Royal College of Physicians | Royal College of Physicians of Edinburgh | Royal College of Physicians and Surgeons of Glasgow

The doctors behind the debate

Supporting the medical workforce to lead change in Northern Ireland

October 2023

Caring for patients during a time of uncertainty

It is difficult to remember a more uncertain time for the health and social care system in Northern Ireland. As the combined impact of Brexit and the COVID-19 pandemic gives way to a cost-of-living crisis across the UK, compounded closer to home by a difficult budget settlement and political flux at Stormont, the findings from the 2022 census of consultant physicians in Northern Ireland paint a grim picture of frequent rota gaps, unfilled consultant vacancies and excessive workloads.

The three UK royal colleges of physicians – the Royal College of Physicians (RCP), the Royal College of Physicians of Edinburgh (RCPE) and the Royal College of Physicians and Surgeons of Glasgow (RCPSG) – have come together once again to highlight our shared concerns and to issue a call for action to our politicians and senior decision makers. As we go to print, it is not clear whether the Executive will return this year, but for the sake of everyone in Northern Ireland – especially those waiting for diagnosis or treatment – we need our elected representatives to show leadership and support clinicians to drive long-term change.

However, all is not lost. It is reassuring to report that a large majority – around 80% – of consultant physicians in Northern Ireland feel valued – not only by patients, but by their colleagues too. Most tell us that they would recommend their workplace to other consultants, trainees and SAS (specialty and associate specialist) doctors, as well as friends and relatives if they became patients.

We can work with this. Our fellows and members remain passionate about providing excellent patient care and are committed to a high-quality health and social care service. Workforce shortages are not insurmountable: in this new joint briefing, we have set out how we think that health and social care trusts in Northern Ireland could improve staff retention and wellbeing, helping the medical workforce to thrive, care, learn and feel valued.

Doctors are ready to lead. As royal colleges, we will continue to support our fellows and members to share good practice, teach the next generation of doctors and provide high-quality patient care. We will play our part – will our politicians play theirs?

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The medical workforce in Northern Ireland at a glance

64% of consultant physicians in Northern Ireland report vacant consultant posts

71% of consultant physicians report daily or weekly trainee rota gaps

74% feel that rota gaps are having a negative impact on patient care

82% of consultant physicians routinely work above their contracted hours

59% of consultant physicians working full time would like to reduce their hours

Only **25%** of consultants feel in control of their workload

57% of consultants say that they have an excessive workload almost always or most of the time

35% of consultant physicians say that they work excessive hours

It's not all bad …

84% of consultant physicians in Northern Ireland say that they feel valued by patients

83% said that they would recommend their workplace to friends and relatives as patients

87% have job satisfaction working in their specialty area of medicine

What is the UK census of consultant physicians?

Every year, the Medical Workforce Unit of the RCP conducts a consultant physician census on behalf of the RCP, the RCPE and the RCPSG. The data that we collect provide us with insight into the state of the physician workforce across the four nations of the UK.

- **Consultant posts are not being filled:** 64% of consultant physicians in Northern Ireland reported vacant consultant posts, with an average of 2.7 vacant posts per department.

- **Consultants are frequently seeing gaps in the trainee rota:** 71% of consultant physicians were aware of gaps on trainee rotas, either daily or weekly.

- **Rota gaps are impacting patient care:** 74% felt that rota gaps had impacted patient care, with the most-cited impacts being increased length of stay (29%), reduced access to outpatient care (22%) and inpatient care out of hours (22%).

- **Consultants continue to work beyond their job plans:** 93% of consultant physicians have a current job plan. However, 82% say that they routinely work more than their job plan – most commonly to do administrative work related to patient care (75%) or to provide direct patient care (64%).

- **Flexible working is likely to grow:** 15% of consultants are working less than full time, with 59% saying that they'd like to reduce their hours, underlining the importance of workforce planning in full-time equivalents (FTE) rather than headcount.

- **Working practices continue to change and evolve:** 84% of consultants now carry out some of their work remotely – most commonly administration and meetings related to patient care, followed by CPD, education and audit / quality improvement. Only 17% hold outpatient clinics remotely. Of those not currently undertaking remote work, 59% said that they wanted to undertake remote work in the future.

- **Consultants feel that their workload is unmanageable:** Only 25% feel in control of their workload. From those reporting three or more high scores on the Maslach burnout inventory, 19% are at risk of burnout. 57% of consultants said that they had an excessive workload almost always or most of the time, and 35% said that they worked excessive hours. 42% did not take their full leave entitlement in 2022 – mainly because they were too busy or unable to organise cover for their clinical service. 50% took unexpected time off for illness, with 69% of these taking time off due to COVID-19.

