



Royal College
of Physicians



Underfunded.
Underdoctored.
Overstretched.
The NHS in 2016.

Mission:
Health

Introduction

The NHS offers some of the highest-quality, most efficient and most accessible healthcare in the world. It tops the Commonwealth Fund ranking of world health systems¹ and heads up polls of what makes people proud to be British.² The UK has a long tradition of medical innovation,³ and continues to make groundbreaking medical discoveries that change the way we treat disease and care for patients. Our clinical guidelines are exported around the globe, and we attract international doctors with our world-renowned programmes of medical education and training.

That's a lot to be proud of. However, it's no excuse for complacency. The Royal College of Physicians (RCP) has long argued that we need to rethink the way we deliver healthcare: breaking down barriers between hospitals and the community, and working in partnership with patients to deliver joined-up care.⁴ To achieve this, we need a national health service that is funded to meet the needs of our growing population. Yet the NHS in 2016 is underfunded, underdoctored and overstretched.

The NHS needs a new plan – no more quick fixes or temporary solutions, but a plan designed to meet the UK's health and care needs in the long term. We need urgent action to address the immediate impact of an underfunded, underdoctored and overstretched NHS on patient safety and staff morale. As a bare minimum, patients and communities need an honest debate about the true choice that we face: increase funding or cut care. The RCP believes they deserve more than that: an NHS funded and staffed to meet their needs, now and in the future.

What does it mean for patients?

With the NHS now missing more than half of its targets, patients are already beginning to feel the impact of an underfunded, underdoctored, overstretched NHS every day of the week.

- > **Longer waits.** People are joining an ever-longer queue for treatment, with waiting lists at their longest since 2007. More people are waiting for longer than 4 hours in A&E than at any time since 2003/4.¹⁰
- > **Delays leaving hospital.** In 2015/16, patients spent more than 1.8 million extra days in hospital because of delays in their discharge. In March 2016 alone, that equated to 5,700 people who were in hospital not because they needed a hospital bed, but because they could not be discharged.¹⁰

> **Restricted access.** Clinical commissioning groups (CCGs) are making the news for considering 'rationing' care by restricting access to non-urgent operations and preventative drugs, such as statins.^{11,12}

> **Closed doors.** Reports of hospitals temporarily closing their doors owing to extreme pressure on beds and staff, usually associated with winter pressures, are now common throughout the year.¹³⁻¹⁶

These conditions put patient safety and recovery at risk every day. A truly 7-day health and care system will only be possible when we address the underlying and immediate threats to patient safety caused by insufficient investment in NHS finance and staffing.

In 2015/16, patients spent more than 1.8 million extra days in hospital because of delays in their discharge.

‘The principal cause of the deficit is the fact the funding has not kept pace with demand.’ King’s Fund²⁹

Underfunded

85% of physicians believe that current health funding is insufficient to meet rising demand for services. This demand increases by 4% every year⁵ but, in real terms, NHS funding will increase by only 0.2% per year to 2020.⁶ Cuts to the budgets of social care and public health services and recorded hospital deficits of £2.45 billion⁷ are already impacting on patient care: growing waiting lists, patients stuck in hospital because of discharge delays, emergency departments closing their doors, and the spectre of ‘rationing’ treatment.

Underdoctored

The UK does not train enough doctors. The number of medical students has fallen and there is a shortage of doctors training to be medical specialists. Seven out of ten doctors-in-training report working on a rota with a permanent gap.⁸ It has also had a knock-on effect on consultant physician posts, with hospitals failing to fill two out of every five posts they advertise.⁹ Nurse shortages have increased the pressure, with 96% of doctors-in-training reporting gaps in nursing rotas.⁸

Overstretched

NHS staff increasingly feel like collateral damage in the battle between rising demand and squeezed budgets. Four of five doctors-in-training report that their job causes them excessive stress; three-quarters go through at least one shift a month without drinking enough water; and, on average, they work an extra 5 weeks per year on top of their rostered hours.⁸ When NHS staff wellbeing suffers, patient safety and experience suffer too: 95% of doctors-in-training report that poor staff morale has a negative impact on patient safety in their hospital.⁸

Underfunded



85% of physicians believe that current health service funding is not sufficient to meet demand

Underdoctored



7/10 doctors-in-training work on a rota with a permanent gap

Overstretched



Doctors-in-training work an extra 5 weeks a year on top of rostered hours

Underfunded

As demand for health services continues to rise, NHS budget figures paint a bleak picture: increasing deficits, missed efficiency targets, short-term borrowing, and suspension of capital investment. More than eight out of ten doctors believe that current health service funding is not sufficient to meet demand.²⁶

The NHS in 2016 faces a stark choice:

- > accept a decline in quality and standards of patient care
- > reduce demand by restricting access to services and treatments
- > increase health funding.

