



Royal College
of Physicians



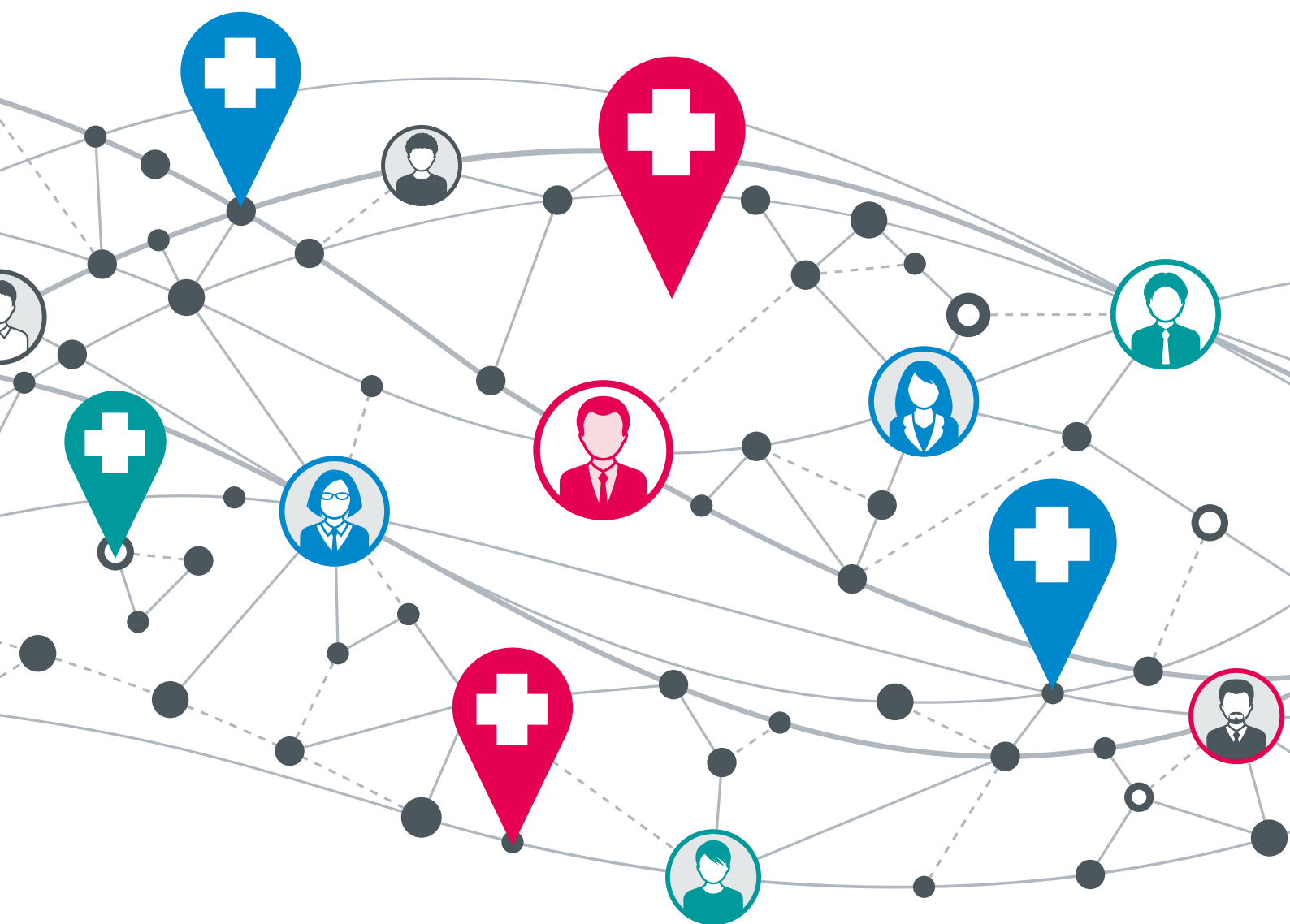
ROYAL COLLEGE
of PHYSICIANS
of EDINBURGH

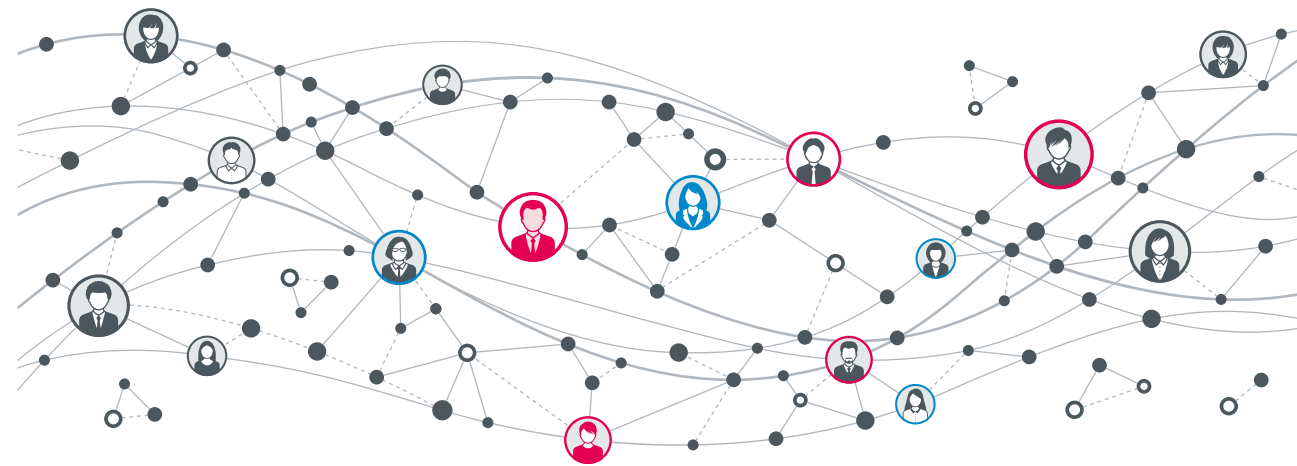


ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW

Focus on physicians

Census of consultant physicians
and higher specialty trainees 2018





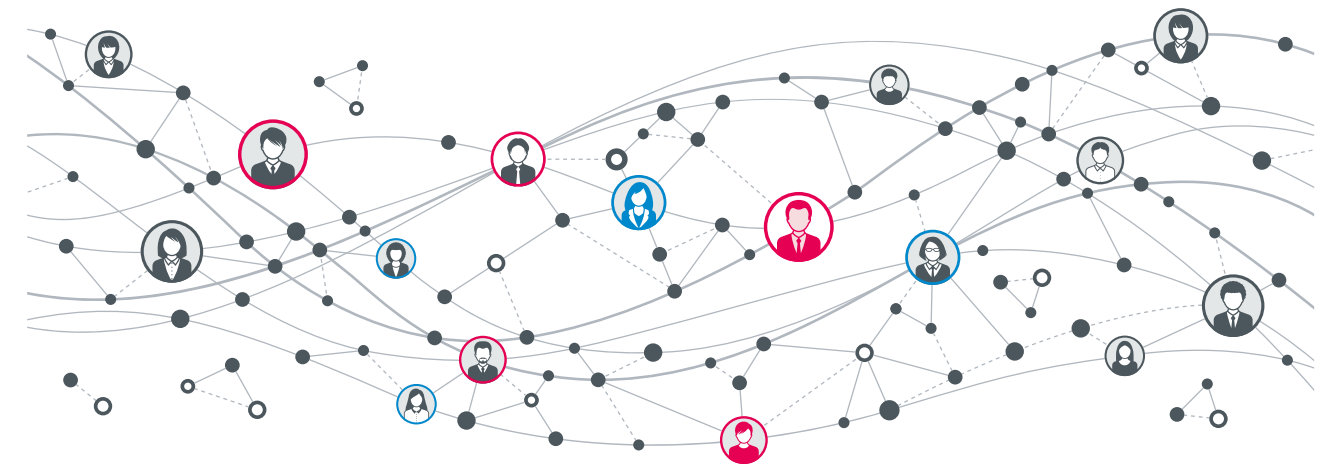
Introduction

Each year the Medical Workforce Unit (MWU) of the Royal College of Physicians (RCP) conducts a census on behalf of RCP London, the Royal College of Physicians of Edinburgh (RCPE) and the Royal College of Physicians and Surgeons of Glasgow (RCPSG). The aim of the census is to provide the three colleges, their partners and others with robust data on the state of the consultant and higher specialty trainee (HST) physician workforce in the UK.

The three colleges also conduct a number of shorter surveys of our memberships which cover a range of topics. Alongside the census, these data help us plan for the future and ensure decision-makers across the UK are fully informed about the physician workforce.

Key points

The census reveals the continuing pressure on the medical workforce and the systems in which we work. This pressure is demonstrated by ongoing problems with rota gaps, unfilled posts and high levels of reported sickness absence. Once again, the census shows that the number of posts needed across the system significantly outnumbers the supply of physicians.



