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Working differently in the shadow of COVID-19: the 2021 UK census of consultant, higher specialty trainee and SAS physicians

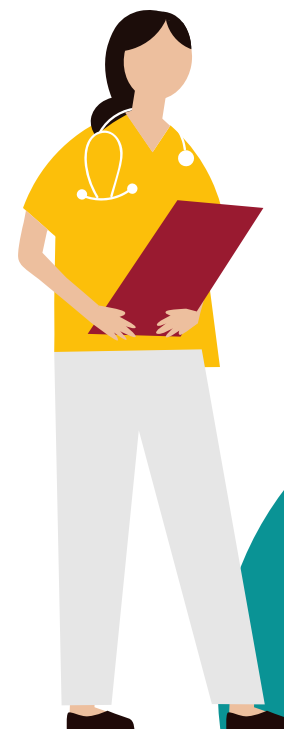
Produced by the RCP Medical Workforce Unit

Key findings

Each year the Medical Workforce Unit of the Royal College of Physicians (RCP) conducts a census on behalf of the RCP, the Royal College of Physicians of Edinburgh (RCPE) and the Royal College of Physicians and Surgeons of Glasgow (RCPSG). The aim is to provide robust data on the state of the consultant and higher specialty trainee (HST) physician workforce in the UK to highlight gaps and trends and support workforce planning. From this year the census also includes staff, associate specialist and specialty (SAS) doctors.

The census results for 2021 reflect a workforce emerging from a life-changing pandemic which will be remembered for the rest of every physician's career. The way in which doctors want to work – and indeed are working – was already significantly different from just 10 years ago, but change has been accelerated by the response to COVID-19.

The demands on the physician workforce are increasing in an unsustainable way. Now more than ever, it is vital that we adapt and innovate in order to retain these doctors within the NHS. However, our efforts will continue to be hampered by a lack of workforce planning that takes into account demand to inform the number of clinicians needed.



Key findings

Only

48%

of advertised posts were filled. This has decreased year on year, and is the lowest rate recorded to date



Full-time consultants worked

10%

more than their contracted hours

While those working less than full time worked

20%

more than their contracted hours, mainly due to clinical workload

Contract



20%

of the current consultant workforce will have reached their intended retirement age by 2025

74%

of consultant and SAS physicians said they undertook some work remotely



More than half

of physicians did not take all of their annual leave entitlement



Next steps

We will continue to:

- 

1 use the census data in our discussions with government about the need for accountability and transparency in workforce planning
- 

2 work with governments across the UK and our partners to double the number of medical school places, and increase the number of training posts
- 

3 work with the NHS across the UK to help develop the workforce strategy commissioned by the secretary of state for health and social care
- 

4 highlight the urgent need for transparent job planning and scrutiny of the amount of work that goes unpaid
- 

5 identify and promote ways of encouraging trainees to work in specialties and locations with the largest recruitment gaps
- 

6 make the case for the UK to be accessible and welcoming to trainees and doctors from other countries.



We will also develop the census and our data collection and presentation so that we:

- > have a picture of the medical workforce by NHS trust / health board
- > increase the number of doctors participating in the census
- > improve our understanding of specialty-specific workforce challenges
- > improve our understanding of the SAS doctor workforce
- > better understand the role of research in a physician's career.

Methodology

We sent the census questionnaire to 18,646 consultants and 746 SAS doctors currently working in the UK. For the first time we included SAS doctors in the census. This initial SAS group was identified through RCP, RCPE and RCPSG membership databases. We will make efforts to reach out to more SAS doctors in future census data collection.

The demographic data we hold about consultants are virtually complete by undertaking a data verification exercise with the General Medical Council (GMC), and the other data in the report are based on responses to this year's survey. The consultant response rate was 23 %, which has declined over the past few years (2020: 24 %). We were pleased with the response rate of 38 % for SAS doctors, given our new focus on them this year. We want to increase this in order to build the same picture of SAS doctors that we have of consultants and HSTs, particularly in terms of demographics. In this report, we have combined the responses of consultant and SAS doctors unless otherwise stated.

The higher specialty trainee (HST) census was sent to all 7,545 HSTs in year 3 (ST3) and above registered with the Joint Royal College of Physicians Training Board (JRCPTB). The response rate was 14 %, which was much lower than in previous years.

We compared the profile of consultants who responded to the census with the profile of all consultants and found that:

- > they were representative of region, age and specialty
- > women were over-represented: 45 % of respondents compared with 39 % of the workforce
- > consultants from an ethnic minority were under-represented: 25 % of respondents compared with 36 % of the workforce
- > those who graduated outside of the UK were under-represented: 18 % of respondents compared with 24 % of the workforce.

In the HST census data:

- > men from an ethnic minority were under-represented: 19 % of respondents compared with 24 % in the overall workforce
- > White women were over-represented: 38 % of respondents compared with 32 % of the workforce.

In the SAS census data (based only on responses):

- > women made up 52 % of respondents
- > the mean age of SAS doctors was 49 years.

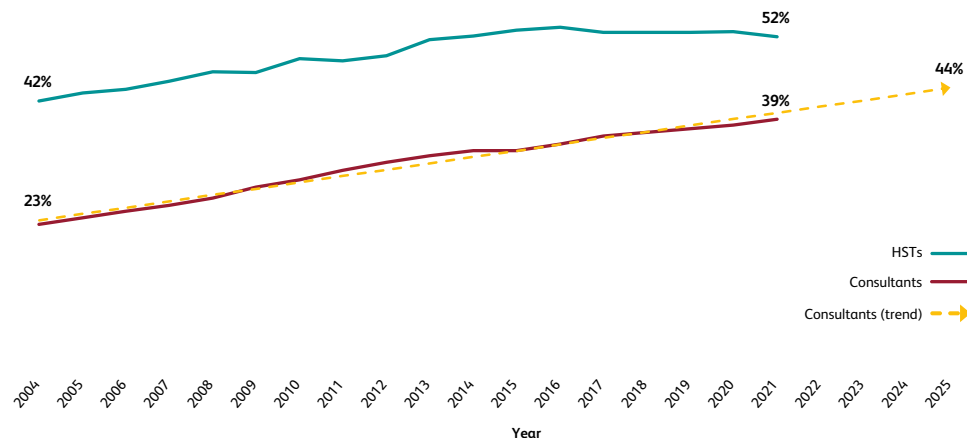


Physician demographics

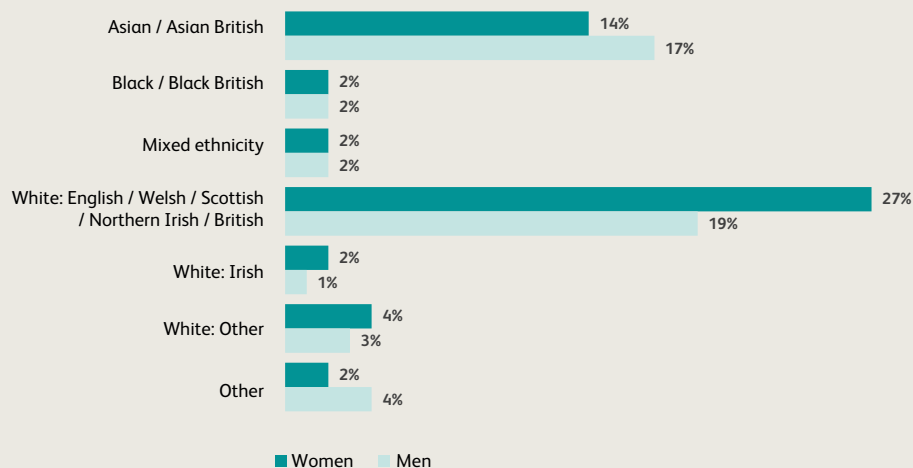
The majority of trainees and consultants were White British men (19 % HSTs; 28 % consultants), followed by White British women (27 % HSTs; 23 % consultants) and then British Asian men (17 % HSTs; 20 % consultants). Women made up 52 % of the HST workforce and 39 % of the consultant workforce.