Hospital activity is increasing

Over the past decade, the number of new admissions to acute hospitals has grown by 30%.⁵ Activity in our hospitals has grown even more: up 37% in the same 10-year period.^{27,a} However, patients in hospital today stay for an average of 2 days less than they did 10 years ago.²⁷ Because their stay in hospital is shorter, patients tend to be more acutely ill when they are in hospital: this means more intensive levels of care and higher workloads for staff.²⁷

In 2015/16, patients spent more than 1.8 million extra days in hospital because of delays in their discharge – an 11% increase on the previous year.¹⁰ Over three-quarters of NHS leaders believe that cuts to social care budgets have increased the length of time that older people spend in hospital.⁵ With local government – the main state providers of social care – predicting a social care funding gap of £4.3 billion by 2020, there is a very real risk that these costs are set to rise.²⁸

The number of hospitals in the red has increased

Hospital budgets are feeling the strain. In 2015, hospitals recorded a deficit of £2.45 billion. That's an all-time high, and three times higher than the previous year.²⁹ Once accounting adjustments and one-off savings are stripped away, the underlying deficit looks even worse, with some estimating it as high as £3.7 billion.³⁰ Only one area in England – Gloucestershire – reports a combined surplus for providers and commissioners.³¹ A £3.8 billion funding injection this year, and some increases to hospital payments, should help hospitals to balance the books – but at what long-term cost? The National Audit Office found that 'long-term investment plans have been set aside for the short-term goal of meeting day-to-day spending'.⁷ This means that investment in new buildings and new equipment is on hold. As the UK has some of the most intensively used MRI and CT scanners in the EU,³² this paints a worrying picture for the long term.

Why is demand for hospital care increasing?

- > **Our population is growing, and ageing.** The number of people aged over 60 is predicted to grow by 2% a year, compared with growth of 0.7% across the population as a whole.¹⁷ Older people often have more than one health condition and a complex range of support needs, such as frailty.
- > **There are more older people in hospital, and they stay for longer.** People aged over 85 spend 5 days longer in hospital than average.¹⁸ Older people in hospital often have complex care needs, like dementia, which can require more intensive support from health and care staff.
- > **Social care funding has been cut.** Social care has seen unprecedented funding cuts over the past 5 years, and the number of people receiving services fell by 29% in the 5 years to 2013/14.¹⁹ Too often, that means people do not have access to timely support to leave hospital, or to avoid hospital in the first place.
- > **The number of people with long-term conditions is rising.** One million more people will have three or more long-term conditions in 2018 than in 2008.²⁰ Spending on long-term conditions already accounts for £7 in every £10 spent by the NHS.²¹
- > **The cost of health harms is increasing.** Lots of illnesses could be prevented if we lived healthier lives. Obesity alone is predicted to cost the NHS one-third more by 2025.²²
- > **Funding for disease prevention is falling.** Investment in public health budgets will fall by £600 million by 2020/21.²³
- > **Drugs and treatments cost more.** Innovative new treatments come at a cost. New drugs, for example, are expected to cost the NHS 4.5% more in 2016 than they did in 2015.²⁴
- > **Our expectations are higher.** What we expect from the health service has evolved, whether that means higher standards of care, greater access to new treatments, or more information and involvement.²⁵

a Measured by 'finished consultant episodes'.

What do we need from the NHS budget?