- > **Close to half (43%)** of advertised consultant posts with an advisory appointments committee (AAC) went unfilled due to a lack of suitable applicants. However, this year the number of consultant posts advertised with an AAC also fell by **33%**.
- > The ratio of consultant physicians to population served varies widely across the UK and regions with fewer consultants also have the highest rates of unfilled advertised posts.
- > **40%** of consultants and **63%** of HSTs said that rota gaps occurred on a daily or weekly basis. Only 7% and 12% respectively said such gaps did not lead to significant patient safety issues.
- > **45%** of consultants and **61%** of HSTs reported that a trainee was absent due to sick leave during their last on-call shift, particularly foundation year 2 (FY2) and core medical trainee (CMT) doctors.
- > **55%** of HSTs reported they had felt pressured to cover rota gaps and 26% said they were encouraged to take on the work of more than one doctor almost always or most of the time when covering a gap.
- > **59%** of consultants and **46%** of HSTs reported that as a consequence of rota gaps, adequate work-life balance was most commonly affected.
- > Consultants and HSTs continue to find their general internal medicine (GIM) work much less satisfying than their specialty work.
- > **Over half (52%)** of trainees with partners and/or children reported that work had affected their relationship with them during the past year.
- > **32%** of HSTs reported that their morale was worse compared with a year ago and only 20% reported that it was better, with 69% reporting that working conditions affected their morale. However, 38% of HSTs felt they had achieved more over the past year, with only 20% reporting they had achieved less.
- > **36%** of consultants will reach their planned retirement age in the next 10 years.

The pressure all physicians are under appears to be the main factor behind the negative experiences documented by the 8,656 doctors who contributed to this year's census. Reducing rota gaps, filling vacant consultant posts and improving consultant and trainee experiences of GIM are crucial if we are to improve the working lives of physicians in the UK and care better for the population we serve.

Next steps

We will use the census data in our discussions with governments about the current pressures on the NHS. The data will also inform our colleagues' work with the NHS in England to develop the People Plan that supports its Long Term Plan. The primary focus must be managing and reducing demand. We need more investment in public health initiatives, including the public health workforce. Indeed, prevention should be the basis of our health and care system. If we are to improve population health, we must recognise and accept the link between poverty and ill health. Government must act to tackle the significant and growing health inequalities that exist in our society. While individuals have a responsibility to look after themselves, the structure of our society also clearly contributes to this imbalance.

- We will continue to call for a significant increase in the number of medical school places across the UK with the aim of a small surplus of supply. We will estimate the costs of such an expansion and explore how it could help regions with lower numbers of doctors.
- We will continue work to identify ways of encouraging doctors in training to take up posts in specialties and locations with the largest recruitment gaps. Our colleges' chief registrar and chief resident schemes and portfolio careers project are examples of how we can meet the needs of doctors and their employers, while improving patient safety.
- With the UK set to leave the EU in October, more than ever we need the UK to be more accessible to doctors and other professionals from countries outside the UK. We continue to call for a substantial increase in the number of the Medical Training Initiative places, but more importantly we need to make sure we are a welcome prospect for doctors looking to work in another country. The recent recommendation by the Migration Advisory Committee to add 'medical practitioner' to the shortage occupation list is the first of many steps that will support international recruitment.

- The NHS is slowly becoming more flexible in terms of working patterns, regulation, moving between training programmes, moving between specialties, and meeting the aspirations of current and future professionals. This year's report on the experiences of doctors 1 year after gaining their certificate of completion of training (CCT) shows it is possible for people who want that flexibility to pursue a medical career.* We will work with the NHS across the UK to make sure it is an option for everyone who wants it.
- We are pleased that Health Education England is developing the single, robust source of data that we need to plan for the long term. We will work with these data to make sure our assumptions and recommendations are based as much as possible in the real world, taking into account the demographic changes the UK will undergo in the next 15 years. We will also work with NHS Education for Scotland and Health Education England and Wales to ensure that the implementation of its new health and social care workforce strategy is informed by data from this census.

* www.rcplondon.ac.uk/projects/outputs/2018-survey-medical-certificate-completion-training-cct-holders-career-progression

Methodology

The census was compiled by the RCP's MWU. Forms were sent electronically on 30 September 2018 to all substantive UK consultants and all HSTs on the Joint Royal Colleges of Physicians Training Board (JRCPTB) database. The MWU verified consultant numbers by working in partnership with the General Medical Council (GMC) to check data for those UK consultants who are members or fellows of the RCP, RCPE or RCPSG. Additional consultant data were checked with representatives of each medical subspecialty, and finally each trust was telephoned to confirm data at a trust level. Data on total consultant numbers, specialty, workplace, gender and age are therefore as accurate as possible. Data on total HST numbers, specialty, location, gender and age are derived from the JRCPTB's database of all registered HSTs.

The census form was sent to 15,891 consultants and 5,826 (37%) responded. Removing consultants who were no longer working in the UK and adding new consultant appointments gave a total of 16,406 consultant physicians in the UK. For data from those who responded to the census, 5,638 eligible UK responses allows 99% confidence with a 1.4% error margin when extrapolating to the whole consultant physician workforce. The census form was sent to 7,363 HSTs and 3,018 (41%) responded, allowing 99% confidence with a 1.8% error margin, when extrapolating to the whole HST workforce.

Consultant workforce

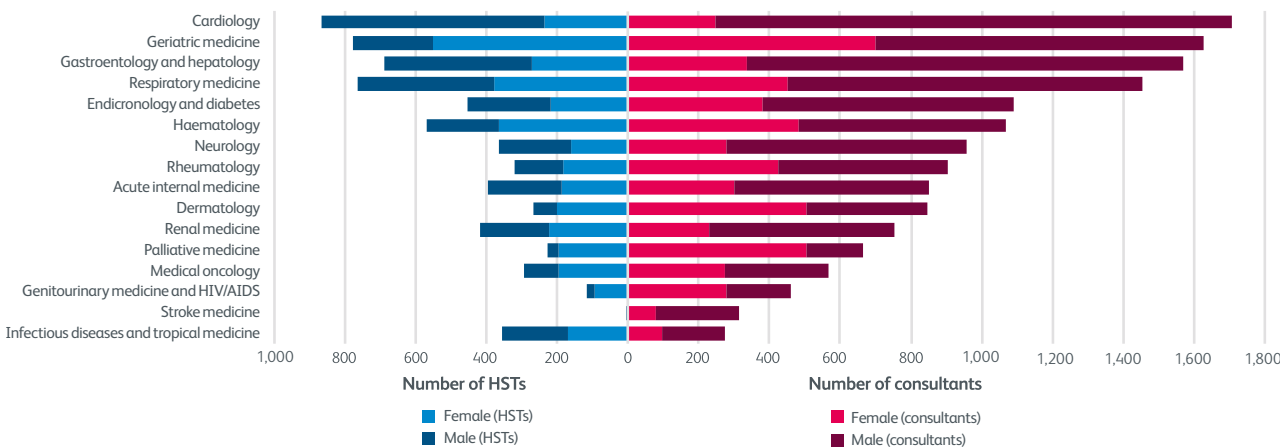
Of 16,406 consultant physicians in the UK in 2018–19; 84% worked in England, 3% in Northern Ireland, 8% in Scotland and 5% in Wales. Consultant physicians are not distributed evenly in the UK according to the background population. The mean ratio of full-time equivalent (FTE) consultant to background population was 4,389. The highest ratios of FTE consultant to population in England were in the East Midlands (5,764); the East of England (5,348); Kent, Surrey and Sussex (5,001); and the south west (4,918). By far the best ratios in England were in London, eg London south (2,488). The FTE consultant ratios were close to the national average in Scotland. There was a high ratio of FTE consultants to population in north Wales (5,759). These regions with high FTE consultant to population ratios also had the highest rates of unsuccessful consultant appointments and an important element of future workforce planning should include interventions to address these disparities.

The largest five medical specialties remained cardiology (10.4% of all physicians), geriatric medicine (9.9%), gastroenterology/hepatology (9.6%), respiratory medicine (8.9%), and endocrinology and diabetes (6.6%). Acute physicians made up 5.2% of consultant physicians. All of these large specialties appeared to have expanded over the past year: cardiology by 3.9%, geriatrics by 4.5%, gastroenterology/hepatology by 5.1%, respiratory medicine by 6%, endocrinology and diabetes by 3.6% and acute medicine by 8.1%.

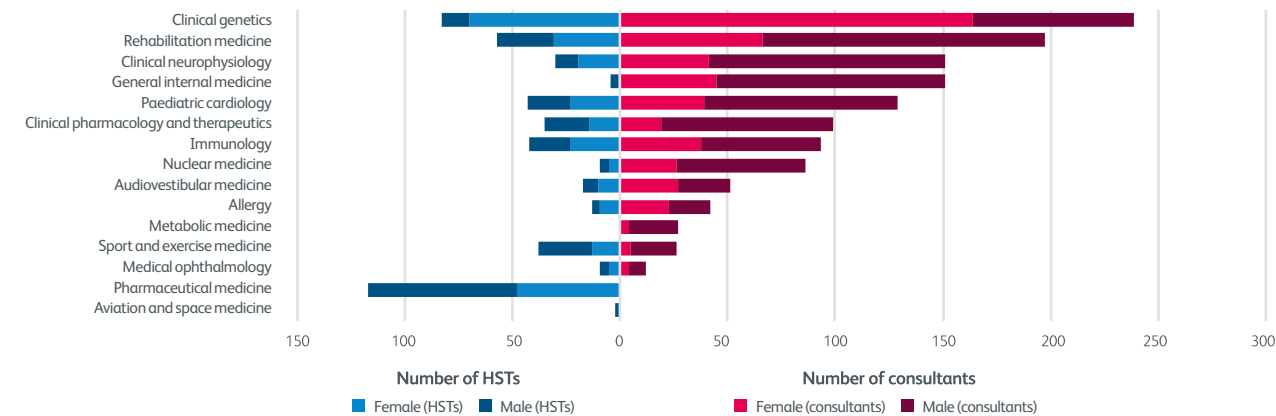
As in previous years, there had been a further increase in the number of consultant female physicians, so that the consultant workforce comprised 63% men and 37% women. This trend is set to continue as the majority of HSTs are women. There continued to be striking variations between the specialties: men made up 86% of cardiologists and 79% of gastroenterologists/hepatologists; whereas 76% of palliative physicians, 61% of genitourinary (GU) medicine physicians and 60% of dermatologists were women.