- **However, most consultants still feel valued:** 84% say that they feel valued by patients, 79% by their medical colleagues and 77% by their non-medical colleagues.

- **Leadership roles are key to job satisfaction:** 44% of consultants said that they had an additional leadership role (either clinical or educational) and 61% of these said that they enjoyed their job more because of it. Most felt supported by both management and specialty colleagues to carry out a leadership role, although only 44% had protected time in their job plan for it and only 33% felt that it was adequately recognised in their appraisal.

- **Consultant physicians in Northern Ireland would still recommend their workplace:** 73% said that they would recommend their workplace to other consultants, 79% said that they would recommend their workplace to trainees, and 82% said that they would recommend it to SAS doctors. 83% said that they would recommend their workplace to their friends and relatives if they were patients.

- **Despite the challenges, most consultant physicians report job satisfaction:** 87% said that they found their specialty work satisfying almost always or often. 21% said that they found their work in general internal medicine (GIM) satisfying almost always or often. This difference in job satisfaction between specialty work and GIM is consistent with previous years.

What else did we learn?

- **83% of consultant physicians are employed by HSCNI** (Health and Social Care Northern Ireland). Almost all the rest are employed on either an academic contract with a higher education institution or a joint contract with their HSCNI trust and another organisation.

- **96% of consultant physicians in Northern Ireland are UK citizens.** 56% describe their ethnicity as White English/Welsh/Scottish/Northern Irish/British, 29% as White Irish, 8% as Asian/Asian British, 4% as White other, 1% as Black/Black British and 1% as other. 14% of consultant physicians graduated overseas and 71% gained their primary medical qualification – usually their medical degree – in Northern Ireland.

- **Women make up 40% of the consultant physician workforce in Northern Ireland and men 60%.** 38% of consultant physicians in Northern Ireland are expected to reach their intended retirement age in the next decade, which is likely to remove more than 200 doctors from the medical workforce.

- **The biggest medical specialties in Northern Ireland are geriatric medicine, respiratory medicine and gastroenterology/hepatology, followed by cardiology, diabetes/endocrinology and renal medicine.** 58% of consultants are qualified to work in GIM or acute medicine, although only 43% have a work commitment to undertake GIM or acute medicine.

Our call to action

The three UK royal college of physicians have come together on behalf of our fellows and members to call on the next Northern Ireland Executive to work with HSCNI, local councils, the third sector and other partner organisations to:

- Deliver **existing strategies and action plans** in full. Approve a multi-year budget for health and social care. Publish an update on the progress made to implement the Bengoa recommendations. Refresh the national vision for the future of health and care in Northern Ireland in collaboration with the HSCNI workforce, developing a collaborative, regional approach to service delivery and multiprofessional workforce models where appropriate.

- Strengthen **workforce data** collection and analysis, broken down by profession, specialty and career stage, including newly qualified staff. Ensure that data are reported regularly in an accessible and transparent format. Develop workforce plans that consider current and future demand across specialties and sites, recognise changing working practices (including flexible working), and take into account the growing number of SAS doctors, locally employed (LE) doctors and medical associate professionals in the multidisciplinary team. Develop, co-produce and publish a social care workforce plan.

'The absence of decision-making by politicians impacts now and into the future, through deteriorating public services. The biggest effects are suffered by the most disadvantaged individuals and communities. Moreover, there continues to be a lack of action to deal with Northern Ireland's longer term policy challenges, many of which have been neglected for years.'

– Governing without government: the consequences, Pivotal

- Reaffirm an overarching commitment to the **prevention of ill health**. Develop a clear cross-government delivery plan for tackling health inequalities to reduce demand on the health and care system. Ensure that all health promotion initiatives are accompanied by a funded workforce plan. Recognise and fund rehabilitation, recovery and self-management of health conditions as essential healthcare provision.

For workforce wellbeing

- Prioritise the **retention** of staff. Support flexible working and ring-fence protected time for non-clinical work, especially education and training. Introduce job planning for all professions that want it. Recognise the contribution and better support the career development of SAS and LE doctors, as well as those of medical associate professionals within the multidisciplinary team. Demonstrate compassionate leadership. Encourage people to speak out about bullying and harassment and take a zero-tolerance approach to discrimination. Enable and support remote working as appropriate. Ensure that staff have access to appropriate rest breaks and enhanced rest facilities, along with healthy, high-quality hot food 24/7. Strengthen the provision of occupational health, wellbeing and mental health support. Invest in IT, facilities and estates to improve the working environment. Widen access to bursaries and apprenticeships. Consider hidden issues such as housing, childcare and transport. Work with the UK government to evaluate the impact of changes to pension tax rules. Support those who want to 'retire and return' and standardise these processes across the health and care system. Consider developing a register of retired emeritus consultants who can be brought in on a flexible contract to help reduce the planned care backlog.
- Renew efforts to **recruit** more staff. Expand training places where possible, while recognising that this is a long-term solution. Develop bursary proposals with the full involvement of all professions. Encourage teams to carry out local succession planning. Support and fund the expansion of new professional roles within the wider team while avoiding role substitution. Actively value and support HSCNI staff from overseas. Work with the UK government to review immigration rules for international staff.