To meet the needs of patients and communities, we need an NHS budget that:

- > **Meets the demand for health services.** In real terms, NHS funding will increase by only 0.2% a year to 2020.⁶ Activity is expected to increase by 3% a year.²⁷ This will cause a budget shortfall and thus a shortfall in care. Modelling suggests that an annual increase in funding of 3–6% in real terms would enable the NHS to meet increased demand.⁴²
- > **Sets realistic targets for efficiency savings.** Targets should be based on the best available evidence of what is achievable, rather than what is needed to close the gap between demand and existing budget commitments. Historical performance suggests that efficiency gains will be no greater than 1.5–2% per year.³⁶
- > **Protects funds for transformation.** Genuine service transformation will require upfront investment to free up staff and to facilitate running services in parallel to allow new models of delivery to embed. There must be realism about the extent to which transformation will save money in the short term: the evidence here is scant.⁴³ The overall NHS budget must be sufficient to protect funding for sustainability and transformation for this purpose, and not used to plug funding gaps. Analysis by the Nuffield Trust suggests that, even if the ambitious new 4% efficiency targets are met, providers will finish 2016/17 with an underlying deficit of £2.35 billion – swallowing up funds intended for service transformation.³⁰
- > **Invests in the long-term sustainability of the NHS.** Funding should enable phased investment in capital improvements, such as upgrading hospital equipment. National and local health and care expenditure should be planned so that the books balance across the system and in the long term. That includes adequate funding for social care and public health.

How have hospitals ended up here?

Tariff payments to hospitals have fallen by 1.6% every year for the past 6 years. Factoring in NHS inflation,^b that's a real cut of 3.8% per year in the face of a 4% annual increase in demand.^{10,30} To balance their books, hospitals would have needed to find efficiency savings of 4% – they managed around 2%, resulting in the deficit.³⁰ Clinical commissioning groups (CCGs) are already making the news for considering 'rationing' care by restricting access to non-urgent operations and preventative drugs, such as statins.^{11,12}

b NHS Improvement predicts health service inflation for 2016/17 of a fairly stable 3.1%.

c The EC has recently changed how these figures are calculated, with adjustments to include privately funded long-term care and publicly funded health-related social care. This increases the UK's total public and private healthcare spend to 9.9% of GDP in 2015. The King's Fund estimates that the public sector spend on healthcare for 2015 is 7.9%.⁶⁴

d At the start of 2016, growth in the UK's GDP between 2014/15 and 2020/21 was anticipated to be 15.2%, compared with growth in UK public spending on the NHS of 5.2% over the same period.

Funding has not kept up with demand

In 2015, NHS England estimated that, if no action was taken, the gap between demand for health services and NHS funding would leave a black hole of £30 billion by 2020/21.³³ In November 2015, the government committed to an £8.4 billion increase in NHS funding by 2020/21,⁷ with £3.8 billion front-loaded for 2016/17.

To bridge the remaining funding gap, NHS England set the health service a target of £22 billion in efficiency savings by 2020/21.³³ In July 2016, an even more ambitious efficiency target of 4% was set for 2016/17.³⁴ Is this achievable? Unlikely – it's at least double the 1.5–2% that trusts have achieved over recent years, and considerably higher than the average historical saving of 0.8% per year.³⁵ Lord Carter's comprehensive review of NHS productivity identified £5 billion-worth of savings that could be made across the NHS – that's some way short of the amount needed to close the funding gap.³⁶ It's likely to impact on patient care too – already in 2015, more than eight out of ten doctors believed that efficiency savings had had a negative impact on staff-to-patient ratios.²⁶

If these ambitious new 4% efficiency targets are met for 2016/17, analysis by the Nuffield Trust suggests that providers would still be left with an underlying deficit of £2.35 billion at year end.³⁰ Even if hospitals achieve efficiency savings of 3–4% every year to 2020/21, they will only balance the books in 2020/21 if they also 'slow the pace of activity growth by around one percentage point ... to 1.9%'. Missing the 3–4% efficiency target would mean that activity growth would need to be scaled back even further. NHS England estimates that around half (approximately 1.5%) of the growth in hospital activity is due to the additional demands placed on the NHS by a growing, ageing population.³⁷ If hospitals were to reduce their activity growth to below 1.5%, this would mean stemming the increase in activity attributable to population growth. To put that in human terms, this could 'effectively mean denying today's 74-year-olds the same hip replacements their 75-year-old neighbour received last year'.³⁰

Can we afford an increase in health spending?