Data on the ethnicity of consultant physicians was available for 82% of consultants. 65% described themselves as being of white ethnic origin. The next largest ethnic group was those of Asian or Asian British origin (28%). Other ethnic groups were much smaller, with the largest being consultants of black or black British origin (2%). 93% of consultant physicians were UK citizens. 72% of consultant physicians graduated in the UK, 8% in Europe and 20% outside of Europe.

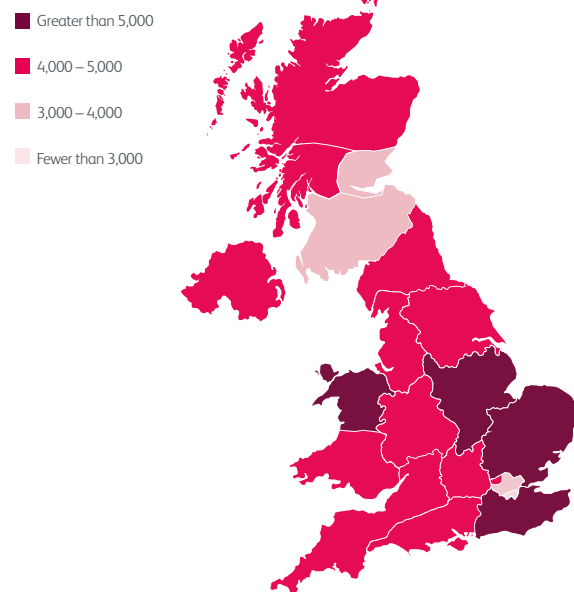
The consultant and HST workforce | By specialty and gender (larger specialties)



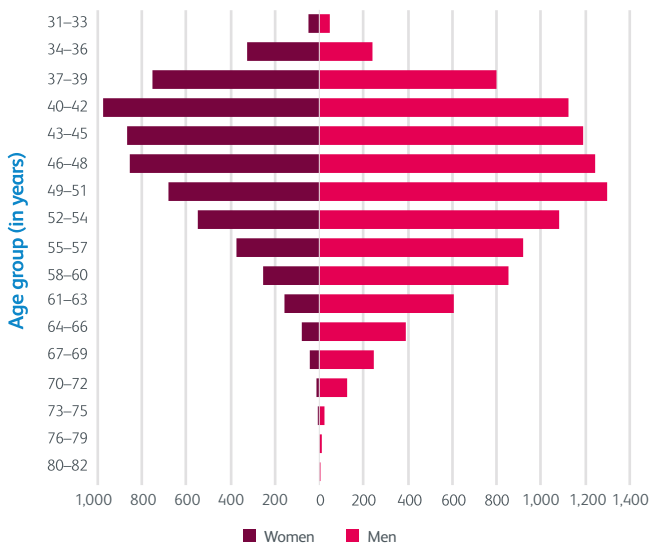
The consultant and HST workforce | By specialty and gender (smaller specialties)



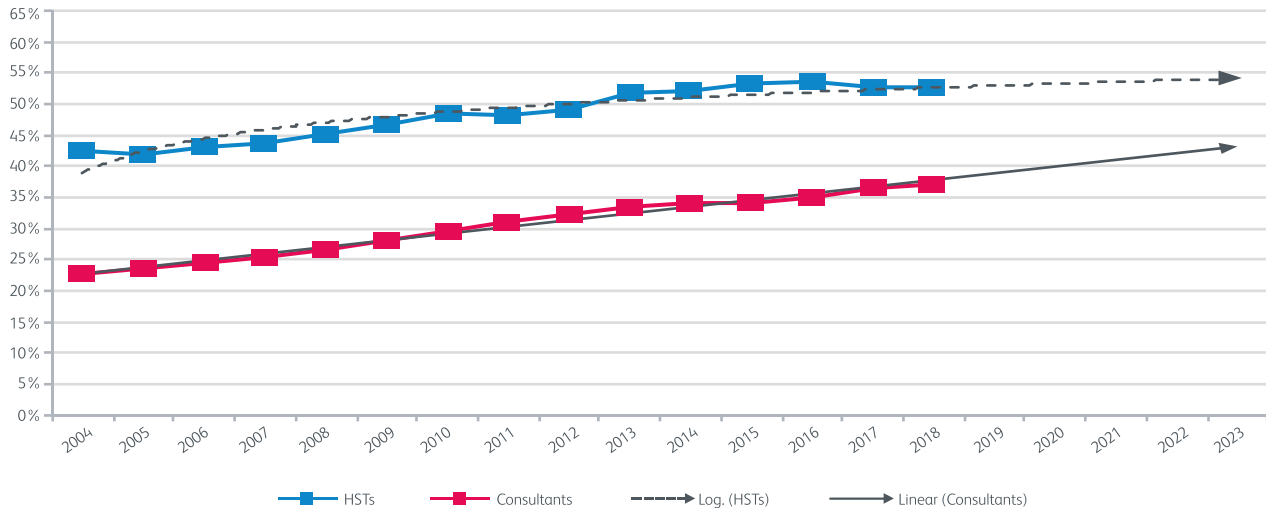
Population per FTE consultant



Age and gender breakdown of the consultant workforce



Trend in percentage of women in workforce | For consultants and HSTs



Consultant appointments

Overall, as in previous years of the census, very high numbers of advertised consultant physician posts with an AAC in England and Wales were again not filled (43%), usually due to a lack of any applicants at all (56%) or any suitable applicants (34%). This year we also noted a large reduction (33%) in the number of advertised consultant posts with an AAC. A number of factors may have contributed to this fall, including the lack of trained HSTs to meet the demand in shortage specialties and the deteriorating financial situation within the NHS, but this is a worrying pattern. This year, acute medicine advertised the highest number of posts (147), followed by gastroenterology/hepatology (122), geriatric medicine (120) and respiratory medicine (101). The highest number of successful appointments was in gastroenterology/hepatology (57% of advertised posts filled), followed by acute medicine (42% filled), respiratory medicine (61% filled), geriatric medicine (51% filled) and cardiology (75% filled).

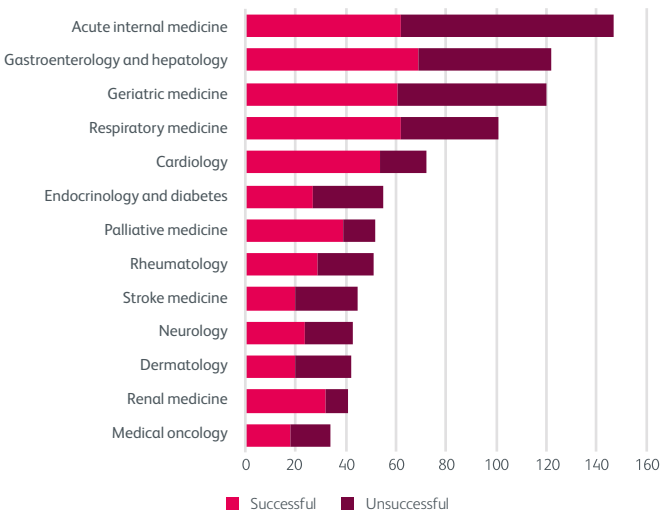
In England, the East Midlands region again had the highest proportion of unsuccessful appointments (53%), followed by the north (46%). North Wales had an even higher proportion of unsuccessful appointments at 73%. It was much easier to appoint consultants in London – only 30% of appointments were unsuccessful. There were also lower rates of unsuccessful appointments in Northern Ireland (27%), compared with 43% in England and 44% in Wales overall.

There was significant variation in the number of advertised supporting programmed activities (SPAs) between nations and also regionally within England. The mean number of advertised SPAs was 2 in England, 1.7 in Northern Ireland and 2.9 in Wales. Within England, regions that struggled to appoint to consultant posts also counterproductively advertised lower numbers of SPAs, eg East Midlands 1.6 and East of England 1.8. Data on consultant appointments in Scotland are available in the *External Advisor Annual Report*, published by the Academy of Medical Royal Colleges and Faculties in Scotland.

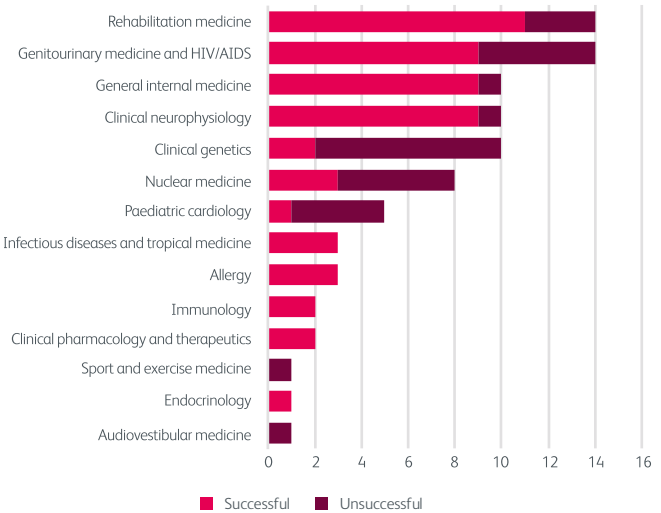
As in previous years of the HST census, trainees clearly regarded geographical location as the most important factor when applying for a consultant post – 55% of women HSTs and 51% of men rated this highest. The second most important factor was the proportion of specialty time in their job plan – 22% of women and 31% of men rated this highest. Less than full time (LTFT) working or the ability to work flexibly was the third most important factor for women (although 29% of LTFT women HSTs rated this highest) and for men it was academic opportunities/links. Specialty 7-day working / on call in job plan, GIM in job plan and GIM unselected take in job plan were all less likely to affect choice of consultant post.

