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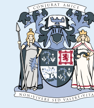
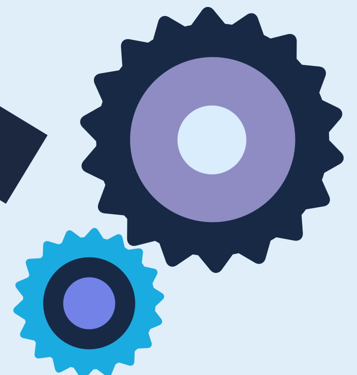
Royal College of Physicians of Edinburgh


Royal College of Physicians and Surgeons of Glasgow

Later careers 2023



In the current workforce crisis, the value of retaining senior doctors is increasingly recognised by those involved in NHS workforce planning at a national level. Working at a later stage of a consultant career brings benefits to patients, the individual doctor, the hospital and the wider medical community.

Experienced senior doctors have a valuable part to play in patient care and in the training and mentoring of the next generation. However, their involvement must be properly planned to ensure that everyone in the team understands and appreciates their roles.

The Royal College of Physicians (RCP) originally produced later careers guidance in 2018, and we have revised it with the intelligence gathered from a 2023 survey of doctors aged 50 and over from all three UK royal colleges of physicians.[1] The quotes are personal communications from individual consultants at a later stage in their careers.

This guidance aims to help physicians, those involved in NHS workforce planning and the General Medical Council (GMC) stem the drain of expertise and skills from the profession. While it is focused on physicians, we hope that it will also be useful for other healthcare professionals and their teams.

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Summary of recommendations

1 Make flexible or part-time working options available to senior doctors.

2 From the age of 60, a consultant should opt into on-calls only if they wish to.

3 Embed time for teaching when job planning with senior doctors.

4 Include mentoring of newly appointed colleagues in the job plan discussion with senior doctors.

5 Employers should provide formal information and support for doctors nearing retirement.

6 Clinical leads should begin discussions about doctors' intentions for the next 10 years as early as felt necessary, but by age 55.

7 Team job planning should be done as a department to ensure that roles are complementary.

8 Employers should consider whether a requirement of a full licence to practise is needed to continue to work in a teaching/examining role in their trust / health board.

Health

9 Departmental job planning is vital to ensure that doctors with ill health or disability have work commensurate with their capacity, to support their valuable contribution to their teams.

10 Issues of revalidation and fitness to practise may need bespoke solutions when someone has had extended periods of ill health. Retaining skilled people by optimising their health and wellbeing should be the guiding principle.

11 Establish regional occupational health departments with experience of individuals with complex conditions.

Appraisal and revalidation

12 Appraisal of senior doctors should be sensitive and proportionate to their working arrangements.

13 IT systems and administrative teams should support the collection of information for appraisal.

14 Mandatory training should be appropriate to the clinical role. Employers should be more flexible in their requirements for doctors in senior roles.

Locums and those returning to work

15 Employers should remain in contact with recently retired physicians or those not currently working.

16 Where appropriate, clinical leads should encourage locum physicians to consider substantive contracts or work on the locum bank.

17 Provide individual information and support on available work, CPD, mandatory training, and appraisal and revalidation.

18 Reduce complexity for doctors returning to work or working sporadically, such as on the locum bank. This includes areas such as HR, contracts, booking shifts, payroll and IT provision.

19 Provide support for doctors returning to work or working sporadically. This can include IT refreshers, mentoring, shadowing and streamlined mandatory training updates.