The UK is experiencing 'the largest sustained fall in NHS spending as a share of GDP in any period since 1951'.³⁸ Once adjusted for inflation, spending on the NHS in England will increase by an average of 0.9% per year.³⁹ That's considerably below the 3.7% growth rate that the UK health service is used to.³⁸

However, the situation is graver still. Once adjusted for *NHS-specific* inflation, the real increase in NHS funding is just 0.2% per year.⁶ UK public spending on health is expected to fall from 7.3% of GDP in 2014/15 to 6.6% in 2020/21.^{40,c} This is likely to increase the gap between the UK and other major EU countries, such as Germany, Sweden and the Netherlands.⁴¹

Growth in health spending is also set to lag considerably behind growth in the UK's economy. At the start of 2016, the King's Fund calculated that, if health spending kept pace with the growth in the economy, by 2020/21 we would be spending £16 billion more than planned on the UK NHS.^{40,d}

Underdoctored

The UK has one doctor for every 360 people, compared with an EU average of one doctor for every 288 people.^{32,e} That's fewer doctors per 100,000 people than almost every other major EU country.^f Together with a shortage of nurses,⁴⁴ this has left our hospitals chronically understaffed. This increases pressure on hard-working NHS staff, puts patients at risk and threatens the future of the NHS. We need immediate action to relieve the current pressure on the NHS workforce, and a brave, coordinated plan to ensure that the NHS is staffed and sustainable in the long term.

Not enough doctors-in-training

The UK does not train enough doctors to meet demand. There are fewer medical students now than in 2010,⁴⁵ despite an increasing number of patients. The number of qualified doctors training to be medical specialists has also fallen,⁹ and in recent years there have been difficulties in filling significant numbers of specialty training posts.⁴⁶ This is in part due to the relatively high number of doctors in core medical training (CMT) who choose not to progress to specialty training and become medical registrars.⁴⁶ Another major factor is a mismatch between the number of doctors at CMT level and the number of specialty training posts: current CMT numbers would fill only around three-quarters of medical registrar posts. This leaves the NHS reliant on importing doctors from other countries and doctors returning from time out of training. The shortage of medical registrars increases the pressure on existing doctors-in-training, discourages core medical trainees from moving into these roles, and compromises patient care.

It also has a knock-on effect on more senior roles: hospitals are unable to recruit to two out of five consultant physician posts that they advertise, owing to a lack of suitable candidates. This failure to appoint is even higher for in-demand roles focused on caring for the acutely ill and older people.⁹ Despite the continuing increase in demand for experts in geriatric medicine, the number of training places for this specialty fell in 2015.⁹

The number of training posts, from medical school onwards, must be planned across the system. The announcement of an additional 5,000 GP training posts is welcome, but must not lead to shortages in specialist medical care. This can only be addressed if there is a coherent plan to increase the overall number of training places across medicine, from medical school onwards.

There are fewer medical students now than in 2010, despite an increasing number of patients.⁴⁵

e Calculated from 278 doctors per 100,000 population (UK) and 347 doctors per 100,000 population (EU average), based on data from 2013, the most recent year available.

f It is noted that such comparisons must be undertaken with caution because of differences in data collection and definitions.



Doctor numbers: NHS stress test

X Does the UK have as many doctors as other EU countries?

No. The UK has 278 doctors per 100,000 population, considerably less than the EU average of 347.³²

X Could hospitals cope with a fall in the number of doctors from outside the UK?

No. Doctors who qualified outside the UK account for two in every five hospital doctors, with nearly one in five qualifying elsewhere in the European Economic Area.^{53,9} This is more than any other major EU country.⁵⁴

X Are there enough medical school places?

No. Since 2010, the number of students entering undergraduate medicine has fallen by 3.6%.⁴⁵ This means that there will be little flexibility to cope with trainees who choose to leave medicine, increasing demand and other external pressures.

X Are enough doctors training to become specialists?

No. Not enough doctors-in-training choose to progress into specialty training, resulting in gaps in training programmes and vacancies in hospitals. The number of doctors training to be medical specialists fell by 2.3% in 2015.⁹

X Are there enough doctors-in-training to staff our hospitals?

No. Seven out of ten doctors-in-training report working on a rota with a permanent gap.⁸ This has led to excessive workloads, reliance on expensive agency staff and less time for training.

X Are there enough doctors to fill vacant consultant posts?