Given trainees' prioritisation of geographical location, illustrated by the fact that only 23% of medical CCT holders reported applying for a consultant post outside their deanery, it is crucial that in future the geographical distribution of trainees in the UK better matches the geographical and population demand for consultant physicians.

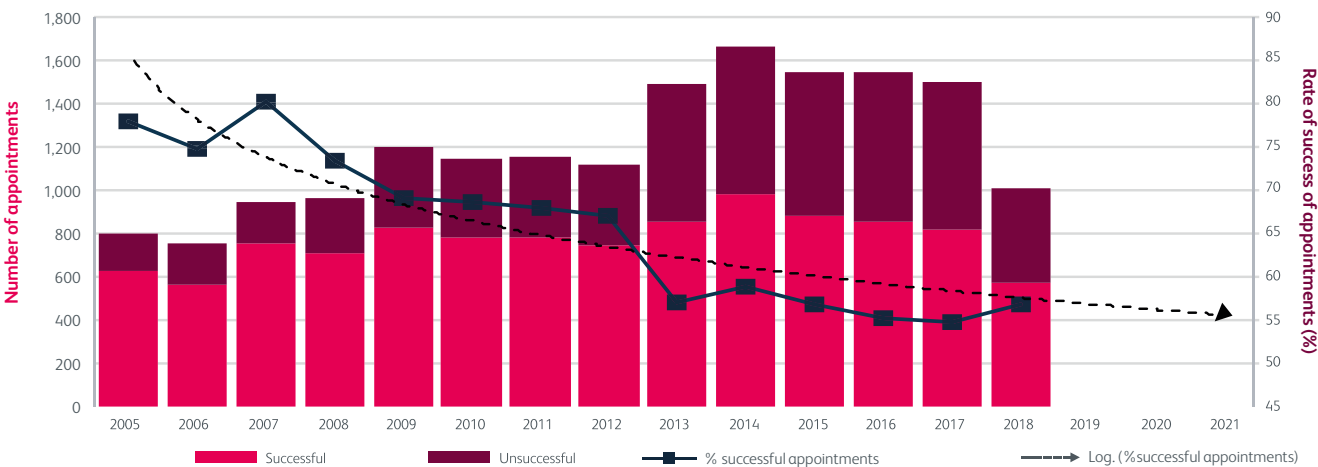
Appointments of consultant physicians | Large specialties



Appointments of consultant physicians | Small specialties



Appointment trend | Success of consultant appointments



Trainee workforce

According to data from the JRCPTB there were 7,363 medical HSTs during 2018–19. The overall distribution of trainees almost exactly mirrored consultants: 84% working in England, 2% in Northern Ireland, 9% in Scotland and 4% in Wales.

81% of trainees were UK citizens and, of non-UK citizens, 32% were EU citizens. 78% of trainees had graduated in the UK, 6% had graduated in Europe and 15% outside Europe.

The distribution of trainees by specialty matched the current distribution of consultants, rather than advertised consultant posts. The largest specialty for trainees was cardiology (12% of total), followed by geriatric medicine (11%), respiratory medicine (10%) and gastroenterology/hepatology (9%). Trainees in acute medicine comprised only 5% of all trainees.

If the number of trainees were to accurately match the consultant posts advertised, there would need to be a greater number of trainees in acute internal medicine and, to a lesser extent, in geriatric medicine and gastroenterology/hepatology.

Consistent with the last 2 years of the census, 53% of trainees were women. The variation in gender balance between specialties followed a similar pattern to consultants in many specialties. For example, 73% of cardiology trainees were male, an already male-dominated specialty. Encouragingly, there were signs of change in other predominantly male specialties: 39% of gastroenterology/hepatology trainees were women. 58% of trainees described themselves as being of white ethnic origin. The next largest ethnic group were those of Asian / Asian British (29%). The number of trainees from other ethnic groups was much smaller, with the largest being trainees of Arab (3%) and black / black British origin (3%).

81% of trainees were UK citizens and, of non-UK citizens, 32% were EU citizens. 78% of trainees had graduated in the UK, 6% had graduated in Europe and 15% outside Europe.

Consultant job satisfaction

Despite the pressures many consultant physicians face, their job satisfaction remains remarkably resilient. Consultants reported finding their specialty work satisfying:

- > 27% always
- > 57% often
- > 14% sometimes
- > 2% rarely
- > 0% never.

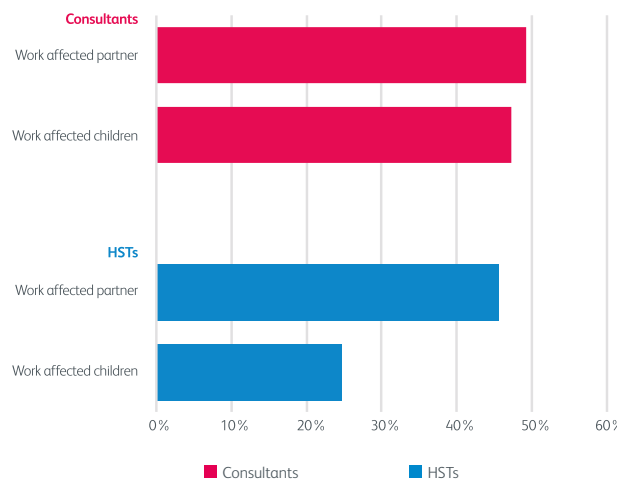
These figures are reassuringly almost identical to last year's census. However, consultant physicians again reported finding their GIM work rather less satisfying:

- > 9% always
- > 34% often
- > 35% sometimes
- > 16% rarely
- > 7% never.

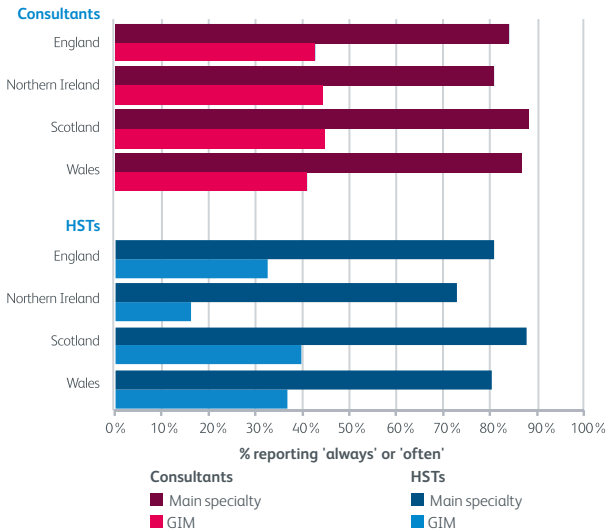
Multivariate logistic regression analysis of factors independently associated with being always or often satisfied with their specialty found significant associations (odds ratio (95%CI)) with: older consultant age (1.02 (1.01–1.03)); working in Scotland (1.64 (1.05–2.56)); and compared with working in acute medicine, consultants from the following specialties – endocrinology/diabetes (2.54 (1.41–4.60)), rheumatology (2.10 (1.17–3.78)), gastroenterology/hepatology (1.73 (1.08–2.77)) and respiratory medicine (1.68 (1.06–2.65)). There was no association with number of SPAs, gender, ethnicity or LTFT working.

Multivariate logistic regression analysis of factors independently associated with being always or often satisfied with their GIM work found significant associations with: older consultant age (1.02 (1.01–1.03)); and compared with working in acute medicine, consultants from the following specialties were less likely to be always or often satisfied with GIM work: gastroenterology/hepatology (0.20 (0.13–0.31)), cardiology (0.23 (0.13–0.41)), respiratory medicine (0.27 (0.18–0.41)), endocrinology/diabetes (0.27 (0.18–0.42)), renal medicine (0.30 (0.17–0.54)) and geriatrics (0.60 (0.40–0.88)). This is reflected in the marked variations in job satisfaction in GIM work between specialties – fortunately only 7% of acute physicians reported rarely or never finding GIM satisfying but this rose to 37% of gastroenterologists/hepatologists and 45% of cardiologists. There was no association with number of SPAs, gender, ethnicity or LTFT working.

Has work negatively affected consultants and HSTs in the last year?



Job satisfaction | By nation



Trainee job satisfaction

HSTs also reported that working in their specialty was satisfying:

- > 26% always
- > 55% often
- > 17% sometimes
- > 2% rarely
- > 0% never.

Multivariate logistic regression analysis of factors independently associated with being always or often satisfied with their specialty found significant associations (odds ratio (95% CI)) with: older HST age (1.02 (1.01–1.03)); training in Scotland (1.77 (1.17–2.69)); and training in any specialty compared with acute medicine. There was no association with gender, ethnicity or LTFT working. However, trainees clearly found working in GIM much less satisfying:

- > 5% always
- > 28% often
- > 43% sometimes
- > 19% rarely
- > 5% never.

Multivariate logistic regression analysis of factors independently associated with being less likely to always or often be satisfied with their GIM work found significant associations with: training in Northern Ireland (0.33 (0.11–0.98)); and training in specialties other than acute medicine, with the strongest dissatisfaction with GIM among cardiology (0.17 (0.08–0.34)), gastroenterology/hepatology (0.19 (0.11–0.31)) and respiratory (0.29 (0.19–0.46)) HSTs.