Women have increased in the consultant workforce year-on-year and have made up more than half of the HST workforce since 2013. Appreciation of this change and differences in the way women may choose to work throughout their careers is critical for workforce planning.

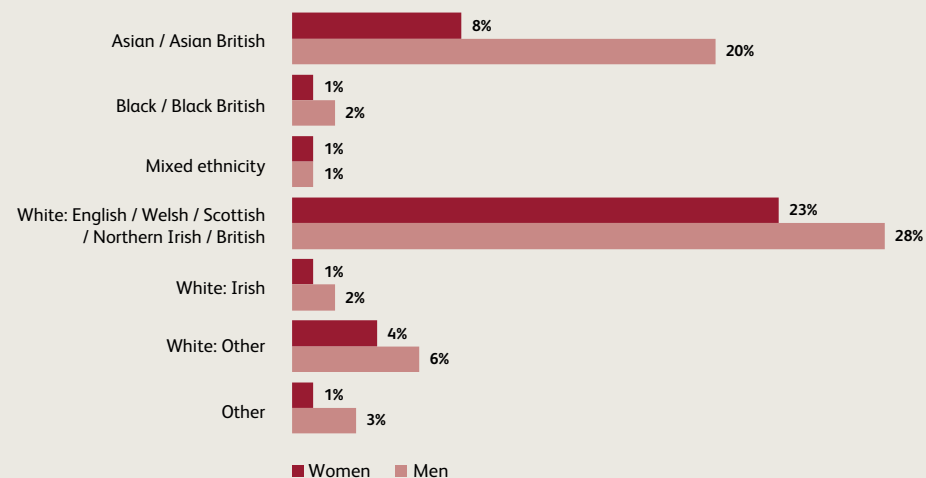
Women in the workforce over time



Sex and ethnicity of HSTs



Sex and ethnicity of consultants

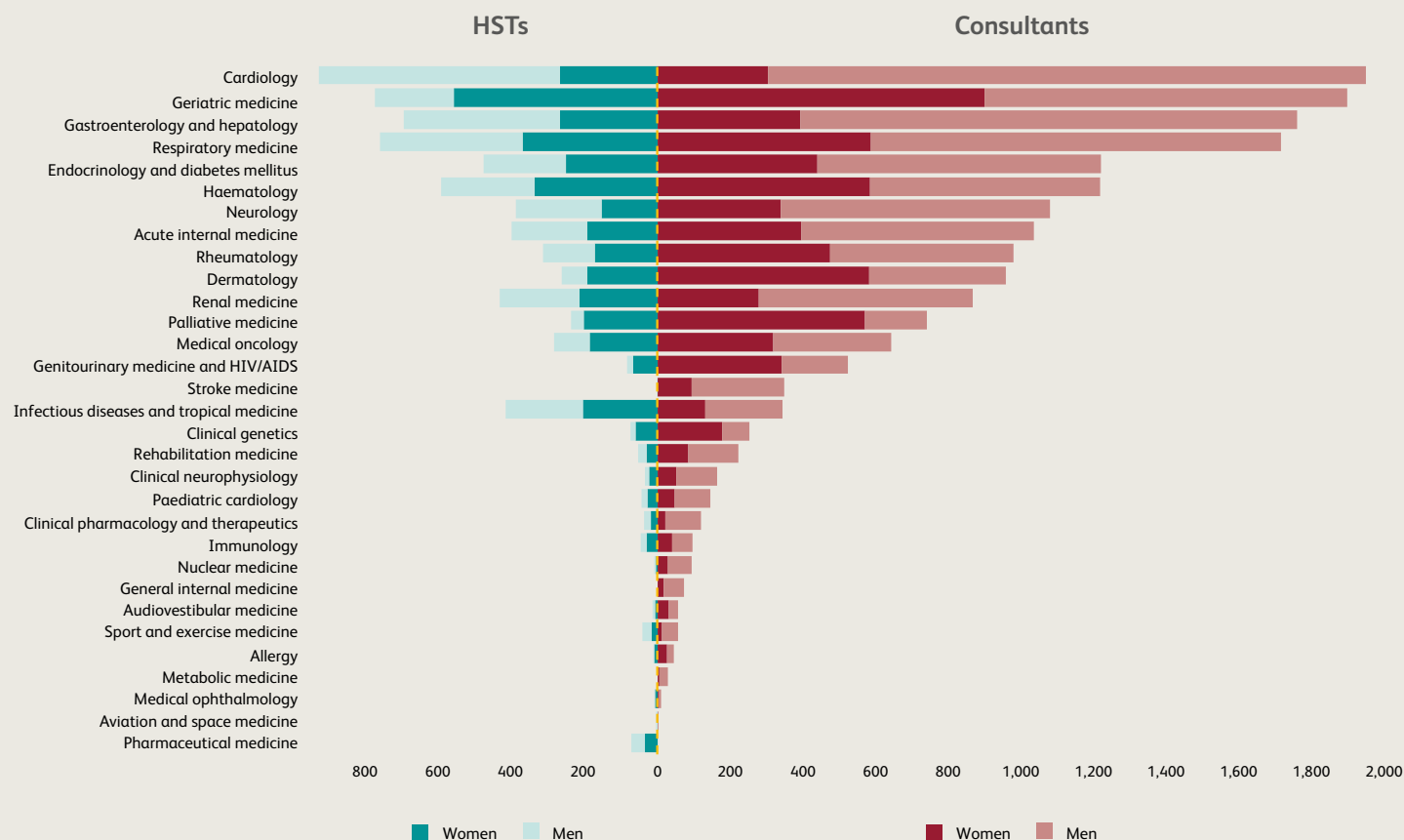


Specialties

Cardiology, geriatric medicine, respiratory medicine, and gastroenterology and hepatology remained the largest specialties for both HSTs and consultants. Each of these specialties employed 1,500–2,000 doctors.

Among consultants, only 16 % of cardiologists and 22 % of gastroenterologists were women. Women were better represented among HSTs in these specialties, making up 29 % in cardiology, and 39 % in gastroenterology and hepatology.