20 Offer proactive and confidential occupational health support to late-career physicians.

Background

There is a well-documented workforce crisis in the NHS, which was recognised in the NHS Long Term Workforce Plan[2] with a welcome increase in medical school places and recognition of the need to retain the workforce. For the past 10 years, approximately half of consultant physician vacancies have not been filled, usually due to a lack of suitable applicants. There are now an average of 2.2 vacant consultant posts per department.[3,4] There are similar vacancies among trainee doctors, resulting in concerns for patient care with rota gaps, acting down and loss of morale.[3]

Almost half of physicians are aged 50 or over, with 14% having retired and returned to work.[1,4] One-third of consultant physicians who have not yet retired say that they want to retire early, representing a considerable potential loss from the workforce.[1] But there is significant interest in working flexibly: 58% would delay retirement if they could work flexibly and/or reduce their hours.[4] This large group of physicians could potentially exacerbate the workforce crisis, but they are part of the solution if involved and supported appropriately.

Pension rules now enable considerable flexibility around retirement: to reduce hours, retire and return, and (from October 2023) to retire partially from age 55, taking pension benefits while continuing to work. The NHS workforce plan recognises this:

> 'We will improve flexible opportunities for prospective retirees to keep them for longer; and make it easier for those who have already left NHS employment to return by creating more options to come back in flexible, contracted roles or as part of the temporary staffing workforce'.
>
> **– NHS England later careers guidance[5]**

There are clear benefits to patients and doctors in retaining an experienced workforce.

For the individual doctor:

- being valued as a professional and as part of a team
- using skills, experience and knowledge in patient care
- continuing interest, knowledge and experience of specialty
- maintaining professional and colleague networks
- financial
- avoiding burnout if working flexibly[6]

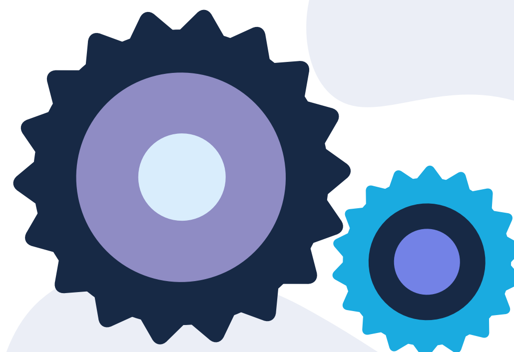
For students, trainees and colleagues:

- teaching
- mentoring

For trusts and health boards:

- avoiding vacancies – rota gaps have compromised patient care[4]
- retention of clinical expertise
- provision of training and teaching by experienced senior leaders.

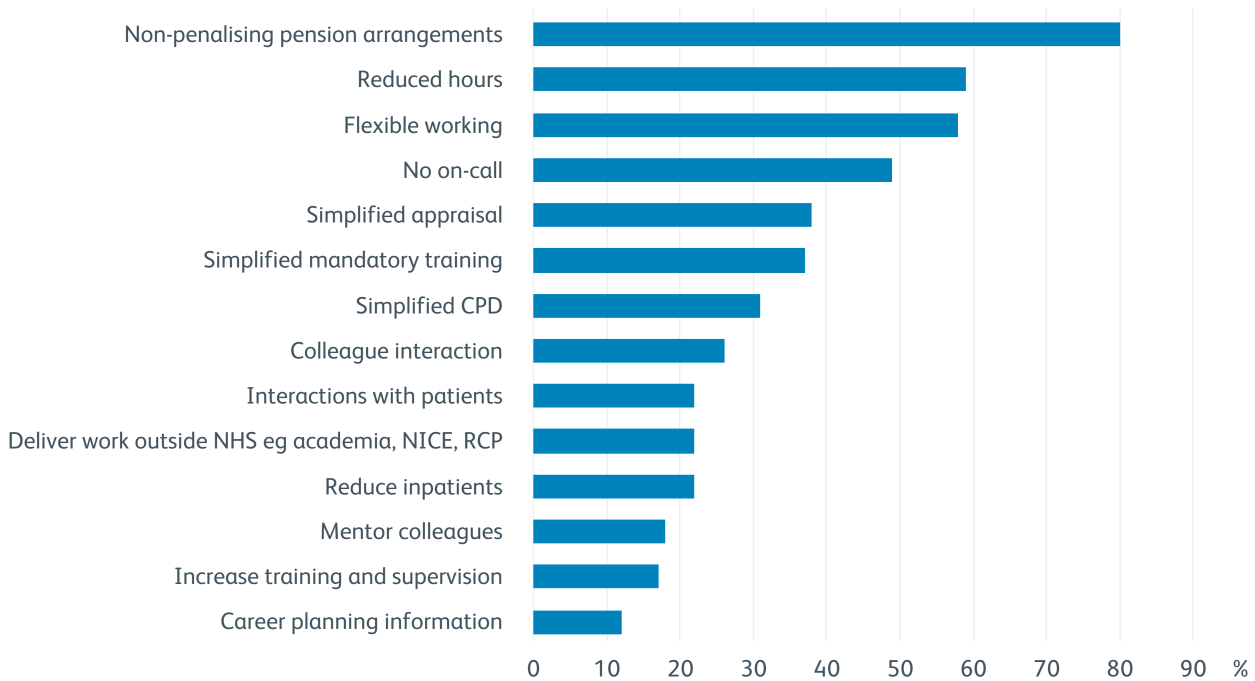
> 'This is the first time in my working life I have really looked forward to coming to work; I arrive early, teach juniors and students, and come home not exhausted.'