No. Between 2013 and 2015, the number of doctor vacancies increased by 60%.⁴⁷ Hospitals fail to recruit to two in every five advertised consultant physician posts, roles that hospitals desperately need.⁹

X Are there enough doctors to deliver consistent care across 7 days?

No. The majority of doctors already work at weekends,⁹ but the total number working on a given Saturday or Sunday is lower than during the week.⁵⁵ Delivering a *full* service across 7 days will require more doctors, and 7-day access to diagnostic and support services.

X Are workforce numbers sufficient to respond to changes in doctors' working lives?

No. An increasing number of doctors are working less than full time, and more are taking early retirement.⁹ This means that slight increases in workforce numbers are not enough to meet rising demand.⁵⁶

⁹ The term 'hospital doctors' is used here to refer to doctors on the GMC's specialist register, as opposed to the GP register.

Between 2013 and 2015, the number of doctor vacancies increased by 60%.⁴⁷

Shortage of doctors in our hospitals

A shortage of doctors-in-training, combined with growing workloads, means that there are no longer enough doctors to staff our hospitals safely. Between 2013 and 2015, the number of doctor vacancies increased by 60%.⁴⁷ Seven out of ten doctors-in-training now report working on a rota with a permanent gap. Over half of doctors-in-training report that rota gaps are having a serious or extremely serious impact on patient care.⁸

Hospital consultants tell a similar story. According to new, unpublished data from the 2015/16 consultant census, eight in ten consultants report gaps in the rotas of doctors-in-training; more than one in four report gaps so serious and frequent that they cause significant problems for patient safety. That's an increase since last year.⁹ These gaps are most common at the sharp end of medicine, where work cannot be cancelled or postponed: acute and general medicine.⁴⁶ An alarming 84% of consultants report gaps in these rotas.⁹ This situation is untenable for staff, for patients and for the NHS.

Hospitals' attempts to find 'workaround solutions' to staff shortages often result in quick fixes that are neither cost-effective nor sustainable:

- > **consultants 'acting down' into less senior roles.** Nearly half of consultants have been asked to 'act down' into less senior roles, with more than one in ten asked to do so regularly.⁹
- > **trainees 'acting up' into more senior roles.** More than one in ten doctors-in-training report that their trust does not have enough staff to ensure that patients are treated by someone with the appropriate level of clinical experience.⁴⁸
- > **doctors covering additional shifts.** This increases the risk of burnout and clinical errors, and squeezes out time for training.
- > **use of expensive agency staff.** The NHS's annual agency bill has hit £3.3 billion,⁴⁹ with general medicine representing 50% of spend on agency doctors.⁵⁰ Despite new caps in agency spending, 85% of core shifts and 56% of unsocial shifts exceed recommended levels.⁵¹

Lack of support

Nursing shortages take their toll on the workload of doctors-in-training and on patient care: nearly all trainees (96%) report that gaps in nursing rotas are having a negative impact on patient safety in their hospital.⁸ Pressures are made worse by falling numbers of support staff.²⁷ This, coupled with an increasing amount of paperwork, has left doctors-in-training overburdened by administrative tasks, to the detriment of patient care. Two in five doctors-in-training consider the administrative burden of their jobs to have a serious negative impact on patient safety in their hospital.⁸

Appropriate staffing levels across the team are essential, and enable hospitals to deliver more effective, efficient and patient-centred care. Innovative models of staffing, such as greater use of occupational therapists on wards that care for older people, should be promoted. Working alongside doctors, physician associates can also provide crucial support, such as taking patient histories or ordering and interpreting diagnostic tests.

Not so 'junior': The journey from medical student to consultant

- > **5 years at medical school.** After medical students complete their undergraduate medical degree, they enter postgraduate medical training.
- > **2 years of foundation training.** This is the first stage of postgraduate training. Now referred to as junior doctors, doctors-in-training or trainees, they work on rotations across the NHS, including in hospitals and GP practices.
- > **2 years of core medical training (CMT).^h** Trainees have made the choice to become a physician (rather than a GP, surgeon or other type of doctor). They do four to six rotations in different medical specialties.
- > **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 including cardiology and geriatric medicine. They take on increasingly senior roles, including as the medical registrar. At the end of specialty training,ⁱ doctors can apply for a consultant post.