Consultants vs HSTs – by specialty and sex



Location

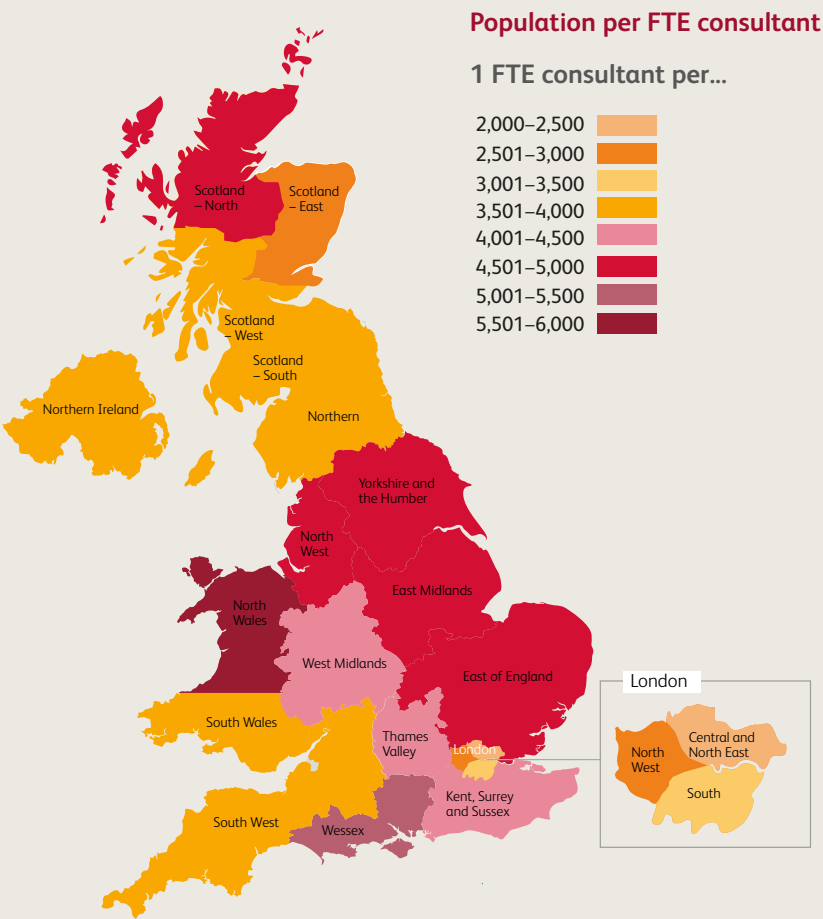
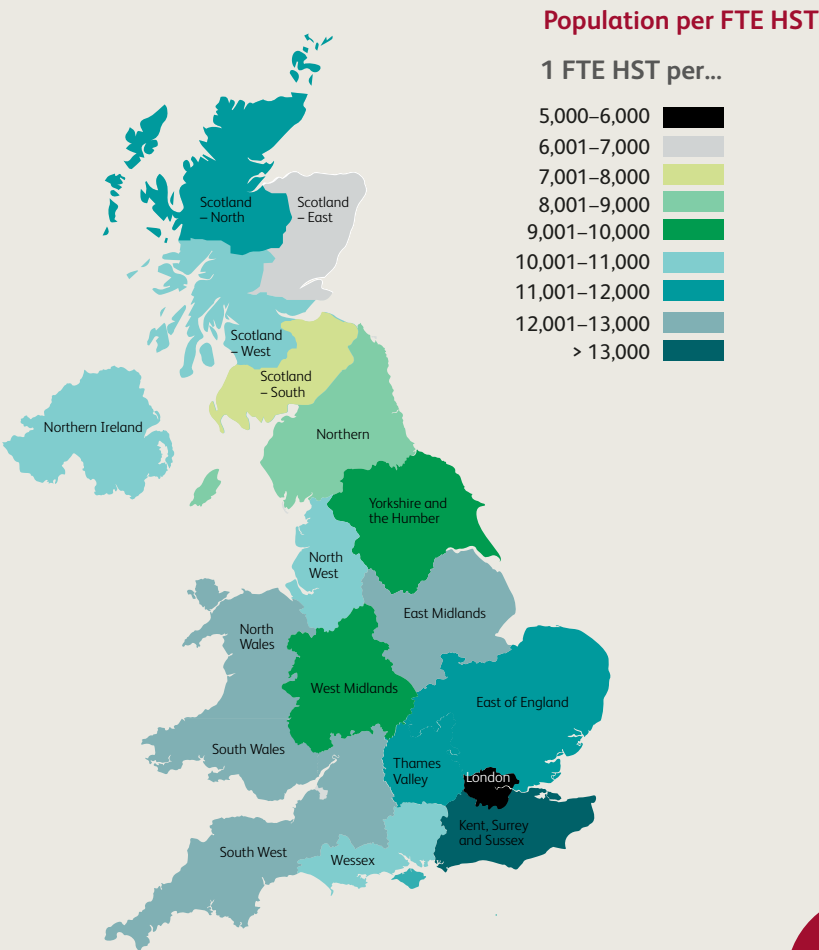
84 %

of all consultants and HSTs worked in England, 3% in Northern Ireland, 8% in Scotland and 4% in Wales

Consultant physicians were not distributed equitably across the UK according to the population. The overall number of full-time equivalent (FTE)* consultants in the UK was one per 3,847 people.** North Wales had the fewest number of FTE consultants per person, one to every 5,522 people. London had the largest number: one consultant to every 2,654 people (although this masks huge variation across the capital).

*based on a 10 programmed activity (PA) contract

**calculated from 2020 mid-year population estimates from the Office of National Statistics



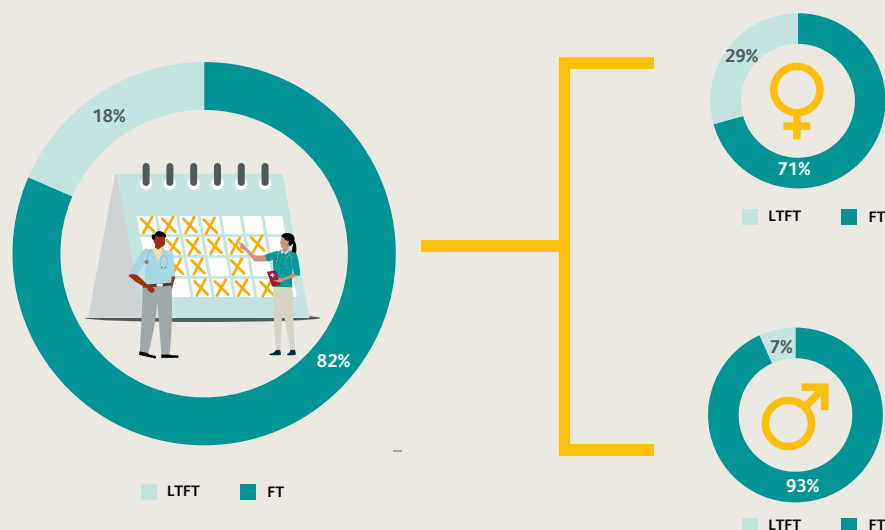
Employing organisations

A total of 83 % of consultants were employed solely by the NHS, compared with 13 % who also had an academic contract and 4 % who were also employed by another type of organisation. Proportionally fewer women had an academic contract (10 % of women compared with 15 % of men). But women were more likely to work for two institutions, for example, 6 % of women worked in a hospital and a hospice or community clinic (compared with 3 % of men). This reflects the number of women working in palliative care and genitourinary medicine.

