Written evidence submitted by The Royal College of Physicians (EPW0031)

The RCP welcomes the opportunity to provide evidence to the Expert Panel's evaluation of the progress the Government has made against its commitments in the area of the health and social care workforce in England. This submission is informed by the data we collect from our members via our annual census and other surveys, consultation with our committees representing physicians at all stages of their career, and data collected by partner organisations.

Planning for the workforce

1. The government has committed to ensuring that the NHS and social care system has the health profession that it needs, but it declined to accept an amendment to the Health and Care Act for regular assessments of workforce numbers needed to meet projected demand for services in the future. Without such assessments it is impossible to say whether the NHS has the workforce it needs in terms of size, make-up or location.

2. The government has access to a wealth of data that could be used to make assessments. For example, we know from the Office for National Statistics that by 2041 over a quarter of the population will be aged 65 and over, and 4% will be 85 and over. We also know from the Office for Budget Responsibility that, as someone gets older, their demand for health and care services increases. So even without a formal independent workforce assessment we can make a reasonable assumption that demand will continue to grow.

3. We of course know that it has grown significantly. Between 2003/4 and 2015/16, the number of attendances at major A&Es increased by 18 per cent, from 12.7 million to 15 million. Nearly a third of the overall increase took place in 2014/15 and 2015/16. Between 2008/9 and 2018/19 GP referrals grew from 10.6 million to 13.75 million. Elective admissions grew from around 6.7 million to 8.5 million. Non-elective admissions grew from just over 5 million to 6.6 million.

4. Since 2009, the number of patients waiting to start consultant-led elective treatment has grown from under 2.5 million to over 6 million. The number of people waiting more than two months from urgent GP referral to first treatment for cancer has grown from around 15% to over 30%, with the waiting time target met in only one month in 7.5 years. Despite fluctuations, patients waiting for more than four hours to be admitted after the decision to admit has steadily grown from around 10,000 is April 2012 to almost 120,000 in December 2021.

5. Recently the government has often repeated that there are more doctors than ever working in the NHS. This is superficially true, but tells us nothing about whether that supply is large enough

or we have the right mix of skills to meet demand. We also have record levels of adult and childhood obesity, the proportion of the population aged 65 years and over and the gap in healthy life expectancy between the richest and poorest people.

6. As the country ages, the consultant workforce is ageing, and we haven't planned for that by training enough new doctors to replace the old. The mean intended age of retirement is 62.4 years and 49% of consultants will reach that in the next 10 years. In our 2020 census, 11% said they had retired but returned to work, 53% of them less than full time.

7. The consultant workforce is also changing and desiring greater flexibility – the proportion working less than full time has steadily increased from 10% in 2004 to 24% today. In the 11th of our series of COVID-19 workforce impact surveys, over half (56%) said they wanted the shift towards more remote and flexible working to become the norm. The same proportion of trainees said that they would be interested in working less than full time (LTFT).

8. Staffing shortages were seen as the key block to the desire for more flexibility. Of those wanting to work more flexibly, over a third (36%) thought it would be difficult or impossible – 79% of them cited 'not enough medical staff' as a barrier. 59% thought their department would support a request to work more flexibly, with 41% saying their department wouldn't. Of those who thought their department would not support such a request, the key issue was again workforce pressures with over two thirds (76%) citing not enough medical staff.

9. Overall, our census shows that 62% of consultants are men and 38% women, with 24% working LTFT. Among those aged 50 and over, the proportion is 70% and 30% women, with 22% working LTFT. Among those aged 49 and under, it's 53%/47% and 23%. And among those aged 34 or under, it's 48% men, 52% women and 13% working less than full time.

10. The proportion of women in the workforce is therefore steadily increasing, overtaking the number of men. While both men and women by far work full time until they reach their mid-30s, things then diverge. Among those aged 35-44 years, 43% of women work less than full time but only 4% of men. Coupled with the growing proportion of women consultants, this means we need to train many more doctors than the number of full time equivalent doctors we will need in the future.