Motivators to continue working

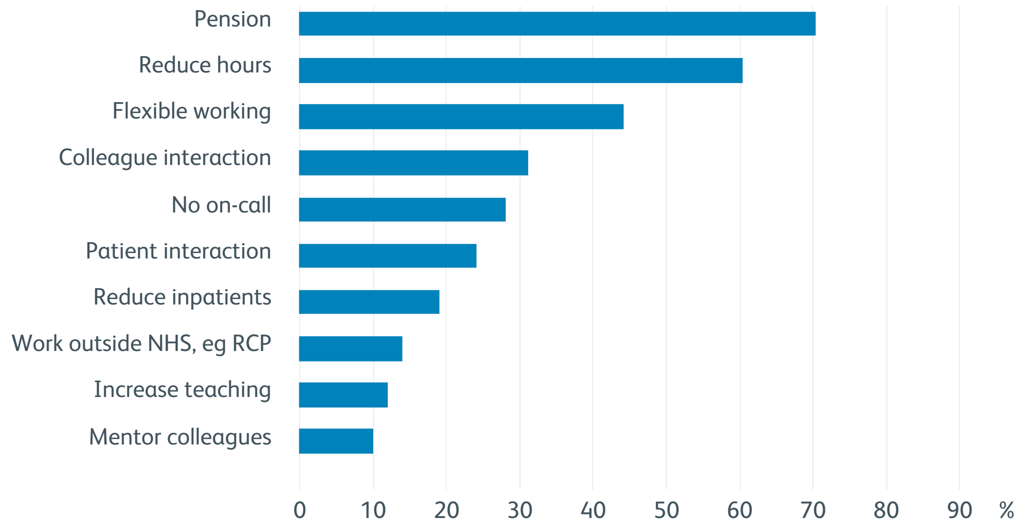
The 2023 Federation of the Royal Colleges of Physicians of the UK survey of physicians aged 50 and over showed that the pension issue, not surprisingly, was the major motivator around retirement.[1] Over half of respondents would delay retirement and continue to work if they could reduce hours and/or work flexibly (Fig 1).

Fig 1. Motivators to delay retirement of physicians who have not yet retired.[1]



These issues were confirmed in those who had retired and returned (Fig 2); their major stated motivators, other than pension issues, were to reduce hours (60 %), work flexibly (44 %) and reduce on-call commitments (28 %).[1]

Fig 2. Motivators of those who had retired and returned.[1]



‘ After 5 years of doing one or two clinics a week in a new trust, I have had time to grow my interests outside of medicine, and now feel ready to retire.’