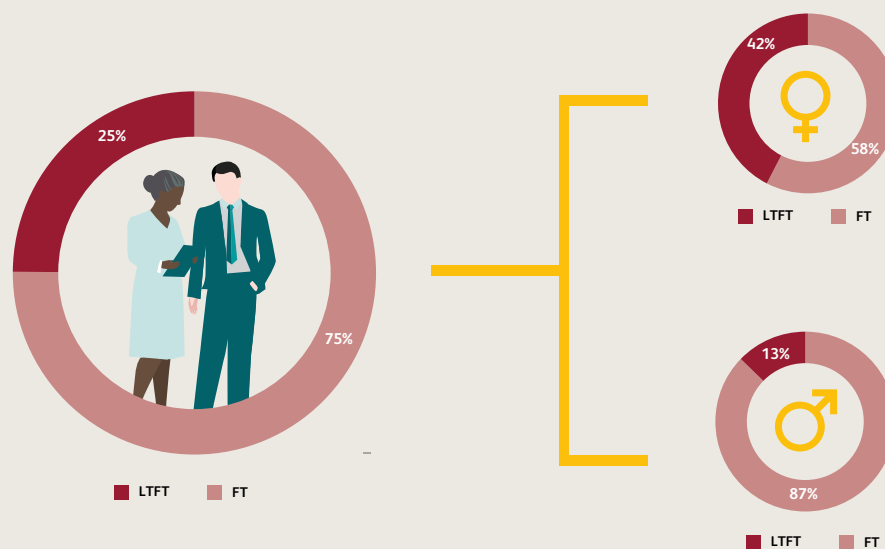
Working patterns

18 % of HSTs and 25 % of consultants worked less than full time (LTFT), ie fewer than 10 contracted PAs. Women made up the majority of physicians working LTFT, both as consultants and as HSTs. Among men it was those who have retired and returned who predominantly worked LTFT, with <10 % of male consultants under the age of 50 working LTFT. Our data show that the number of doctors working less than full time increases every year. The NHS needs to accept that this is becoming the norm and plan accordingly. This means flexible rotas, transparent job planning and a cultural shift to accept flexible working. In order to deliver this, there needs to be an increase in the number of national training numbers to enable more job-sharing, rather than underfilling of full-time posts at HST level.

Full time and less-than-full-time working – HSTs



Full time and less-than-full-time working – consultants



Excess hours worked

Consultant and SAS doctor job plans are split into work periods called programmed activities (PAs). These are 4 hours long between 7am and 7pm Monday to Friday and 3 hours long outside of these hours. A full-time consultant is contracted for a median of 11 PAs and a LTFT consultant for a median of 7.5 PAs.

All respondents reported working more than their contracted hours: full-time consultants worked a median of 12 PAs, and LTFT consultants worked a median of 8.5 PAs. Working around 1 PA more than contracted has been the case for at least 8 years. Full-time consultants therefore worked 10% more than they were contracted and LTFT consultants 20% more.

Full-time consultants worked

10%

more than they were
contracted and LTFT
consultants 20% more

Reasons for working more

Clinical workload was cited by 75% of consultants as the main reason for working more than their contracted hours. Non-clinical workload and additional responsibilities (such as working for a specialist society) were also commonly cited. 31% said the impact of a vacancy or covering for a colleague was the reason they worked more.



Appraisals

13 % of respondents did not have a current job plan and 5 % had not had an appraisal in the past 2 years. Of those who did have an appraisal, 28 % did not find it useful and 41 % did not feel the process adequately recognised the leadership role they performed. Improvement of the appraisal process by employers is urgently needed for the workforce to feel valued by their organisation.

Annual leave

53 % of consultants and 29 % of HSTs did not use their full annual leave entitlement in the previous year. This is of great concern as achieving a balance between work and the rest of your life is important for good mental health. We will aim to find out more about the reasons for this in future years.

Work–life balance

49 % of consultants wanted to work fewer programmed activities (PAs). This is slightly lower than last year's 53 %, but consultants clearly want to work less. There was no significant difference between men and women. This desire was much more marked among HSTs: 62 % said they wanted to work LTFT if they could. The most common reasons cited were improved work–life balance and preventing burnout. The other change HSTs would prefer is Flexible Portfolio Training (49 % would prefer this). This offers opportunities to undertake work other than direct clinical care, such as quality improvement or research.



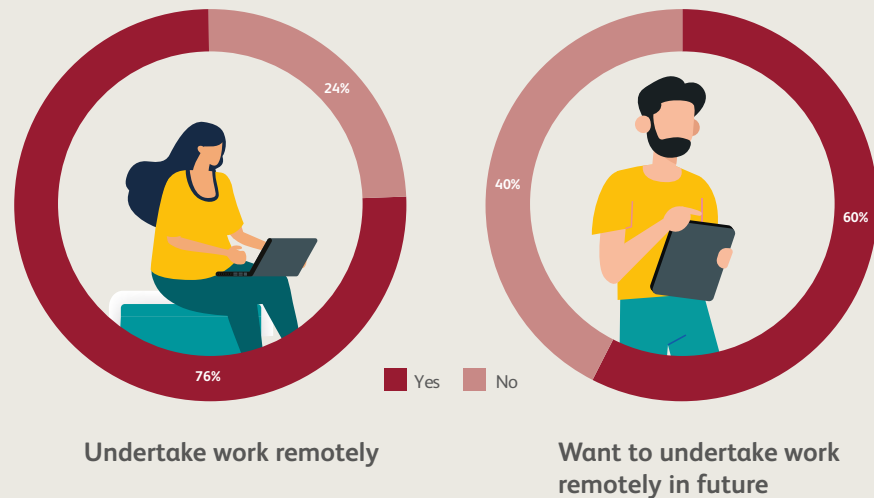
Remote working

Over three-quarters of consultants said they undertook some work remotely. The majority of this work was continuing professional development (CPD), followed by administration related to patient care. For remote working to be sustainable this activity needs to be reflected in job plans and recognised as contributing to the workload of consultants.

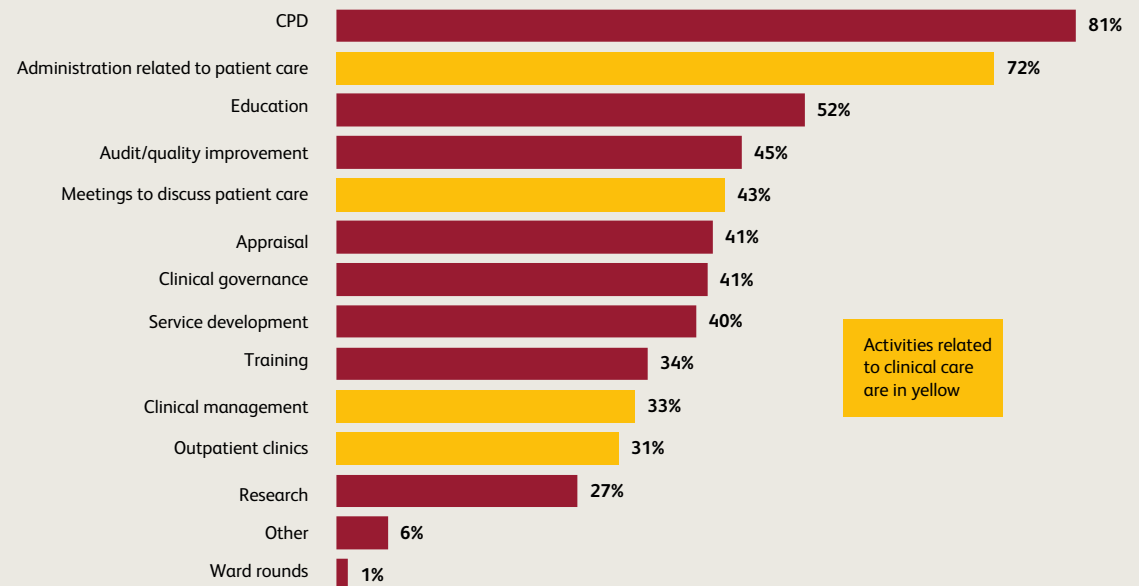
Patient admin

80% of consultants and SAS doctors reported an increased amount of work related to patient administration in the past 5 years. This is predominantly the sending of patient letters, emails relating to patient care, reading and acknowledging patient results and providing support to GPs. 60% said they had less than 0.5 FTE administrative or secretarial support, and the same proportion said they needed closer to double that amount.