For a highly skilled workforce

- Ensure that all staff have **protected time** for education, teaching, research and quality improvement across all professional groups and career stages. Make maximum use of the skills of all team members. Invest in modern teaching spaces and innovative technologies including robotics, diagnostics and artificial intelligence. Actively support and encourage people from a wider range of health and care professions to become clinical leaders. Offer structured mentoring and coaching programmes to more professions and career grades. Fund staff to undertake postgraduate qualifications and research degrees where appropriate. Consider offering enhanced study budgets or grants to ease the financial burden of professional exams.

For high-quality care closer to home

- Invest in **community models of care**. Roll out electronic patient records at scale and pace to all settings and professions. Develop ways to ensure that information travels with the patient. Invest in allied health professionals, especially in the community. Consider what role SAS doctors can play in supporting primary care teams. Support rural and remote teams to develop new ways of working that improve care quality and patient experience. Invest in multiprofessional teams that focus on early intervention and prevention of hospital admission, especially for those living with chronic conditions.

'Health and care workers in all parts of Europe are experiencing overwork, with high levels of burnout. They describe feeling undervalued and disaffected and are losing trust in the systems in which they work. Healthcare is becoming more complex due to changing patterns of diseases, such as the growth of multimorbidity in ageing populations … the health workforce is ageing too [and] older workers are being joined by those with young families in questioning what can be an unhealthy work–life balance.

'[The way forward] places health and care workers at its heart, recognising that failing to engage them in the search for solutions is pointless … the challenge … is how to rebuild trust, by patients, health workers, and politicians, in health systems and transform services to make them truly person centred. This will only be possible with an engaged and motivated health and care workforce.'

– Fixing the health workforce crisis

10 quick wins: Helping staff to thrive, care, learn and feel valued

A workplace environment where staff can thrive

1 Improve **staff wellbeing** by providing facilities for rest, spaces to carry out non-clinical work, and easily accessible hot food and drink. Invest in occupational health and ramp up efforts to stamp out bullying and incivility.

2 Facilitate improved **work–life balance** through helping employees to access flexible, affordable childcare and school holiday play schemes, and that ensuring staff can take time off for significant life events, enabling the right to a planned private life.

3 Ensure that all staff can access **clinical leadership** opportunities and are supported with a cohesive and inclusive team culture to become compassionate leaders who inspire others.

A workplace environment where staff can care

4 Alleviate pressures on staff and delays for patients by supporting **social care** to help reduce hospital admissions and speed up discharges.

5 Support the development of **multiprofessional teams**, accelerating steps for the regulation and recruitment of the medical associate professions.

6 Invest in **community** models of specialist care to help staff prioritise early intervention, prevent ill health and avoid hospital admission, especially for older people or those living with frailty.

A workplace environment where staff can learn

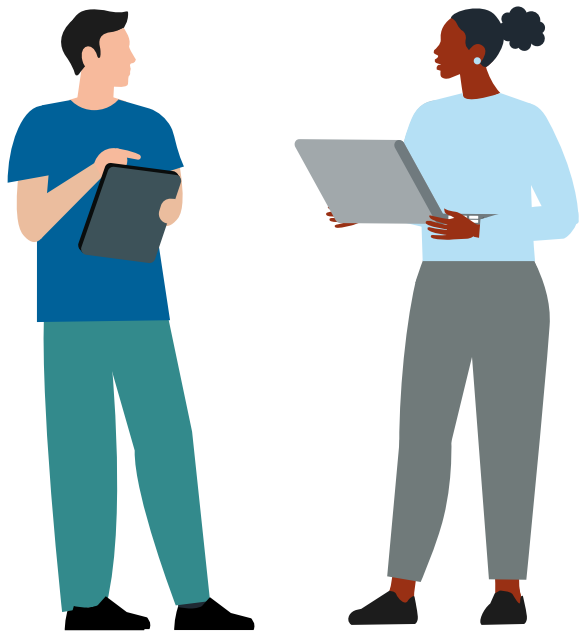
7 Ensure that job planning for all professions and at all levels facilitates flexible training and working, ensures **protected time** for non-clinical activity, and recognises professional activities such as education and training, clinical leadership, quality improvement and governance. Consider offering enhanced study budgets or grants to ease the financial burden of professional exams.