^h Some medical trainees take a different route and enter the acute care common stem (ACCS), which combines three years of acute medicine, critical care, anaesthetics and emergency medicine.

ⁱ Many trainees spend valuable additional years doing academic research, participating in leadership programmes or gaining experience in other countries. This increases the overall length of training time.

Short-term thinking

To cope with the shortage of doctors-in-training, the NHS has become increasingly reliant on doctors who qualified outside the UK.⁵² Doctors from outside the UK account for two in every five hospital doctors, with nearly one in five qualifying elsewhere in the European Economic Area.^{53,9} This is one of the highest levels of any OECD country, and higher than any other major EU country.^{27,54} This leaves the NHS vulnerable to the potential impact of the Brexit vote and changes to immigration rules.

An increasing reliance on older doctors⁵² is also problematic, with an increasing number of doctors taking early retirement.⁹ This is already a major issue for the GP workforce, which has lost large numbers of experienced and skilled staff. We must take urgent action to avoid this pattern repeating itself in hospital medicine. Flexible models of working, including in acute and general medicine, are also crucial if the system is to respond effectively to the growing proportion of doctors who work less than full time.⁹ Two out of five (40%) women in consultant posts work less than full time, compared with only 4% of their male counterparts.⁹ As the proportion of women in the medical workforce increases, training numbers must be sufficient to support the growing number of less-than-full-time posts.

We need joined-up action across government if we are to address the workforce challenges facing the NHS. The Department of Health, Treasury, Home Office, Department for Exiting the European Union, and Department for Work and Pensions need to work together with the healthcare professions and NHS organisations to find immediate and long-term solutions. Migration rules and plans for exiting the EU must enable staff from outside the UK to work in the NHS; pension rules should not disadvantage doctors for staying longer in the NHS; and medical school and medical careers should be accessible across society.

Doctors from outside the UK account for two in every five hospital doctors ...

Urgent action is needed to:

- > **ensure that overall training numbers are sufficient to deliver enough doctors across all parts of the medical workforce, from GPs to physicians**
- > **realign the workload balance across the medical workforce, and find innovative ways to incentivise work in acute and general medicine**
- > **address nurse shortages and promote innovative models of staffing, such as physician associates working alongside doctors**
- > **relieve immediate pressure on the NHS workforce, and to deliver a sustainable NHS staffing model in the long term.**

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^g The term 'hospital doctors' is used here to refer to doctors on the GMC's specialist register, as opposed to the GP register.

