducting the research, improves patient outcomes, rewards the department and the employer through enhanced status – making it more attractive as a recruiter – and subscribes to the NHS’s stated direction of travel. Clinical research is critical for understanding, for example, disease trends and risk factors, and outcomes of public health interventions. Consultant clinicians play a vital role in this regard which has been highlighted through COVID-19 where the involvement of clinicians has been crucial to the UK’s public health response.

Barriers to undertaking research include a lack of time and workplace culture. Organisations are frequently reluctant to offer time not devoted to clinical throughput, yet such a policy worsens rather than improves the likelihood of consultant staff retention. We also know from the Keogh Review that having a research-active workforce helps to ensure high standards of clinical care.⁵³

There has been an erosion of SPA (supporting professional activities) time overall, which needs to be addressed. SPAs are defined in the contract as activities that underpin direct clinical care. These may include participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities. Sufficient SPAs, therefore, need to be included in job plans for the benefit of the employer and employee to ensure that the work of these doctors is underpinned by effective quality control and patient safety standards. Employers should explore ways to allow clinicians more time to participate in research, do more to publicise research focused mentoring schemes and provide resource and funding to promote and celebrate research activity.⁵⁴

A recent estimate by the DDRB places the consultant undersupply rate between 6.8 – 7.7% – or 3,400 – 3,756 FTE doctors

Long Term Solutions

Over the next 20 years the UK population aged over 65 is expected to grow significantly, alongside a general growth in population numbers. An appropriately sized consultant workforce is both essential to look after this growing and ageing population and unlikely to be delivered by current workforce policy as it applies to consultants. It can take up to 15 years to train a doctor to consultant level.

Ensure an appropriate future supply of consultants

From data supplied by Health Education England to the DDRB (doctors’ and dentists’ review body) in 2017, it was estimated then that 6.8 – 7.7% or 3,400 – 3,756 FTE more consultants were needed.⁵⁵ As set out earlier in this paper, the picture has worsened since then. Despite the recent

52 [Research for all: Developing, delivering and driving better research](#), Royal College of Physicians (August 2020)

53 [Review into the quality of care and treatment provided by 14 hospital trusts in England](#), Professor Sir Bruce Keogh (July 2013)

54 [Research for all: Developing, delivering and driving better research](#), Royal College of Physicians (August 2020)

55 [Review Body on Doctors’ and Dentists’ Remuneration Forty-Seventh Report 2019](#), p. 78-80 (2019)

increase in numbers in some specialties,⁵⁶ overall growth within the consultant workforce has evidently not been keeping pace with demand. Royal college census data indicates current and anticipated consultant workforce deficits across a range of specialty areas.⁵⁷ It is vital that the Government and arms-length bodies urgently take action to ensure appropriate future supply.

Even more worryingly, ONS data suggests population growth of 9% over the next 25 years.⁵⁸ Further analysis reveals that this includes a sizeable increase in the proportion of those aged over 65 – the so-called ‘Baby Boomer’ generation of the 1960s. Healthcare consumption is at its greatest at the extremes of life; those under the age of one and over the age of 65. In terms of NHS workforce planning, it is therefore alarming that population projections indicate that the number of people aged 85 and over will double over the next 20 years, before numbers begin to return to a more even spread across all age groups in the mid to late-2040s. Prior to that, however, the proportion of over 65s is set to increase from approximately one in 10, at present, to one in three or four by the early 2040s. Given this population demographic increase comes at a stage of peak healthcare usage in these citizens’ lives, it is inconceivable that the present consultant complement will be adequate to service this need.

It is therefore vital that the Government and arms-length bodies take urgent action to guarantee safe levels of future consultant supply now and in the decades to come.

To sustainably grow the consultant workforce, medical school, FP and specialty trainee numbers must be increased.

Medical royal colleges and the BMA have called for additional medical school and FP places. In 2018, the Royal College of Physicians (RCP) estimated that medical schools places would need to double by 2023/24 in order to meet projected overall doctor supply requirements for the future.^{59,60} The Royal College of Psychiatrists (RCPsych) followed this up in 2019 with a similar call for the annual medical school intake to rise to 15,000 over the next 10 years.⁶¹ Given the confirmed medical student intake was 6,800 in 2019/20,⁶² an increase of around 7,500 places would be required take us to an annual cohort of around 14,000-15,000 medical students per year by the middle of this decade. It is difficult to estimate the full cost of increasing medical school places. However, based on the data available from the DHSC’s own estimates in 2017, this amounts to an expenditure of at least £3.45 billion per annum on medical school placements alone.⁶³

There is also the issue of recruitment and retention of clinical academics to train future generations of doctors, but the Medical Schools Council⁶⁴ reported a vacancy rate of 3.8% among senior clinical academics in 2019. A considerable proportion of the foundation knowledge and clinical skills education occurs in the university setting prior to clinical placements. The last 10 years, however, has seen a 27% reduction in the senior clinical academic workforce despite a 25% growth in medical student numbers.⁶⁵ Clearly, this expansion in medical students cannot occur, whilst also still maintaining the UK’s world-leading research status, without an expansion in the clinical academic sector.