Consultants working remotely



Type of work undertaken remotely

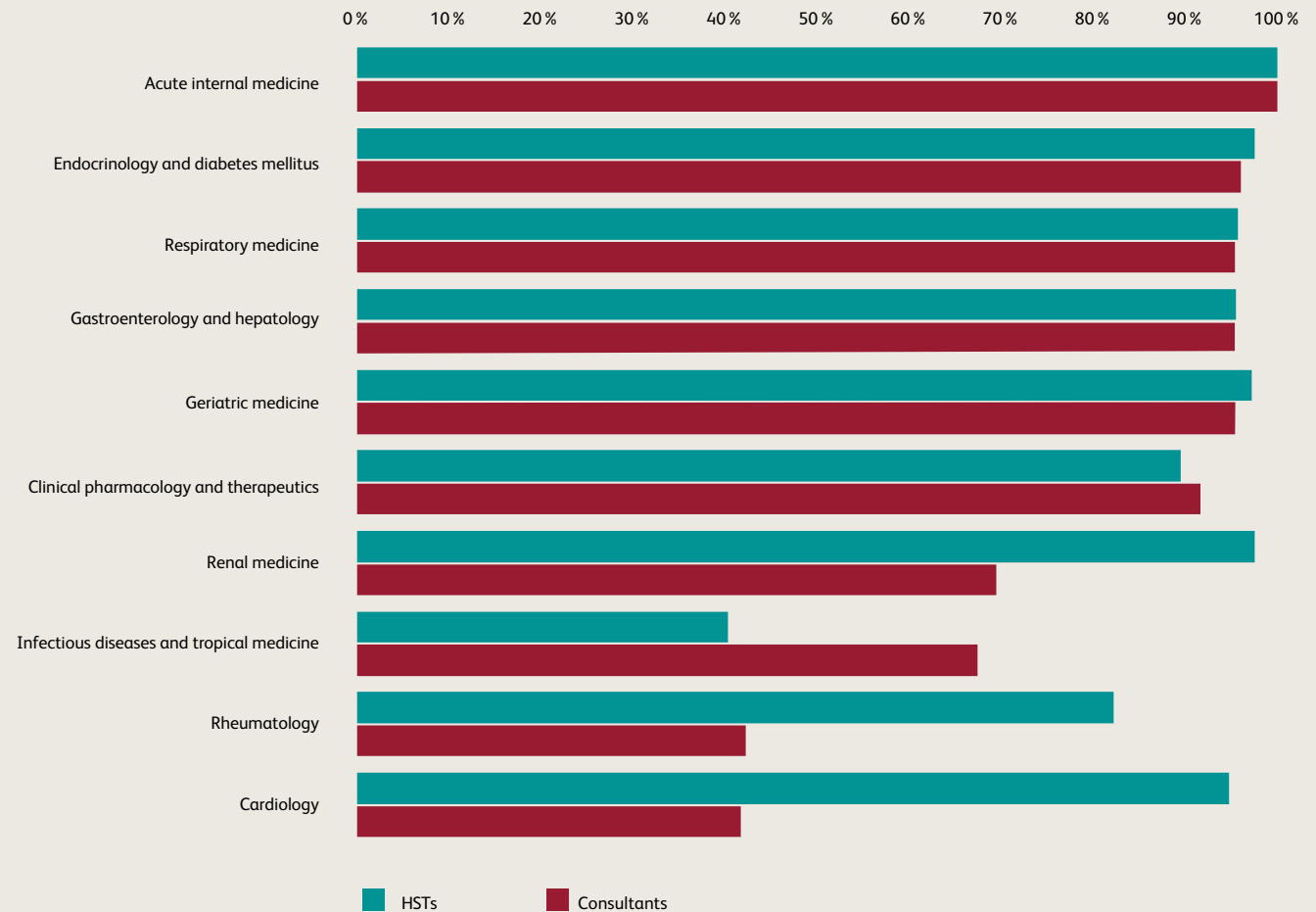


Acute and general internal medicine

Around two-thirds (64%) of HSTs said they contributed to the acute/GIM workload in hospitals. The proportion of infectious diseases HSTs was much lower (40%) as these trainees may be aiming for a combined CCT with medical microbiology or virology rather than GIM.

Overall, 55% of consultant physicians said they contributed to the acute/GIM workload, but there was significant variation. Less than 50% of consultant cardiologists and rheumatologists contributed to the acute and GIM workload in a hospital, compared with more than 80% of HSTs in those specialties. This may affect the ability to educationally supervise HSTs within the GIM component of their training.

Highest-contributing specialties to acute/GIM work (based on % of doctors undertaking work, not specialty size)

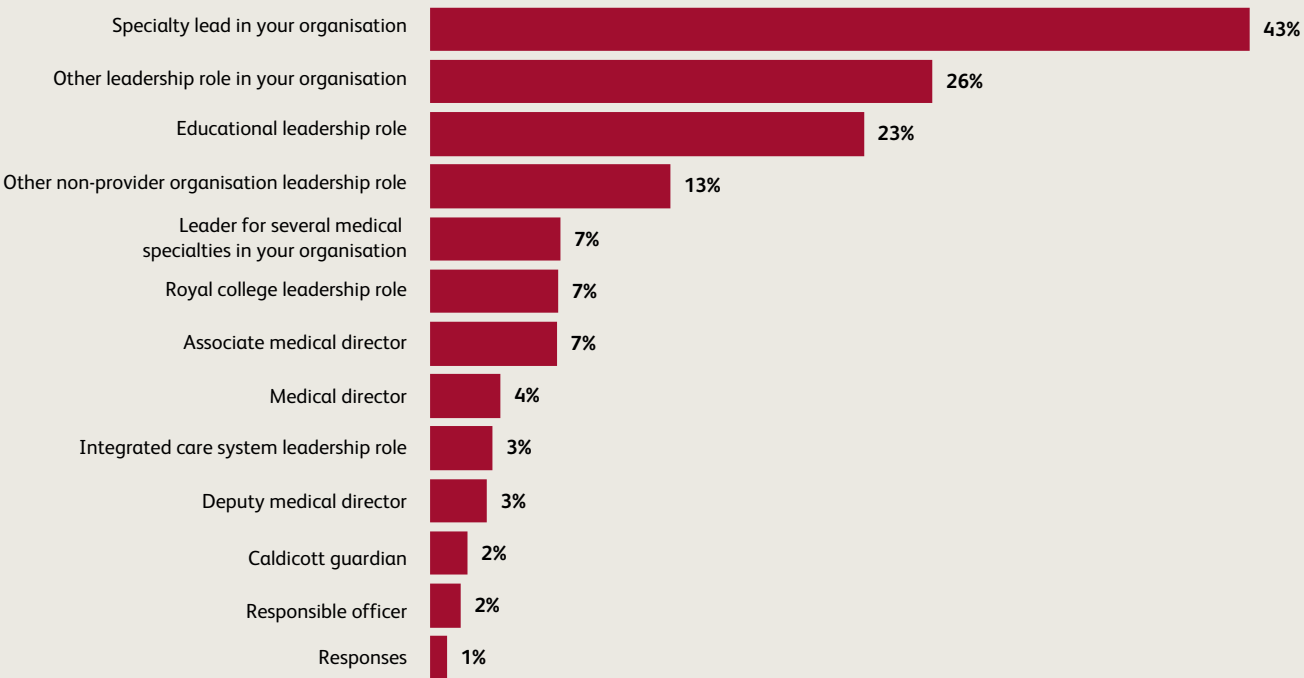


Leadership roles

44 % of respondents had a leadership role in addition to the day-to-day clinical leadership of their teams. Of those, 43 % were working as a specialty lead in their organisation and 23 % had a role in educational leadership. 41 % did not feel their leadership role was adequately appraised, and 25 % felt that it impacted negatively on their ability to deliver their clinical work. 75 % of SAS doctors said they worked autonomously, but the majority (62 %) were not aware of established processes within their trust/health board to promote this independent practice.