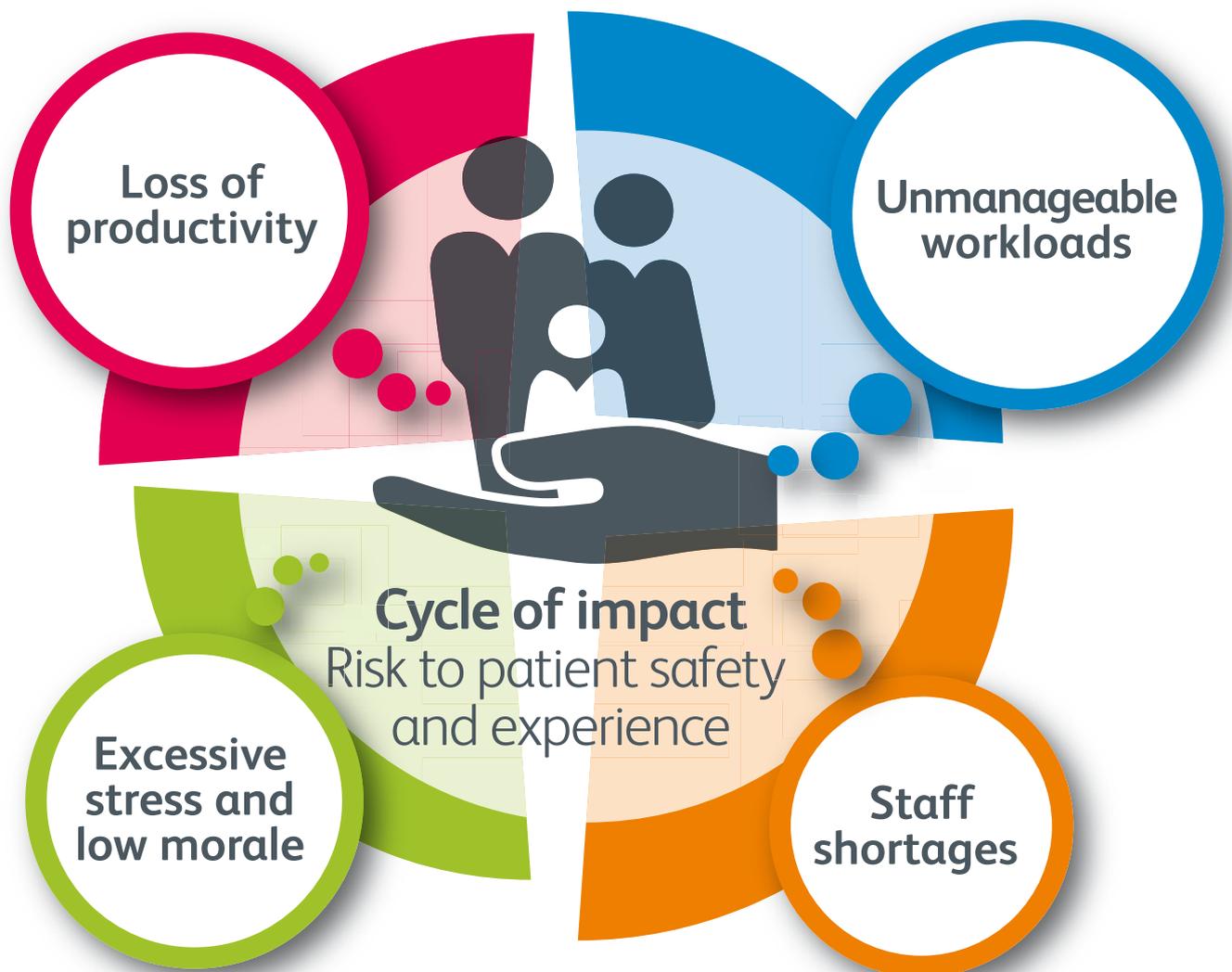
Overstretched

Doctors and their teams are feeling the pressure and reporting excessive stress,⁸ increased sickness rates among physicians and high dropout rates from medicine.⁵⁶ That's bad for the medical profession and the long-term viability of the NHS. It's also bad for patients. Excessive stress and low morale are red flags for patient safety; we need to prioritise them, and take urgent, preventative action when they are threatened.

Increasing workloads

Being a doctor is intense, rewarding and challenging. More than four out of ten doctors-in-training report a heavy or very heavy workload,⁴⁸ and 91% of physicians report that their workloads have increased over the past 5 years.²⁶ Often it is those working in the most intense and challenging roles – such as general medicine – who have experienced the biggest increase in workload.⁴⁶ Medical registrars^j in particular have been squeezed by increasing workloads,

staff shortages, lack of time for training, and patients with increasingly complex combinations of problems.⁵⁷ Doctors regularly work longer than their contracted hours. This has long been a trend for consultants, who continue to put in extra time despite a slight increase in the number of hours that they are contracted to work.⁹ Similarly, six out of ten doctors-in-training work longer than their rostered hours on a daily or weekly basis.⁴⁸ On average, speciality trainees work an extra 5 hours per week.⁹ That's equivalent to each trainee working an extra 5 weeks every year.^k



^j Doctors at the start of their higher speciality training.

^k An extra 5 hours per week (43 hours rostered compared with 48 hours worked) across a 46-week working year (taking account of 30 days of annual leave).⁹

Poor working conditions lead to doctors feeling undervalued and disengaged.