56 [NHS Workforce Statistics May 2020](#), NHS Digital (August 2020)

57 [RCM Workforce Recommendations 2018](#), FCIM [In Depth Review of the UK’s Anaesthetic and Intensive Care Medicine Workforce 2015](#), RCoA’s [The UK’s Anaesthetic Workforce 2019](#), RCPsych’s [Workforce Strategy 2020-23](#), RCOG [O&G Workforce Report 2018](#), RCPCH [Workforce Briefing 2018](#), RCR [Clinical Radiology Workforce Census Report 2019](#), RCP [Focus on physicians: 2018–19 census](#)

58 [National population projections: 2018-based](#), Office for National Statistics (October 2019)

59 [Double or quits: calculating how many more medical students we need](#), Royal College of Physicians (2018)

60 [RCP response to ‘Facing the Facts, Shaping the Future: A draft health and care workforce strategy for England to 2027’](#), Royal College of Physicians (2018)

61 [Double the number of medical school places to stop mental health services imploding](#), Royal College of Psychiatrists (2019)

62 [Medical and dental intake 2018-19 and 19-20](#), Office for Students (January 2020)

63 [Expansion of Undergraduate Medical Education](#), Department of Health and Social Care, (March 2017) – the cost to put a UK/ EU national through medical school is around £230,000

64 [Clinical Academic Survey](#), Medical Schools Council (2019)

65 [Clinical Academics Survey](#), Medical Schools Council (2019)

Other medical royal colleges have noted that, in respect of their members, there are too few trainees within the system to fill all of the posts anticipated to be required. For example:

Royal College of Anaesthetists



The Royal College of Anaesthetists estimates that to keep up with patient demand whilst counter balancing annual retirement attrition, the annual anaesthetic consultant CCT (certificate of completion of training) output must reach **417 per year** by 2023-2027.⁶⁶

Royal College of Psychiatrists



The Royal College of Psychiatrists anticipates there will **only** be an additional **200 consultant psychiatrists** entering the workforce by 2023/24, which is far below the NHS Long Term Plan requirement of 1,040.⁶⁷

Royal College of Obstetricians and Gynaecologists



The Royal College of Obstetricians and Gynaecologists concurs with Health Education England's estimate in its latest workforce report;⁶⁸ that the demand for O&G consultants is expected to be between **2,336** and **2,490 FTE doctors** in 2021.⁶⁹

Royal College of Paediatrics and Child Health



The Royal College of Paediatrics and Child Health (RCPCH) estimates that **162 specialty training** places have gone unfilled between 2018 and 2020. The RCPCH estimates that the demand for paediatric consultants in the UK outstrips 2017 workforce levels by around **21%**. An increase of approximately 850 FTE consultants above the 2017 workforce is therefore required to meet demand.

Royal College of Emergency Medicine



The Royal College of Emergency Medicine⁷⁰ highlights that although the EM (emergency medicine) consultant workforce has grown over recent years (6-8% per year between 2012-2020), this has **not kept pace with the demand** and complexity of care required. In 2018, approximately 26% of advertised consultant posts remained unfilled. The NHS in England also spent **£2.94 billion** on locum and agency staff in 2016/17, **16%** of which (£470 million) was spent in EM.

Royal College of Pathologists



The Royal College of Pathologists estimates that a minimum of **288 trainees** will be needed to fill all current and predicted vacancies and retirements in England only over the next two years. The predicted number of haematology trainees expected to obtain a CCT in the whole of the UK is **only 234**.⁷¹ A 2018 histopathology workforce report confirmed that 'more than three-quarters of departments reported vacancies for consultants – 78 per cent'.⁷²

Royal College of Radiologists



The Royal College of Radiologists states that the current **shortfall of 1,876** radiologists (33%) is forecast to rise to 3,331 (43%) by 2024. Over the past year alone, volumes of computed tomography (CT) imaging examinations in England have increased by 10% and MRIs by 8%. This compares with **3% growth** in the clinical radiology workforce⁷³.