44 %
had a leadership role in addition to the day-to-day clinical leadership of their teams

Types of leadership role



NB: answers may be multiple so total is more than 100 %



Working with physician associates

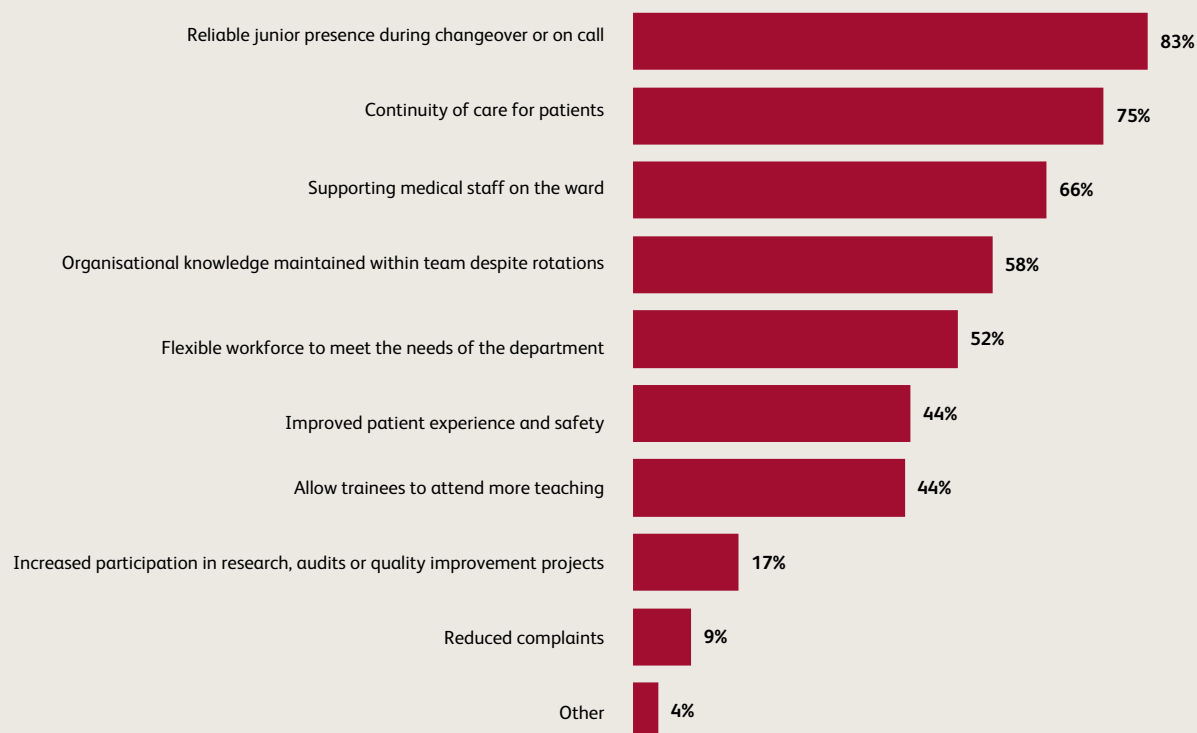
25 % of consultant and SAS doctors said they worked with physician associates. This was most common in geriatric, acute and respiratory medicine. Doctors felt that the main benefits of working with PAs included continuity of care during times of changeover or on call, and maintaining organisational knowledge when doctors rotate to their next training post.



1 in 4

consultants work with physician associates

Benefits of working with physician associates



Consultant appointments

Less than half (48 %) of advertised consultant physician posts with an advisory appointments committee (AAC) in England, Northern Ireland and Wales were filled in 2021. This is the lowest rate recorded to date (in our dataset covering 2008–21).

As in previous years, acute medicine advertised the highest number of posts (197) with 69 new appointments, followed by geriatric medicine (166 advertisements and 78 appointments) and respiratory medicine (149 advertisements and 47 appointments). A full breakdown of data from 2008 to 2021 is available in the [data toolkit](#) on the RCP website

It is likely that this only represents part of the mismatch between supply and demand at consultant grade as

many trusts/health boards and specialties will not advertise a post if they know they will not find any suitable candidates.

Of those appointed, 44 % were women, a decrease on previous years and lower than the proportion of women HSTs who are approaching the end of training. We will explore this in more detail in our annual survey of new consultants one year after gaining their CCT.

In terms of ethnicity, 38 % of those appointed were White British and 35 % were British Asian. This has remained relatively constant for the past 11 years, with between 41 % and 50 % of appointees coming from an ethnic minority background. More detail is available in [the data toolkit](#).

As we reported in an article in the [February 2022 issue of *Commentary* magazine](#), it is crucial that the geographical distribution of trainees in the UK better matches the geographical demand for consultants. While there was one HST for every 5,349 people in London, in the South West there was one per 12,095, in Wales one per 12,290, and in Kent, Surrey and Sussex it dropped to one HST for every 14,891 people.

We know that trainees prioritise geographical location in their choice of consultant post, with around three-quarters of CCT holders applying for a consultant post within their deanery. But we also know that schemes such as [Flexible Portfolio Training](#) are successful, offering protected time for professional development in exchange for taking a post in a hard-to-fill area.

Impact of rota gaps

47 % of consultants said that their trainee rotas had daily or weekly gaps and 46 % said that there was at least one consultant vacancy in the department. 62 % of trainees reported there were gaps on their rotas on a daily or weekly basis.

Nearly half (46 %) of consultants reported that consultant vacancies in their department had negatively affected the balance between their working and personal lives.



Retiring ... and returning

On average, consultants intended to retire at 62–63 years. By 2025 a fifth of the current consultant workforce will have reached that age.