Falling morale

In these circumstances, it's little surprise that one-quarter of doctors-in-training report that their working pattern leaves them feeling short of sleep on a daily or weekly basis.⁴⁸ Yet, despite compelling evidence showing the benefits to patient safety,⁵⁸ many doctors are actively discouraged from taking naps during night shifts.⁵⁹ Three-quarters (74%) of doctors-in-training go through at least one shift per month with insufficient hydration, and over one-third (37%) do not drink enough water on seven shifts per month.⁸ Over one-quarter (28%) have worked four shifts per month without a meal, while over half (56%) have worked at least one shift per month without a meal.⁸

Poor working conditions lead to doctors feeling undervalued and disengaged, and contribute to workplace stress. Four out of five doctors-in-training report that their job often or sometimes causes them excessive stress,⁸ and half of consultants report working under excessive pressure.⁹

Falling productivity

It's little wonder, then, that we are seeing increased sickness rates among physicians.⁵⁶ That's bad for the NHS, which lost 15.7 million days to sickness absence in 2015.⁶⁰ Two out of every five doctors have considered taking leave owing to work pressures, while one-third (36%) have seriously considered reducing their hours. One-third have also considered leaving medicine for another career,⁶¹ and we are seeing an increasing number of doctors taking early retirement.⁹

Seeing more senior colleagues under pressure discourages the next generation of consultants: for eight out of ten doctors-in-training, the lack of work-life balance for medical registrars is a deterrent to pursuing a career in medicine.⁵⁷

Falling recruitment figures

Against this backdrop, it is no surprise that hospitals find it particularly difficult to recruit to jobs at the front line of hospitals, resulting in significant shortages for 'generalist' posts caring for those with urgent healthcare needs.⁶² This is a vicious circle: fewer doctors choosing to work in general medicine increases the workload for those who do, leading to a poorer trainee experience and more challenging working conditions.

Only half of trainees are satisfied with their posts in general medicine.⁶³ Yet general medicine is at the core of what it is to be a physician, and can be the most intellectually stimulating and rewarding part of the job. It is also what the future demographic of patients – with increasingly complex, multiple conditions – need. We must think radically and long term, invest in our trainees, and strive to achieve the holistic model of medicine set out by the Future Hospital Commission.⁴

Falling patient safety and experience

Poor staff wellbeing and morale threaten patient care: 95% of doctors-in-training report that poor morale is having a negative impact on patient safety in their hospital, with half reporting a serious or extremely serious impact.⁸ Engaged doctors make fewer mistakes, and better staff wellbeing is associated with lower death and MRSA infection rates.⁶⁰ When staff wellbeing suffers, patient satisfaction and experience suffer too: NHS organisations with 'poor' staff health and wellbeing are, on average, among the 25% worst performers in patient satisfaction reviews.⁶⁰ We need to start prioritising staff wellbeing and engagement as red flags for patient safety, taking urgent, preventative action when they are threatened. ■

About the RCP

The RCP aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 32,000 members worldwide work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Get involved

The RCP provides expert advice to government, national organisations and policymakers. We are always keen to hear about examples of good practice, and suggestions of how we can address the challenges faced by hospitals and the wider NHS. Join the debate and help shape the future of health, healthcare and the NHS.

For report references, and more info, visit
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Social media
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Facebook: @RCPLondon

Time for action

The NHS in 2016 is underfunded, underdoctored and overstretched. Patients and communities deserve to know the true choice that we face: increase funding or cut care. The RCP believes they deserve more than that: an NHS funded and staffed to meet their needs, now and in the future. The NHS in 2016 needs a new plan – a plan designed to meet the UK's health and care needs in the long term, and to value, support and motivate NHS staff.

Increase NHS funding

The NHS budget has not kept pace with rising demand for services. We need a new NHS budget that:

- > meets the demand for health services
- > sets realistic targets for efficiency savings
- > protects funds for transformation
- > invests in the long-term sustainability of the NHS.

Train more doctors

The UK does not train enough doctors. Hospital teams are feeling the pressure of staffing gaps. That's bad for them, and it's bad for patients. We need to:

- > ensure that overall training numbers are sufficient to deliver enough doctors across all parts of the medical workforce, from GPs to physicians
- > realign the workload balance across the medical workforce, and find innovative ways to incentivise work in acute and general medicine

- > address nurse shortages and promote innovative models of staffing, such as physician associates working alongside doctors
- > take cross-governmental action to relieve immediate pressure on the NHS workforce, and to deliver a sustainable NHS staffing model in the long term.

Improve the working lives of NHS staff

Being a doctor is intense, rewarding and challenging. A valued workforce delivers better outcomes for patients. In late 2016, the RCP will launch a new campaign to value and support doctors working in the NHS. We will:

- > work with our member doctors to find new solutions to workforce pressures
- > push for action from across government and the NHS
- > showcase the very best of medicine.