11. The commitment to increase the number of medical school places by 1,500 has been met. In addition, in August 2021 the Department for Education announced funding for up to another 9,000 medical and dentistry places, dependent on university capacity. The government has said

that places will return to pre-pandemic levels of around 9,300 per year, although the target intake for 2022-23 remains at just over 7,500. The confirmed total intake for 2020-21 was 10,461 and for 2021-22 it was 10,543.

12. Even in the absence of a government assessment, we know the number of medical school places is still too low. In 2018 the RCP estimated that the number of places needed to be doubled, following it up with a blueprint for an expansion in 2021. In 2019 the Royal College of Psychiatrists also called for the number of places to be doubled. In July 2021 the BMA called staffing shortages 'chronic' and called for 'sufficient medical school, foundation programme and training places'. And in October 2021, the Medical Schools Council recommended that the number of medical school places be increased by 5,000 to 14,500 graduating per year.

13. Increasing medical school places will only have an impact in the long term, as it can take up to 13 years to train a physician. In the meantime, the RCP annual census of consultant physicians and higher specialist trainees (HST) consistently finds a large proportion of advertised consultant posts go unfilled – 48% in 2020, 43% in 2019 and similar in 2018 (but the number of posts advertised dropped by a third). This is mostly due to a lack of suitable applicants. The result is that, in 2020, consultants estimated that they worked 11% more than they were contracted to work, mainly due to their clinical workload. When asked, most say they do not want to work fewer hours, but they do want time away from direct clinical care to pursue research, teaching, quality improvement and more.

Building a skilled workforce

14. The lack of staff compared to demand creates a situation in which many individuals and organisations struggle to find time for anything other than direct clinical care. Research, quality improvement, education and training all suffer.

15. For example, if we are to successfully integrate care and provide more of it in the community, doctors need to develop new skills and new relationships. This year we have been working with social care professionals to identify how we can help to improve the working relationship between the professions. While we expected the solution to be quite technical, in terms of care pathways, the overriding factor is mutual understanding. That is developed by working together, but the current pressure means this does not happen nearly as much as it should.

16. As medical school places are increased, it is important that we also increase the pool of clinical academics and educators. In our 2021 blueprint for an expansion, we said that the NHS needed

to address the challenges and opportunities facing the clinical academic workforce in the people plan. That needs to include year-on-year growth and the development of clear clinical academic career pathways to create a sustainable pipeline to meet future demand.

17. Clinical academics undertake the vast majority of work to develop and deliver the curricula and support students through medical school. Clinical academics also make a vital and world-leading contribution to research (as demonstrated in the academic endeavour to address the current COVID-19 pandemic) and are a crucial element of the workforce. Despite this, the BMA showed in its 2021 report that over the past 10 years the senior clinical academic workforce reduced by 27% while the number of medical students grew by more than 25%.

18. In terms of Physician Associates (PA), we are concerned that the placement tariff is not sufficient. While medical students attract a tariff of £30,750 plus market forces factor (MFF) per student, for a PA student it is just £5,000 (plus MFF) per FTE as they are on the clinical tariff. While there is a difference between PA and medical students, PAs are still supervised by a consultant. This discrepancy militates against the provision of placements for PA students. This is another result of the lack of comprehensive planning.

Wellbeing at work

19. The wellbeing of the NHS workforce – or any workforce – is inextricably linked to working conditions. Consultants and trainees consistently tell us that morale is low and continues to fall, with the main reason being their clinical workload.