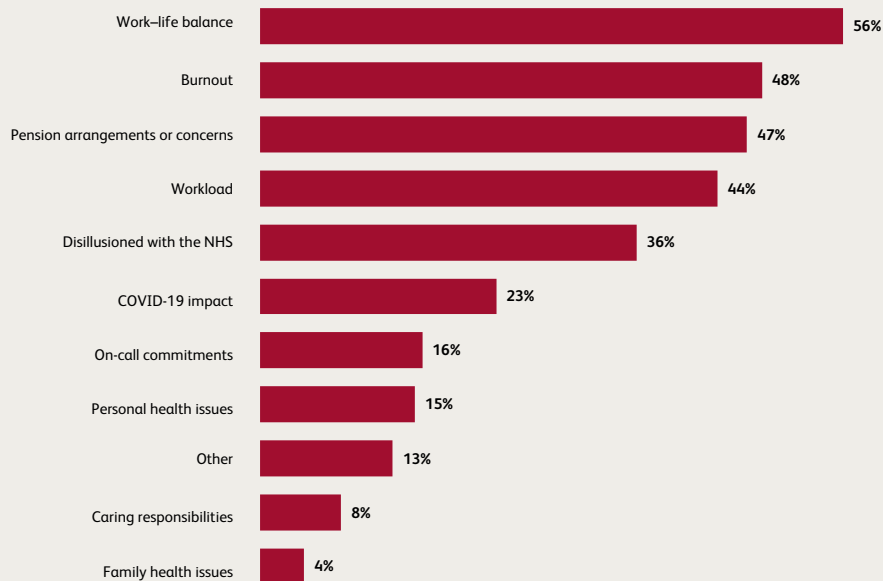
32 % said they had brought forward their intended retirement age over the past year. Their main reasons were wanting an improved balance between working and personal life, burnout and pension concerns.

4 % intended to retire from and return to NHS practice in the next year. Upon return they planned to deliver outpatient work and teaching.

Of those who had actually retired and returned (6 % of overall respondents), 79 % were working in outpatient services. However, only around a third of these experienced senior leaders were supervising (32 %) and

a fifth (22 %) mentoring other physicians. This is an invaluable role for all involved and should be promoted by employing organisations.

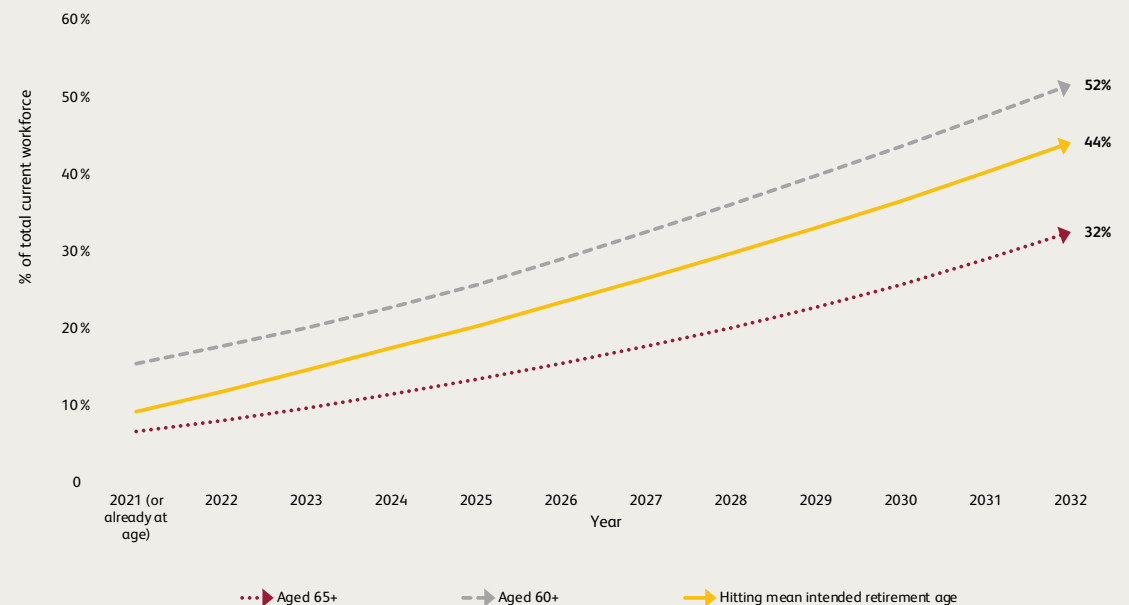
Reasons for intended early retirement



Expected retirements over the next decade

Various scenarios

Mean intended retirement age = 62–63 years of age



Feeling valued and satisfied

By far the majority of physicians felt that their medical and non-medical colleagues valued them almost always or most of the time (77 % and 72 % respectively). 82 % of consultants and 78 % of HSTs felt valued by patients almost always or most of the time.

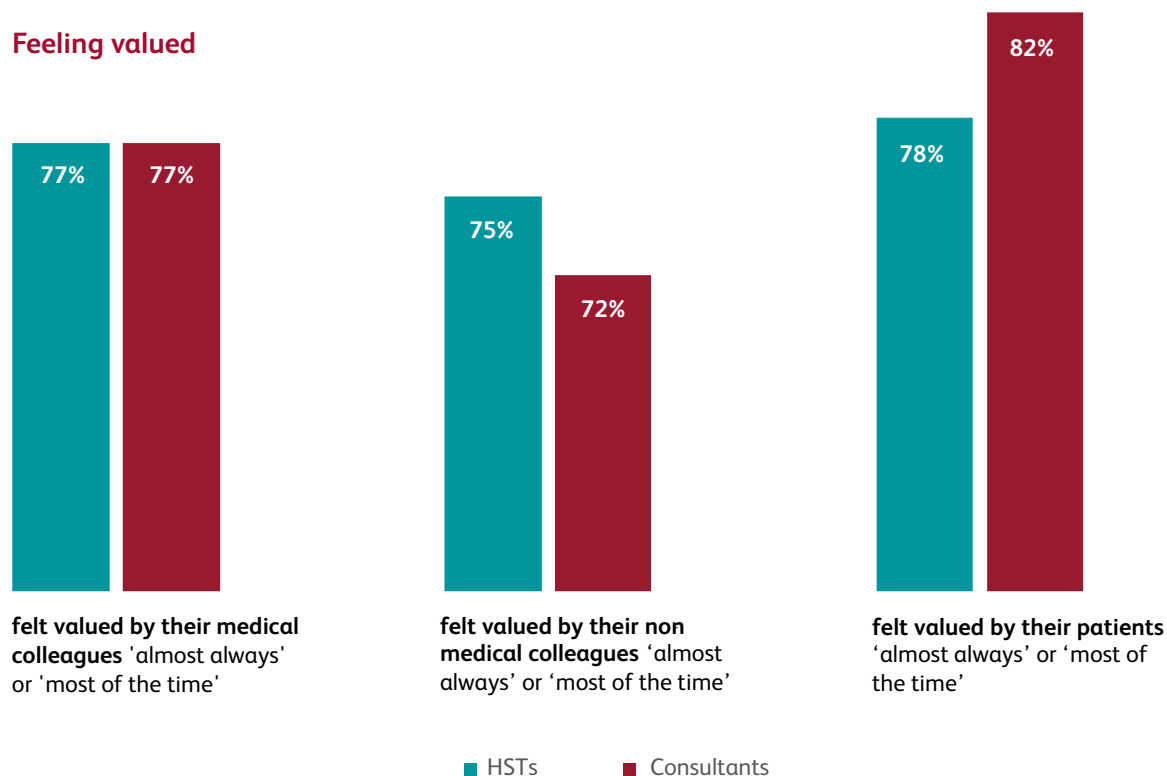
This feeling of being valued likely contributes to the remarkable resilience of a workforce managing a growing workload and significant rota gaps. Satisfaction with specialty work remained high, with over 80 % of HSTs and consultants always or often enjoying their work.

Similar to previous years, working in GIM remained less enjoyable. Less than 40 % said they enjoyed it always or often, and over a fifth (28 %) rarely or never enjoyed it. Although many factors contribute to this, it is likely to reflect staffing levels in particular.