There were marked variations in job satisfaction in GIM between specialties – only 6% of acute medicine HSTs reported rarely or never finding GIM satisfying but this rose to 31% of gastroenterology/hepatology HSTs and 39% of cardiology HSTs. There was no association with gender, ethnicity or LTFT working.

Trainees consistently felt valued by colleagues, patients and their clinical supervisors but 40% reported only ‘sometimes’ or ‘almost never’ feeling valued by their hospital/trust management. 69% of trainees reported that they felt confident in their work ‘almost always’ or ‘most of the time’, but only 44% reported ‘almost always’ or ‘most of the time’ being in control of their workload, with 31% saying they only ‘sometimes’ or ‘almost never’ felt in control of their workload. 5% of HSTs reported feeling short of sleep at work every day, with 24% saying this occurred weekly.

We examined the frequency of six symptoms that suggest a person may be at risk of burnout, based on the Maslach Burnout Inventory, among HSTs, as we did for consultants last year. 37% of HSTs experience two or more of the six features of burnout almost always or most of the time. 26% experience three or more always or most of the time. Among the 25% of HSTs most at risk of burnout, men were slightly more at risk (27%) than women (23%). Age had no impact but HSTs working LTFT (18%) appeared at lower risk of burnout than full-time HSTs (26%). Similarly HSTs with a GIM commitment were at higher risk of burnout (29%) compared with those without such a commitment (19%). HSTs in some nations appear to be at greater risk of burnout – England 26%, Northern Ireland 33%, Scotland 18% and Wales 23%.

There were also differences between individual specialties. Respiratory medicine, gastroenterology/hepatology, renal medicine and endocrinology/diabetes have the highest numbers of HSTs at risk of burnout. Palliative medicine, GU medicine, dermatology and neurology have low numbers of HSTs at high risk of burnout.

Over half (52%) of trainees who had a partner reported that work had affected their relationship with them during the past year. This was also the case for trainees with children (51%).

When asked how their morale was compared with a year ago: 32% said it was worse, 48% the same and 20% better; 69% reported their working conditions had affected their morale. However, 38% of trainees felt they had achieved more over the past year, 42% the same and only 20% less.

Rota gaps

Consultants

Gaps in trainees’ rotas were reported frequently by consultants:

- > daily (10%)
- > weekly (30%)
- > monthly (19%)
- > 16% reported that rota gaps cause significant patient safety problems in their hospital
- > 74% stated that gaps could potentially cause patient safety problems but there are solutions to prevent this
- > only 7% said rota gaps have no impact on patient safety.

Rota gaps were reported as occurring in all areas of the UK with similar frequency and patient safety implications. The most common solutions for rota gaps reported by consultants were an internal locum (76%), followed by redistributing trainees (63%), an external locum (60%), a consultant acting down (47%) and sending home a daytime trainee so they can cover the night (46%). Worryingly non-medical staff, eg physician associates, advanced care practitioners or advanced nurse practitioners, were reported to have been used to cover rota gaps (11%). It is also worth noting that most of these solutions add to the existing workloads of medical and other staff within the organisation. Consultants reported high levels of sickness related to being on call among trainees of all grades. 33% reported at least one trainee being absent due to illness the last time they were on call during the day in the week.

When on call during the night in the week, 18% reported at least one trainee being absent due to illness. There was a similar pattern with weekend on calls: 26% reported at least one trainee being absent due to sickness in the daytime and 14% at night. Sickness appeared less common among foundation year 1 (FY1) doctors.

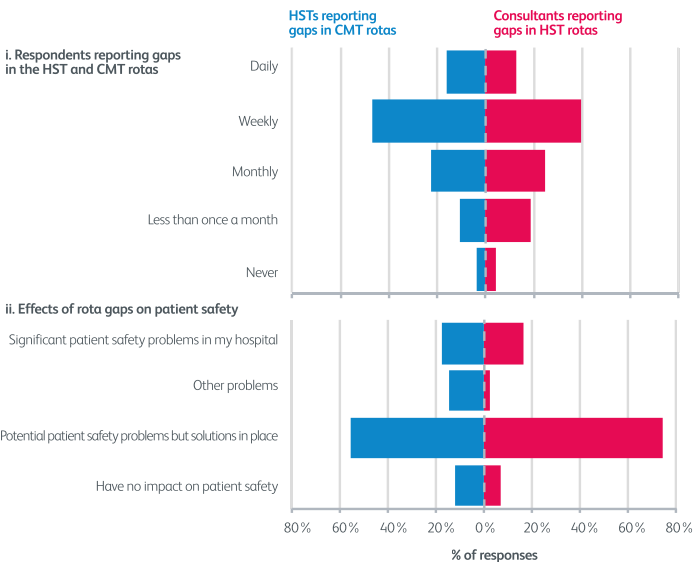
Impact on consultants

23% of consultants had been asked to cover a gap in the HST rota: 2% daily, 9% weekly and 18% monthly. As last year, 58% of consultants reported receiving no compensation at all for acting down; 23% received extra payment; and 24% took time off in lieu. Of those taking time off in lieu, 6% took time off the next day (with elective work cancelled), 7% took time off and a colleague was asked to cover the planned work, and 11% took time off at a later date.

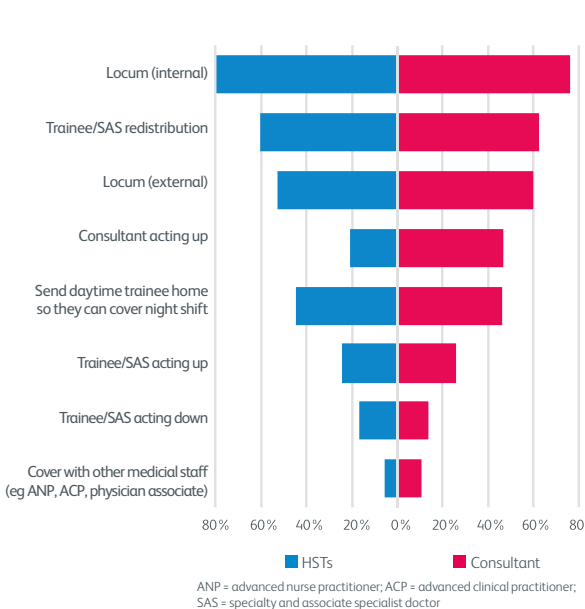
When consultants were asked what was affected by rota gaps, they most commonly reported adequate work–life balance (59%) followed by educational supervision/assessments (41%), informal teaching (39%), continuing professional development (CPD) (31%), and elective work and formal teaching sessions (both 30%).

When consultants were asked what was affected by consultant vacancies, they again reported adequate work–life balance (77%), followed by audit / quality improvement (44%), CPD (39%), management (38%), educational supervision/assessments (37%), informal teaching (35%) and formal teaching (32%).

Rota gaps



In-hospital solutions to rota gaps / vacancies



Trainees

Gaps in trainees' rotas were reported more frequently by HSTs than consultants:

- > daily by 16%
- > weekly by 47%
- > monthly by 22%
- > 17% reported that rota gaps cause significant patient safety problems in their hospital
- > 56% stated that gaps could potentially cause patient safety problems but there are solutions in place to prevent this
- > only 12% said rota gaps have no impact on patient safety.

Rota gaps were reported as occurring in all areas of the UK with similar frequency and patient safety implications. The most common solutions for rota gaps reported by HSTs were an internal locum (79%), followed by redistributing trainees (60%), an external locum (53%), sending home a daytime trainee so they can cover the night (45%) and a trainee acting up (25%). There were fewer reports of non-medical staff being used to cover rota gaps from HSTs (6%). HSTs reported much higher levels of sickness when on call among trainees of all grades than consultants, with a similar pattern to data reported in last year's census. 47% reported at least one trainee being absent due to illness the last time they were on call during the day in the week. When on call during the night in the week, 31% reported at least one junior trainee being absent due to illness.

There was a similar pattern with weekend on calls: 39% reported at least one junior trainee being absent due to sickness in the daytime and 27% at night. Trainees may be more reluctant to take time off when unwell at the weekend or at night given the disproportionate impact on colleagues when fewer trainees are around in the hospital.

Impact on trainees

15% of HSTs had been asked to cover gaps in the CMT rota and 55% had actually covered a gap: 8% daily; 9% weekly; and 24% monthly. 65% of HSTs had been asked to cover gaps in the HST rota and 77% of those had actually covered a gap: 1% daily; 7% weekly; and 32% monthly. 55% of HSTs reported feeling pressured to cover rota gaps and 49% said they had missed training opportunities due to the need to cover gaps.

In compensation for covering rota gaps the situation had improved for HSTs from last year: HSTs were offered nothing in only 34% of cases, they were paid more in 49% of cases and offered time off in lieu in 28% of cases. When HSTs were asked what was affected by rota gaps, they most commonly reported adequate work-life balance (74%), followed by informal teaching (61%), formal teaching (59%), elective work (57%) and educational supervision/assessments (55%). Organisational issues clearly contribute to some of the problems rota gaps cause. Only 48% of HSTs reported a HST was involved in rota design, planning, rostering or rota gap coverage at their hospital, when this should clearly be higher.

When asked how much notice they typically had of the need to cover a rota gap, HSTs reported: hours only (23%); 24 hours (13%); less than a week (29%); 1 week (14%); 1 month (12%); and only 9% were given more than a month's notice. Short-term sickness will always be an issue but many rota gaps are caused by events with sufficient notice to plan cover, such as HSTs leaving to become a consultant, LTFT working or maternity leave, and these data suggest a lack of forward planning within NHS organisations.