20. We refer the panel to our previous evidence to the Committee's inquiry on *Workforce burnout and resilience in the NHS and social care*. We said that

    a. just before the pandemic we surveyed members and found that

        i. 43% were never or only sometimes in control of their workload
        ii. 49% described their workload as excessive always or most of the time
        iii. 47% worked excessive hours always or most of the time
        iv. 49% said morale was worse than a year ago and only 12% that it had improved.

    b. based on the Maslach Burnout Inventory, women and consultants of white ethnicity appeared at higher burnout risk than men and consultants from black, Asian and minority ethnic backgrounds; working less than full time carried a lower burnout risk;

and consultants who were disabled or had a long-term health condition had a higher burnout risk

c. mental wellbeing scores using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) showed that consultant physicians had lower (worse) mean scores (men 47.5, women 46.2) than the background UK population (men 50.1, women 49.6).

21. Key findings of our 2020 census included:

    a. 36% of consultants described being in control of their workload only 'sometimes' or 'almost never'. 38% said that they worked excessive hours or had an excessive workload 'almost always' or 'most of the time'.
    b. 35% of consultants had experienced being undermined and 35% had witnessed a colleague being undermined, usually by managers or fellow consultants. This was more common among women and consultants from an ethnic minority.
    c. 55% of consultants reported that their morale was worse during the pandemic and only 5% reported that it was better. 69% reported that morale was worse in their department and only 4% reported that it was better.

22. In 2019 we asked about bullying, but consultants said that what they often experienced was more accurately described as feeling undermined. We altered the census to better reflect their concerns, finding that 35% of consultants reported feeling undermined at work, usually by a manager (62%) or a fellow consultant (57%). The same proportion had witnessed a colleague (usually other consultants) being undermined by consultants or managers. Women consultants were more likely to report feeling undermined (40%) or witnessing undermining (39%) than men (31% and 32%). This was more common among consultants aged 40–44 (40% and 37%) and less common among consultants aged 60–65 (24% and 27%). Experiencing or witnessing undermining was also more common among consultants from an ethnic minority background (38% and 38%) than among consultants of white ethnic origin (33% and 34%). While we are going to explore this situation in greater detail, we feel it is likely that working in a pressurised environment is a significant factor in how people treat each other.

23. A 2020 GMC survey – reported in Completing the picture – views of doctors who have stopped practising in the UK, why they left and what might encourage them to return (October 2021) – found that many doctors were motivated to leave the NHS by workplace issues, including dissatisfaction (36%), burnout (27%) and bullying (5.5%). Other headline findings were

a. doctors with some protected characteristics were more likely to include certain negative reasons for leaving: disabled doctors were more likely to report bullying as a factor, BME doctors and some religious groups reported higher levels of bullying and harassment, and LGBT doctors more commonly reported mental health issues
b. more than half (55%) of doctors who had left UK practice were still working clinically abroad.

24. The GMC 2021 national training survey [PDF] found that

    a. a third of trainees and a quarter of secondary care trainers felt burnt out to a high/very high degree because of their work
    b. 60% of trainees and 50% of secondary care trainers always or often felt worn out at the end of the working day
    c. 15% of trainees and 11% of trainers were at high risk of burnout
    d. yet 81% of trainees agreed that their working environment was fully supportive and 78% of secondary care trainers said their trust, board or practice was fully supportive.

25. Given that the majority of trainees and trainers report that they feel supported, it is difficult not to conclude that how they feel is a result of the workload. Providing direct clinical care is always a stressful job, and with demand high and growing in relation to doctor supply, that pressure will grow. While this is of course concerning in terms of the impact on the health of doctors, of great concern is its impact on patient safety. As many studies have shown, there is an inverse relationship between clinician burnout and patient safety.

26. In terms of new services for NHS employees, the mental health and wellbeing hubs are in place. We are aware the NHS is collecting feedback on them. In addition, during the first wave of the pandemic, many hospitals put wellbeing facilities in place to support staff. But we have since visited many where doctors say they have either now been withdrawn or radically scaled down.

27. While NHS England and trusts may make efforts to provide mental health services for staff, they also have to focus on providing direct clinical care as the first priority. We often hear from members that they are offered wellbeing or yoga classes for free, but to be attended in their own time. When consultants are working on average 11% more than they are contracted for, that is simply not enough.

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