This dissatisfaction was further reflected in only 22 % of HSTs reporting good or excellent GIM training. That compared with 70 % reporting excellent or good training in their specialty.

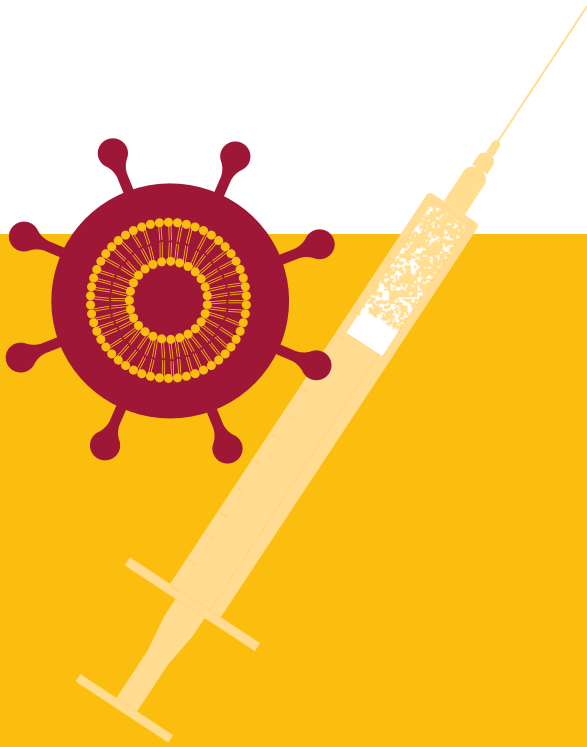
Addressing these persistent issues around the enjoyment and training of physicians participating in acute and general internal medicine is vital if we are to provide high-quality clinical care to an increasingly complex and frail inpatient population.

Feeling valued

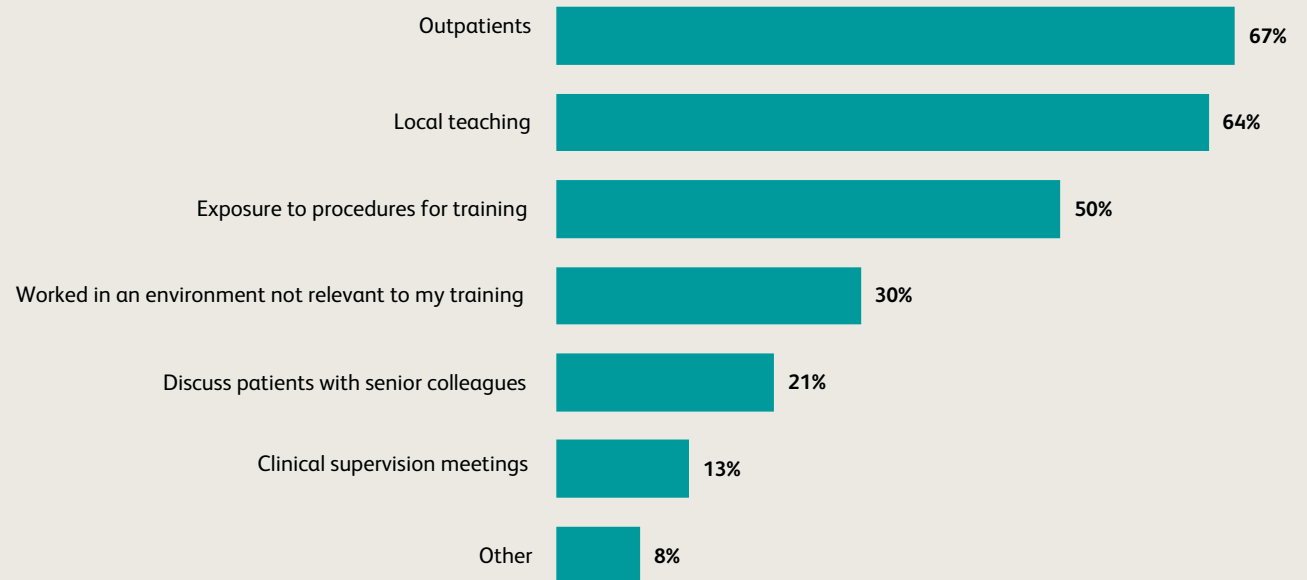


Impact of COVID-19 on training

HSTs continued to describe the significant impact of the pandemic on training. 74 % reported missed training opportunities, predominantly in outpatients and in local teaching. 50 % felt that their exposure to procedures was also negatively impacted.



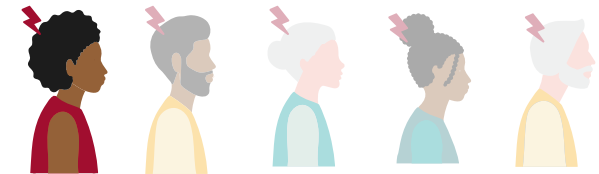
Missed training opportunities due to COVID-19



Burnout

Occupational burnout is defined in the International Classification of Diseases (ICD-11).¹ It is a syndrome resulting from chronic workplace stress that has not been successfully managed. The Maslach-Burnout Inventory is a validated psychological tool to assess an individual's risk of burnout.²

Doctors are at higher risk of burnout if they respond negatively to three specific questions. We have asked these questions in the census for the past couple of years and it has revealed that one-fifth of all respondents were at risk of burnout.



Conclusion

This year's census describes a workforce that continues to work above and beyond. It is smaller than it should be, inequitably spread across the country and mainly engaged in direct clinical care. A significant proportion is at risk of burnout.

The workforce is changing and wants to work differently. In the near future, the majority of physicians will be women and working LTFT. But all will expect greater flexibility.

A large proportion is nearing retirement and thinking about bringing it forward. Some of those who retire do return to work LTFT, but not nearly as many as we need.

Given all this, and that less than half of advertised consultant roles were filled this year, great attention must be paid to workforce planning for the long term. If it is not, we will struggle to manage the steep increase in the age of our population and the complexity of care over the next 20 years.

The continued resilience of the physician workforce despite all these pressures is astounding. It is likely connected with high levels of satisfaction with specialty work and training within specialty, as well as feeling valued by colleagues and patients. However, we cannot take for granted that it will continue.

20%

of all respondents were at risk of burnout

¹ <https://icd.who.int/en> (Accessed July 2022)

² Maslach C, Jackson SE, and Leiter MP. Maslach Burnout Inventory: Third edition. In CP Zalaquett and RJ Wood (eds), Evaluating stress: A book of resources (pp 191–218). Scarecrow Education, 1997.

Acknowledgements

The census was conducted and this report produced by Sarah Logan, Christopher Phillips, Darin Nagamootoo and Nina Newbery of the RCP's Medical Workforce Unit.

We are very grateful to the following individuals for their insight, experience and support in the preparation and production of the census. They have given significant input into gathering data, creating the census questions, distributing the census, analysing the data, and designing and proofreading this report.

Marion Slater and Paul Gillen from the Royal College of Physicians of Edinburgh; Richard Hull and Fraser Paterson from the Royal College of Physicians and Surgeons of Glasgow; Lucy Myatt and Thomas Oppé from the General Medical Council; and Warren Lynch and Erin Brooke from the Joint Royal Colleges of Physicians Training Board.

For more census info and to use our interactive census data toolkit, visit

www.rcp.ac.uk/guidelines-policy/census-data-toolkits

Email: mwucensus@rcp.ac.uk



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