In addition, increased resources and staff/educators – including consultants and academics – in medical schools are also required to deliver the increased education and training workload; otherwise this will mean another additional pressure on the workforce.

There are also more and more doctors working Less Than Full Time, which makes it increasingly vital that workforce planning, based on accurate workforce data, is done properly.

66 [Workforce Data Pack 2018](#), p. 14, The Royal College of Anaesthetists (March 2018)

67 [Next steps for funding mental healthcare in England: A comprehensive settlement that invests in infrastructure, prevention, people and technology](#), Royal College of Psychiatrists (September 2020)

68 [O&G Workforce Report 2018](#), Royal College of Obstetricians and Gynaecologists (2019)

69 [Maternity Workforce Strategy – Transforming the Maternity Workforce](#), Health Education England (March 2019)

70 [Workforce Recommendations 2018](#), Royal College of Emergency Medicine (February 2019)

71 [The haematology laboratory workforce: challenges and solutions – a meeting pathology demand briefing](#), Royal College of Pathologists (2020)

72 [Meeting pathology demand: Histopathology workforce census](#), Royal College of Pathologists (2018)

73 [Clinical radiology UK workforce census 2019 report](#), Royal College of Radiologist (April 2020)

Conclusion

The current consultant workforce is inadequately sized to deliver all of the patient care required now and into the foreseeable future. There are particular challenges for the NHS at present, given the COVID-19 outbreak and its impact on NHS capacity and waiting times. Those challenges have further exacerbated the pre-existing problems with undersupply of the consultant workforce. Unless there are swift changes to working methods and organisational culture, it is hard to be confident that the NHS will be able to resolve its current waiting time difficulties.

Without urgent policy intervention at Government level now, there will also be insufficient consultant staff available to the NHS in the future. This will have serious consequences for the quality of patient care. A wide range of medical specialties report significant workforce shortages at a time when population growth and demographic change is highly likely to place increasing demands on the healthcare system.

Action to implement short, medium and long-term solutions is needed *now* to increase consultant numbers and make earnest efforts to retain them. This is the only way we will meet the expected rising patient need for specialist care. Furthermore, given the long lead-time to produce fully trained consultants – longer than any other staff group in almost any other industry – we cannot afford for the expansion of the consultant workforce to be delayed any further.

Early decisions are needed to avoid a reduction in the quality of NHS care and worsening patient outcomes. Effective action must be taken now; to do nothing is an unacceptable alternative. Failing to take action would mean failing British citizens.

Appendix 1 – Productive work for staff not able to work in face-to-face roles

This appendix sets out a number of areas where staff not able to work in face-to-face roles can be deployed to meet overall demand on the NHS.

Teaching & training

- On-line teaching – trainees, nursing and other staff, staff in other institutions
- Writing webinars, slide presentations, ARCP (Annual Review of Competence Progression), VC teaching
- On-line appraisals and supporting revalidation
- Virtual procedural supervision

Service improvement

- Local/regional/national protocol development
 - How to make my departmental practices more online based
 - Guidance for patients with particular conditions
 - Referral guidance development
 - Guideline development
 - Working cooperatively with the IPS (see below)
 - Updating local guidelines and documents
 - Work with specialty colleges
 - Developing relationships with primary care
 - Formal management roles

Online working and its facilitation

- OP work online
 - New referrals – identify which conditions suitable for electronic review. What are inclusions/exclusions)
 - Follow Up – likely more suitable for non-face to face review as diagnosis is already made
 - Review results, dictate letters, order prescriptions, book further investigations and follow up
- Triage of eRS referrals – review referrals (identify which referrals should be seen as priority, within X weeks/months etc) and adjust clinic profiles to accommodate emergency referrals when necessary
- Online follow up of inpatient admissions – eg ITU patients (undertake reviews for other hospitals in local area or more widely), results review, VC liaison with allied health professionals, medication adjustments
- Review of waiting list across specialty (this has resulted in dramatically cut waiting list length with patients no longer wanting or needing some surgery)
- Pre-face-to-face review – ie an online review of a patient prior to face-to-face review
- Pre-admission assessment of elective surgery patients by teleclinic, enables faster assessment on day of surgery. Pre-operative assessment can cover large amounts of work of standard preop assessment. Major and intermediate surgical elective admissions could have a teleclinic review by surgeon and anaesthetist
- Virtual multidisciplinary team

Working with Primary care

- Advice line for GPs (local, wider area for specialised services)
- Rapid access to video clinic for GP from surgery so that the patient can have history taken by consultant with GP providing examination
- Referral advice line – ie provide advice to GPs about which cases/whether to refer a case or to manage in another way
- Both GP advice line and GP referral advice could be either by phone or by virtual clinic
- Outpatient clinics for primary care – ie review cases at discretion of GP
- Shared care development – pathways for sharing ongoing care between primary and secondary care