Worryingly HSTs reported that they were often encouraged to take on the workload of more than one member of staff when covering a rota gap:

- > almost always (12%)
- > most of the time (14%)
- > about half of the time (10%)
- > sometimes (38%)
- > almost never (26%).

When covering a consultant vacancy, HSTs reported that they were not usually asked to act beyond their competence – 3% reported almost always or most of the time being asked to act beyond their competence. They also usually received sufficient senior support when acting up (always 48%, most of the time 17%), although 17% reported only sometimes receiving support and 13% reported almost never receiving sufficient support .

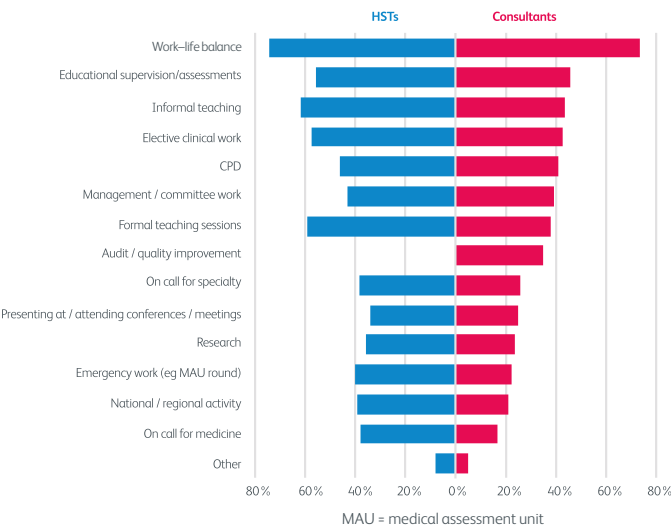
Less than full time working

The number of consultants working LTFT or who are paid less than 10 programmed activities (PAs) per week was the same as last year at 23%. 41% of women and 11% of men reported working LTFT. Variations in LTFT working between specialties, as would be expected, depended on the proportion of men and women in the specialty. For example, 55% of palliative care consultants reported working LTFT, but only 9% of cardiologists.

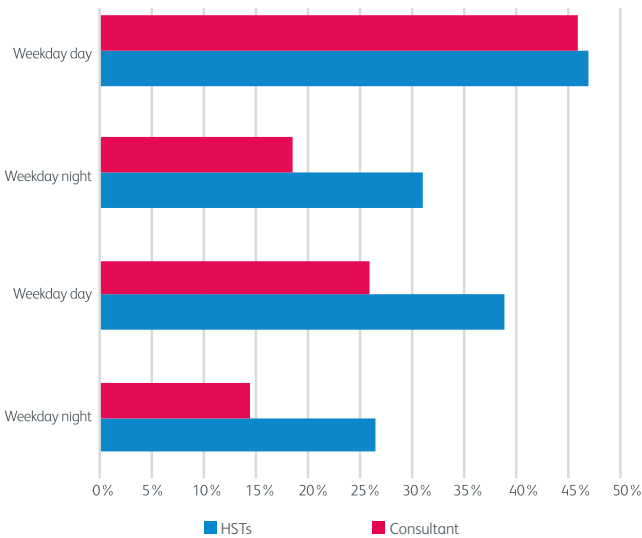
LTFT working is common at all ages among women consultants but it is particularly common in men after the age of 60. The highest proportions of consultants working LTFT are among those aged 60–65 (36%) and over 65 (60%). This reflects the increasing importance to the consultant workforce and the NHS of consultants who 'retire and return', who now constitute 4.9% of all consultant physicians.

Exactly the same proportion of HSTs worked LTFT (at 15%) as reported in last year's census. 90% of all LTFT trainees were women. 26% of all women trainees and 3% of all men worked LTFT.

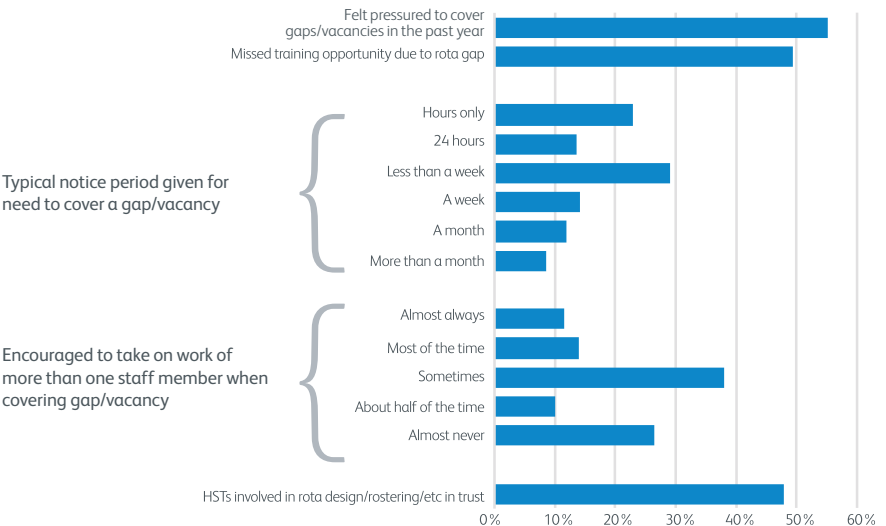
Work affected by HST rota gaps or consultant vacancies



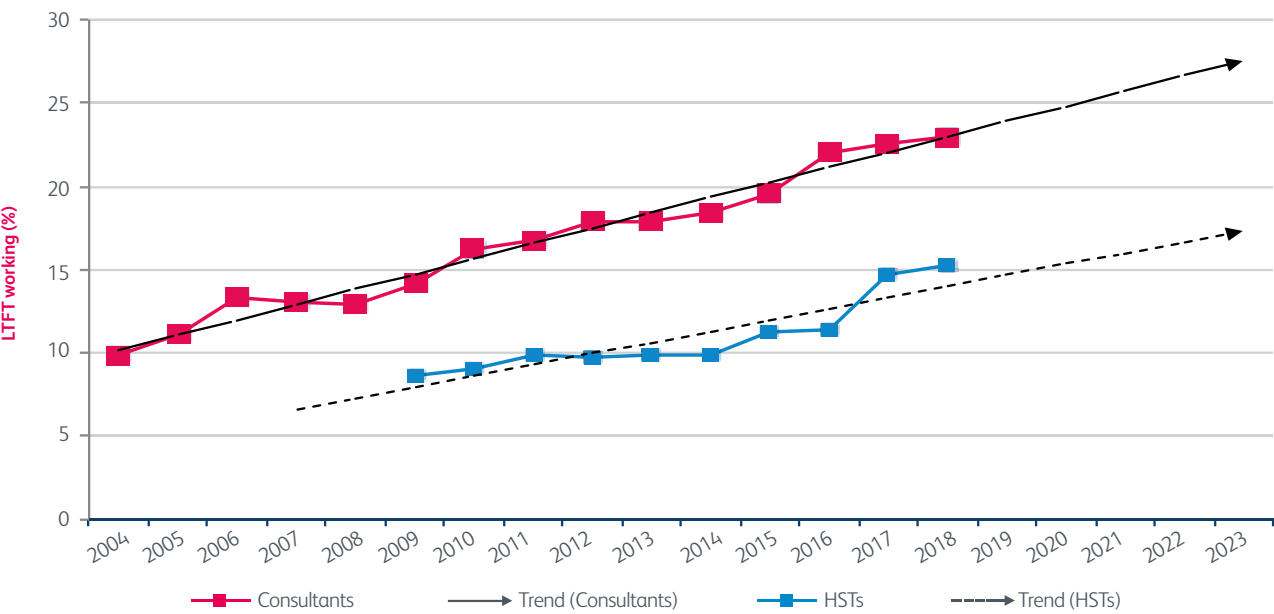
Last time you were on call, was at least one junior doctor absent due to illness? If yes, what grade and shift?