A workplace environment where staff can feel valued

8 **Reduce administrative burdens** on staff by streamlining mandatory training processes, introducing staff passports and simplifying appraisal and revalidation.

9 Use **'stay' (not just exit) interviews** to identify staff at risk of leaving and find solutions that might encourage them to stay (such as mentoring, flexible or less-than-full-time working).

10 Improve **retire and return** arrangements by ensuring clearer and more consistent policies and facilitating flexible approaches, including access to remote working and portfolio job plans.



Doctors demystified

Who are consultant physicians?

Consultant physicians are senior hospital doctors working across over 30 medical specialties from cardiology, gastroenterology, respiratory and geriatric medicine to clinical genetics and sports and exercise medicine. It takes at least 10 years to train a consultant physician, although more and more doctors are choosing to take time out for research/education or to work more flexibly, which can extend the training pathways by several years.

Who are specialty and associate specialist (SAS) doctors?

SAS doctors are a significant and experienced part of the medical workforce and make up around a quarter of all doctors. They work in non-training senior roles with at least 4 years of postgraduate medical training. Many SAS doctors have made a positive choice to step into an SAS role, maybe for geographical stability or a better work–life balance. SAS doctors can work towards the certificate of eligibility for specialist registration (CESR) or apply for a training post to become a consultant, although many prefer a career as an SAS doctor.

Who are doctors in training?

Doctors in training, also known as trainees or 'junior' doctors, deliver patient care in a range of settings. Trainees working in the 30 medical specialties are responsible for assessing and admitting the majority of unwell patients who attend hospital via emergency departments, as well as looking after inpatients on the wards.

A typical day for a trainee would include identifying all patients for whom their team is responsible and ensuring that they are reviewed on a ward round, booking and checking the results of investigations, communicating with patients, relatives and other medical teams, and making arrangements for patients to be discharged. They may also see patients referred from the community in an outpatient clinic to decide ongoing treatment and support, and undertake routine procedure lists. Trainees are usually the first to attend an unwell or deteriorating patient and have no option to opt out of weekend, overnight or shift work. Posts rotate every 4–6 months, with longer posts of up to 1 year offered to more senior doctors in training, ensuring exposure to a range of learning skills and environments.

Not so ‘junior’

The journey from medical student to consultant physician

5 years at medical school. Most medical students complete an undergraduate medical degree (5 years) before they enter postgraduate medical training. Others may have completed an undergraduate degree (3–4 years) in another subject before entering a postgraduate medical course (4 years).

2 years of foundation training. This is the first stage of postgraduate training for medical graduates. Referred to as junior doctors, doctors in training or trainees, they rotate into different jobs across the system, including in hospitals and GP practices.

3 years of internal medicine training (IMT). Trainees make the choice to become a physician (rather than a GP, surgeon or other type of doctor). They do a variety of rotations in different medical specialties, including acute and geriatric medicine. In their third year, they take on the more senior role of a medical registrar. Some trainees in a small number of specialties will specialise after 2 years of internal medicine.

At least 4 years of specialty training (ST). Trainees have now decided what type of hospital specialist they want to be, choosing from around 30 medical specialties. Most will train in internal medicine alongside their specialty. At the end of specialty training, doctors can apply for a **consultant post**, in which they will continue their learning throughout their career.

Time spent out of programme. Many trainees spend valuable additional years doing academic research, participating in leadership programmes or gaining experience in other countries. Some medical students take a year or more out of medical school to study a specific area of interest – this is called an intercalated degree. This could be a bachelor’s degree, a master’s degree or even a PhD.

About the three UK royal colleges of physicians

The Royal College of Physicians, the Royal College of Physicians of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow are charities committed to the development and delivery of the highest possible standards of patient care in the UK and beyond.

The three colleges work collaboratively to deliver postgraduate training, assessment and continuing medical education in the UK. We advocate on behalf of patients and our fellows and members, campaigning for improvements in patient care and public health.

We have previously come together in Northern Ireland to launch *The time is now: an action plan to rebuild the health and care system in Northern Ireland* and *Talking with trainees*, as well as a joint statement calling for a multi-year budget for health and social care.

The three royal colleges of physicians represent around 50,000 physicians worldwide, including around 1,000 fellows and members in Northern Ireland. Our collaborative approach reflects shared concerns about the challenges facing healthcare in Northern Ireland.

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