Other Secondary Care Working

- Virtual ward rounds
- Virtual ward round in other healthcare settings eg care home, secure accommodation etc.
- In-hospital advice line for particular service (calls directed to a consultant away from hospital who is able to give advice. Liaises with on-site colleague who fields cases needing hands-on care. Can be used to support existing telephone helplines (eg IBD helpline) and specialist nurses
- Radiology relies heavily on outsourced reporting. Greater access to home reporting implemented during COVID-19 should be extended to reduce outsourcing costs, support retention and reduce footfall in the department. Distant review (could be for hospital or primary care requests where investigation has been done but awaits report) of:
 - Specialist blood work and histology
 - Cardiological investigation
 - Other investigations such as pulmonary function tests
 - Imaging
- Shared care development – pathways for sharing ongoing care between primary and secondary care
- Pre-operative assessment – aim for all forthcoming admissions to improve on the day throughput (see above)
- Assessment of patients for other trusts

Administration Including Management of Risk

- Audit
- Discharge summaries
- Medication reviews
- CQC preparation
- Safety review inc. review of Datix, root cause analysis etc.
- Future departmental workload/capacity planning
- Future recruitment
- Continued virtual engagement with external duties such as those for specialty and royal colleges, BMA, GMC, CQC etc.

Appendix 2 – Policy Principles for Trust’s Retention Policy Including Retire and Return Scheme

Who might be considered a “target group” for retention?

All consultant staff will need to be actively supported to stay in NHS employment if providers are to retain their existing staff. Employers will need to adopt a range of approaches each designed to retain different groups of consultant medical staff depending on where they are in their careers. In the later stages of a career alternatives should be offered to encourage consultants to stay in the workforce and to create circumstances where they will want to maximise their participation. Earlier in a career some of those considerations will still apply alongside a range of other policy offers.

General Principles

- 1. Be clear – tell people you need & want to retain them.** It is important that staff feel valued and supported in their role. No-one will consider staying on with an employer if they do not feel valued or realise that the employer would like them to remain.
- 2. Be flexible and accommodating** – a range of potential offers is likely to have a greater success rate than a single response. Individual flexibility will help too.
- 3. Don’t penalise** – positive persuasion is needed rather than trying to impose barriers to leaving.
- 4. Tailor your offer and be inclusive** – different employees or groups of employees may prefer different things. It is important that employers make a retention offer that is seen as desirable, useful, and appropriate by the group that is targeted for retention.
- 5. Ensure you target everyone and at all stages of their career** – without a visible, consistent and clearly expressed policy, employers may lose staff to others who have such a policy in place. Current retention efforts are largely directed at retaining staff who would otherwise reduce work commitments as a prelude to retirement. Colleagues at earlier stages in their careers must also be incentivised to remain.
- 6. Be timely** – once an employee begins to consider or to make preparations to leave then the opportunity to retain them may have already been lost. Try to prevent that mental first step from being taken.
- 7. Be clear on what local support is available** – ensure staff know where they can access support if their mental or physical health deteriorates.
- 8. Don’t rely upon staff to work for free** – consultants often work outside of their regular work hours which damages morale.

Retire and Return

Trusts should have clear and transparent policies regarding retire and return for consultants. There are several areas where such clarity is needed:

- **To whom does this apply?** Retire and return should be applied to all consultants, across all specialty groups. Rather than relying on departmental or even individual offers, trusts should agree a local policy that applies consistently across the trust and is clearly flagged to all employees. Otherwise there is a risk that the process may be unfairly applied or the approach is haphazard.
- **What is the length of the contract?** Many consultants are deterred from seeking retire and return arrangements because they have only been offered a single year contract of employment. Such brief and possibly precarious contracts of employment are unattractive and discouraging, and trusts should offer a longer contract period for those that desire them.
- **What point on the salary scale is offered?** Most consultants retire at the top of the consultant salary scale; however, many employers will only offer retire and return arrangements that remunerate consultants at the mid-point or even entry point of the consultant salary scale. This seems inappropriate: employers gain an employee of immense experience – both of the clinical specialty and the local healthcare system – that allows that consultant to function at maximal productivity from the point of engagement. There seems little justification to offer a lower level of remuneration. It is also a source of frustration that consultants cannot keep the value of their existing CEAs as it means they have a lower salary than before. Obviously, if offered, they should be external to any CEA pot for new CEAs.

BMA

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

© British Medical Association
20200396

BMA 2020