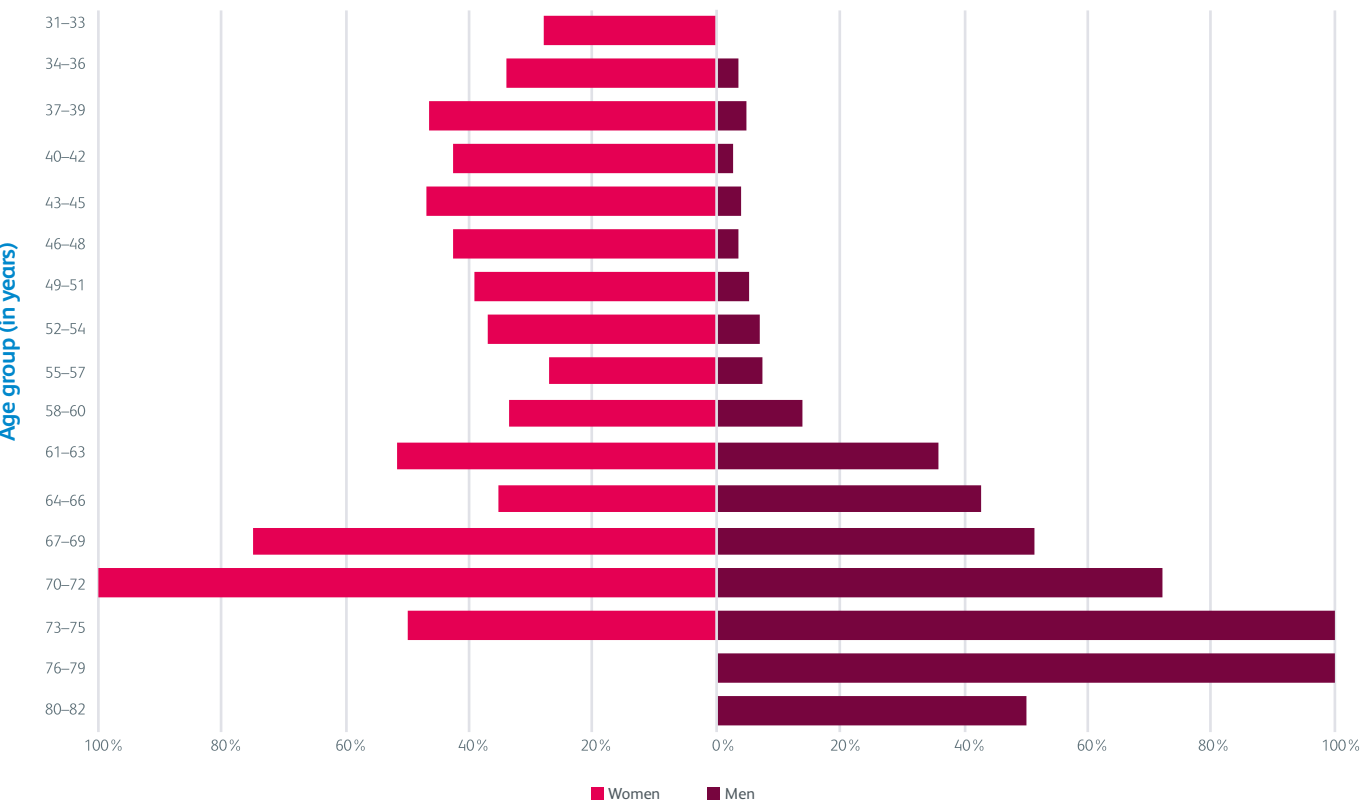
HSTs reporting rota gaps



Trend in percentage of LTFT working by consultants and HSTs



LTFT consultants working by gender and age group



General internal medicine

Consultants

The proportion of consultants participating in the acute unselected medical take and looking after GIM patients on wards was very similar to data from the last two censuses. This trend is unlike previous years of the census, in which participation in both consistently fell.

The unselected medical take was undertaken by 34% of consultants. Of consultants who did not undertake unselected medical take, 23% had done so when appointed as a consultant and had given it up a mean of 11 years after appointment. GIM duties including care of GIM inpatients were undertaken by 44% of consultant physicians and of those who did not undertake GIM duties, only 15% had done this when first appointed.

We estimated the total contribution to GIM duties (including the acute medical take) by medical specialty and this came principally from five large specialties:

- > 18% from geriatric medicine
- > 17% from respiratory medicine
- > 16% from gastroenterology/hepatology
- > 13% from endocrinology/diabetes
- > 11% from acute internal medicine.

The next largest specialty contribution was cardiology with 6% and all other specialties combined were 19%.

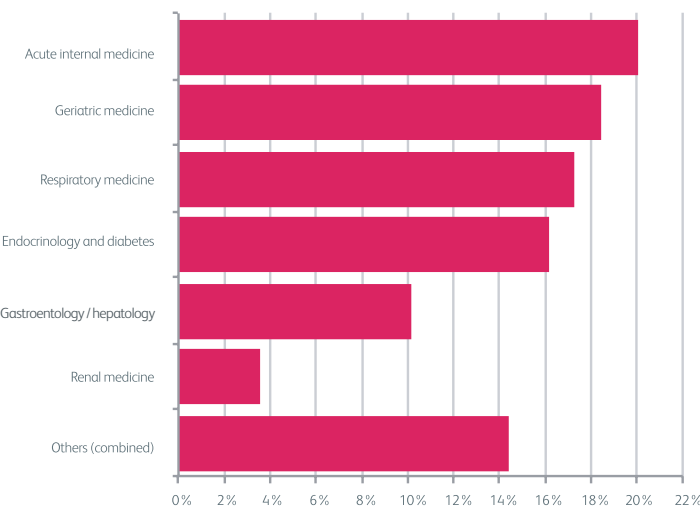
There are variations across the four nations in undertaking the acute take and caring for GIM inpatients:

- > 58% of consultants in Wales
- > 44% of consultants in England and Scotland
- > 35% of consultants in Northern Ireland.

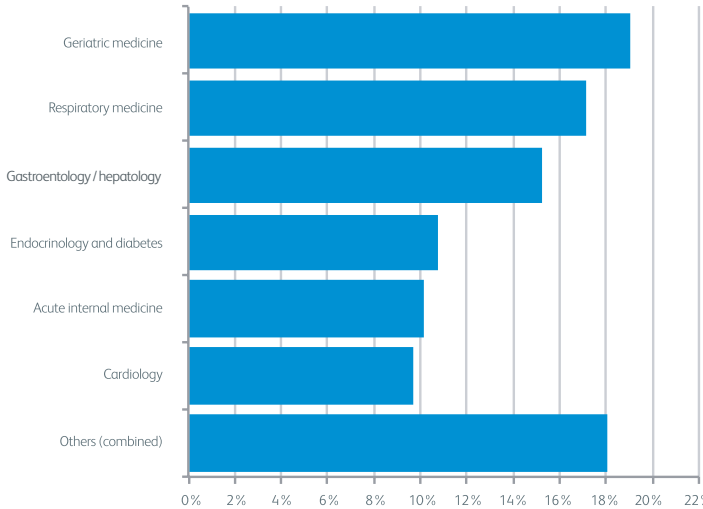
In addition, we asked consultants how they viewed themselves:

- > 42% regarded themselves as pure specialists
- > 43% as specialists with some generalism
- > 12% as generalists with some specialism (mostly acute physicians and some geriatricians)
- > only 2% as pure generalists (just acute physicians).

% of total acute unselected take undertaken | By specialty for consultants



% of total acute unselected take undertaken | By specialty for HSTs



Trainees

Specialties with very high numbers of trainees participating in the acute take or looking after non-specialty GIM inpatients included:

- > acute internal medicine (99%)
- > geriatric medicine (98%)
- > endocrinology/diabetes (95%)
- > respiratory medicine (91%)
- > gastroenterology/hepatology (89%).

This was less common among other large specialties in which consultants do not usually undertake GIM:

- > renal medicine (78%)
- > rheumatology (68%)
- > infectious disease (64%)
- > cardiology (50%).

Fewer than 10% of trainees in other specialties were involved in GIM.

As with consultants, we asked HSTs how they viewed themselves:

- > 25% regarded themselves as pure specialists
- > 52% as specialists with some generalism
- > 17% as generalists with some specialism (again mostly acute physicians and some geriatricians)
- > only 2% as pure generalists (just acute physicians).

We asked trainees if they had needed to contact a consultant at home outside standard working hours and the majority had (85%). Nearly all who had done this reported it was ‘very easy’ or ‘easy’ to contact the consultant (88%) and that they felt ‘very supported’ or ‘supported’ when they contacted them (91%).

Quality of training

Similarly to last year’s census, 68% of trainees described their specialty training as ‘excellent’ or ‘good’ but only 26% felt this way about their GIM training. There was no significant variation in reported quality of training by gender or working pattern (such as LTFT working). Trainees appeared to rate both their specialty and GIM training more highly in Wales and Scotland than in England and Northern Ireland.

Specialty training rated excellent or good:

- > Wales 77%
- > Scotland 71%
- > England 67%
- > Northern Ireland 64%.

GIM training excellent or good:

- > Wales 33%
- > Scotland 35%
- > England 25%
- > Northern Ireland 26%.

Trainees in acute medicine again rated their specialty training the lowest among medical specialties: only 9% of trainees rated it excellent, 38% good, 42% satisfactory, 10% poor and 1% very poor.

Trainees were asked what would improve their experience of their specialty and GIM training. Similarly to last year they suggested for specialty training:

- > protected time for professional development (75%)
- > better service and training balance (63%)
- > no rota gaps (57%)
- > full-time (but flexible) working (44%)
- > more study leave (36%)
- > modular training (34%).

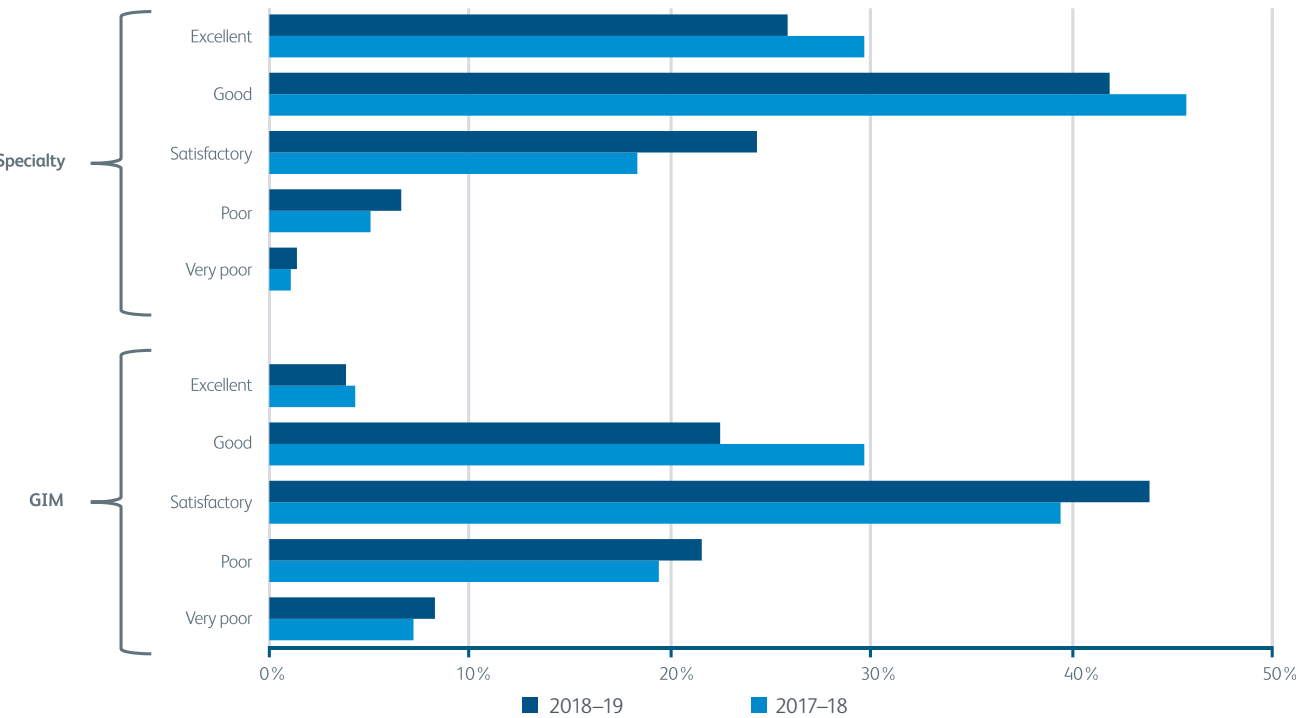
For GIM training suggestions were again similar to last year:

- > no rota gaps (52%)
- > better service and training balance (51%)
- > protected time for professional development (45%)
- > full-time (but flexible) working (27%)
- > modular training (23%)
- > more study leave (21%).

If they were able to turn back time, as in last year’s census, 60% of GIM trainees would not choose to train in GIM, but only 10% of trainees would alter their specialty. In addition, 21% of trainees would prefer to train in a different location. More worryingly, if they could turn back time, 29% of trainees reported they would take a medical job outside the NHS and 35% a job in a different sector outside medicine.

Multivariate logistic regression analysis of factors independently associated with choosing to train again in GIM found significant associations (odds ratio (95%CI)) with: training in Scotland (1.49 (1.04–2.14)). Choosing not to train again in GIM was associated with training in specialties other than acute medicine: endocrinology/diabetes (0.29 (0.18–0.47)), gastroenterology/hepatology (0.52 (0.36–0.74)), cardiology (0.53 (0.33–0.84)), and respiratory medicine (0.53 (0.38–0.75)). There was no association with gender, ethnicity or LTFT working.

HSTs | Quality of training



Job planning

A current, agreed job plan is a key contribution to consultant productivity and job satisfaction. 92% of consultants again reported having a current job plan. This was consistent throughout the UK. The job plan of 83% of consultants had been reviewed and agreed within the last year, as is recommended. This appeared to be less common in Northern Ireland (70%).

It is good practice to undertake job planning together in teams but this remains a relatively uncommon practice with no change since last year’s census. There also remained significant variation in the prevalence of this practice between the four nations: 31% prevalence in England, 28% in Wales, 20% in Scotland and 10% in Northern Ireland. Some specialties had embraced team job planning more widely with 40% of acute physicians, stroke physicians and palliative medicine consultants reporting that they undertook this.

30% of consultants in England reported having an annualised contract, compared with 27% in Scotland, 15% in Wales and 18% in Northern Ireland.

Contracted PAs

Consultant job plans are split into 4-hour periods of work called programmed activities (PAs). They are further split into four categories of PA:

- > direct clinical care (DCC), eg ward rounds, outpatient clinics, treatment sessions, patient administration, meetings to discuss patient care, emergency / on-call duties
- > supporting professional activities (SPA) – eg training, education, CPD, audit, job planning, appraisal, research, clinical management
- > academic
- > other – additional responsibilities within or external to NHS organisations.

The mean number of contracted PAs per consultant across the UK was 10.5. Consistent with last year’s census, on average, 7.4 PAs were spent in DCC work, 1.9 in SPA work, 0.6 in academic work and 0.7 in ‘other’ work.

Full-time consultants were contracted for a mean of 11.4 PAs – 8.0 DCC, 2.0 SPA, 0.7 academic and 0.7 other. LTFT consultants were contracted for a mean of 7.4 PAs – 5.2 DCC, 1.4 SPA, 0.4 academic and 0.4 other.

Worked PAs

The mean number of PAs consultants across the UK estimated they worked was 11.6. 7.8 were spent in DCC, 2.1 in SPAs, 0.8 in academic work and 0.9 in ‘other’ work. Full-time consultants estimated they worked a mean of 12.5 PAs – 8.5 DCC, 2.2 SPA, 0.9 academic, 1.0 other. LTFT consultants estimated they worked a mean of 8.3 PAs – 5.7 DCC, 1.7 SPA, 0.5 academic, 0.5 other.

These numbers are in keeping with previous years of the census, when it was estimated that consultants worked on average 10% more than they were contracted to do. LTFT consultants proportionally work even more above their contract (12%) than full-time consultants (9%).

Balance of PAs

Although there was no significant variation in the mean total number of PAs by nation, there were differences in the mean number of SPAs. Consultants in Wales were contracted to undertake a mean of 2.4 SPAs and worked the same number. In contrast, consultants in England were contracted for a mean of 1.8 SPAs and worked 2.1; in Scotland were contracted for 1.9 and worked 2.1; and in Northern Ireland were contracted for 2.0 and worked 2.2. Such differences may contribute to the generally higher levels of job satisfaction and lower levels of burnout for consultants in Wales. Furthermore, 30% of consultants in England reported having their SPAs reduced in the past 5 years, compared with 17% in Scotland, 17% in Wales and 24% in Northern Ireland. For 73% of consultants, this SPA reduction was with no reduction in total PAs worked.

Trainees

Full-time trainees were contracted to work an average of 44 hours, but estimated they worked a mean of 5.5 hours (13%) above this. LTFT trainees were contracted to work an average of 30 hours but estimated they worked a mean of 4 hours (13%) above this.

We asked trainees if they had submitted an exception report in the past year and 9% had – this was much more common in England where 10% had submitted exception reports compared with 5% in Wales and 2% in both Scotland and Northern Ireland. A creditable 67% said they had received feedback after submitting an exception report. However, 11% reported being discouraged from making an exception report.

The reasons given were:

- > they did not think it will make any difference (54%)
- > a consultant had discouraged them (46%)
- > it was too time consuming (34%)
- > they were not sure how to submit report at current workplace (33%)
- > an educational/clinical supervisor (21%) had discouraged them
- > a manager had discouraged them (18%)
- > a guardian of safe working had discouraged them (4%)
- > a college tutor had discouraged them (1%).

The European Working Time Directive specifies a maximum average 48-hour working week and by their estimates, many full-time consultants and trainees must be close to this limit.

Retirement plans

It is expected that 25% of the current consultant workforce will reach 65 years of age in the next 10 years, and 43% will reach 60 years of age.

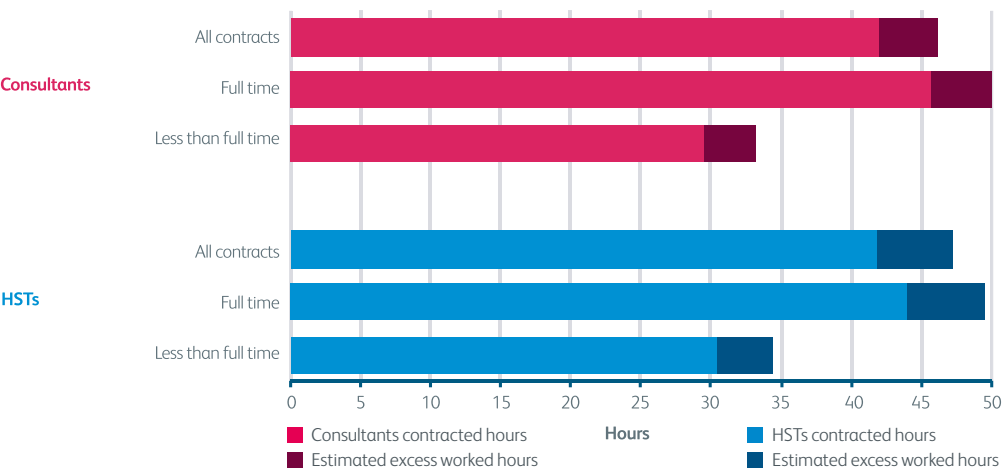
The mean reported age of planned retirement among consultants was 62.5 years (with a range of 60–66). Based on this, it is expected that 36% of the current consultant workforce will reach their intended retirement age in the next decade, so we need to ensure there are sufficient numbers of physicians in training to replace them.

Women again reported a slightly lower mean age of planned retirement (62 years) than men (63 years). There was some variation by specialty, such as a mean age of 61 years for palliative medicine and 66 years for allergy. The current age of consultants, LTFT working, GIM commitment and region of the UK had no influence on planned age of retirement.

Consultants who retired and returned to work comprised 4.9% of consultants completing the census and reported undertaking the following work:

- > outpatients 80%
- > care of specialty patients 37%
- > management 22%
- > specialty on call 20%
- > elective work 18%
- > unselected medical take 15%
- > care of GIM patients 15%.

Mean contracted and estimated worked time | Summary for consultants and HSTs



Get involved

To be more responsive to current issues, the RCP's Medical Workforce Unit (MWU) will undertake a series of further short surveys of representative portions of the consultant workforce during the year. Our aim is not to survey any consultant more than one additional time, and to publish online to provide quick, accurate and relevant data on the present issues affecting doctors. Please get involved!

For more census info, visit

www.rcplondon.ac.uk/census

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