Flexible working

Reduced hours and flexible working are clear motivators for continuing to work. 31% of physicians aged 50 or over already work less than full time (LTFT).[4] Practically, flexible working means working in a non-standard week, full time or reduced hours – there are examples in the 2020 RCP flexible working toolkit.[6]

Flexible working allows for a portfolio career, including delivering essential activity outside the NHS such as with national bodies, eg royal colleges, the National Institute for Health and Care Excellence (NICE) or specialist societies. It is likely that senior physicians may have valuable external commitments in parallel with clinical careers.

'My portfolio career started the day I became a consultant, and as I developed my interests outside medicine, I gradually reduced my clinical commitments, finally ending being a clinician but remaining a physician who facilitates clinical leadership courses. Utilising transferable skills has opened doors to being a trustee on a national charity, a NED, a president and an activist. I've taken risks but never regretted stretching myself – I've enjoyed every moment because 'retiring' is entering the university of the third life.'

Current NHS working options allow:[7]

- retire and return: retire, claim pension benefits, then return to work
- wind down, working fewer days
- partial retirement: taking pension benefit while continuing to work and contribute, while pensionable pay is reduced by at least 10% for at least a year, from 1 October 2023.

In peri-retirement, flexible working might involve:

- reducing hours
- working from home for some sessions
- introducing a job share, dividing a full-time role between two people. The time could be divided over a week, or over a longer period such as a year; for example, one doctor working term time only, the other (in peri-retirement) working school holidays predominantly. As well as facilitating LTFT working, this can be a beneficial learning experience.

'I have returned to work doing a job share with a former trainee. We both work 3 days a week, overlapping on a Wednesday, and it has been an eye-opener for me working so closely with a colleague at this stage of my career. We are still learning from each other.'

- annualised hours: agreeing a number of clinics or lists per month/year.

The British Medical Association (BMA) provides further information on all options.[8]

Recommendation 1:

Make flexible or part-time working options available to senior doctors.

Out-of-hours working

Stamina for out-of-hours work may reasonably have deteriorated during a consultant's career. The 2022 RCP census shows that participation in acute medical on-calls drops throughout a career, from 46 % at the start to 31 % in those aged 50+. Similarly, participation in specialty out-of-hours work drops from 85 % at the start to 71 % at age 50+.[4]

A later careers survey by the Academy of Medical Royal Colleges (AoMRC) identified on-call commitments as the main influence to retire after pension arrangements.[9] Among physicians, half (49 %) said that on-call commitments were their main driver for retirement. That rose to 59 % among gastroenterologists, for whom on-call working requires them to be at the hospital.[1] The AoMRC has suggested that, from age 60, doctors should not be asked to do overnight on-calls, but could opt in if they desire.[9]

Recommendation 2:

From the age of 60, a consultant should opt into on-calls only if they wish to.

General internal medicine (GIM)

UK census data show that, of physicians aged 50+, 41 % participate in GIM and 31 % in the acute take.[4] Of locums working aged 50+, 50 % were involved in the acute take.[1] This clinical experience is a valuable resource and, while we recommend that overnight on-calls are opt-in from age 60, there are opportunities to utilise GIM skills in rapid-access clinics, teaching and mentoring.

Teaching

Doctors working in peri-retirement constitute a reliable group for managing planned activity when they are not subject to inpatient or on-call demands. Teaching is often cancelled due to immediate patient activity demands, but those working in peri-retirement have shown both interest in teaching and an ability to commit to it.[1,10] At a time of increasing medical student population, this group of doctors could contribute valuably to the teaching workforce.

Recommendation 3:

Embed time for teaching when job planning with senior doctors.

Mentoring

Senior doctors have a key role to play in mentoring. As well as passing on what they have learned during their career, senior doctors can act as an exemplar and an ambassador for their specialty. Mentoring should also benefit the mentor in terms of job satisfaction.

Mentoring of newly appointed consultants, SAS doctors or trainees is recommended by the AoMRC, all three UK royal colleges of physicians and the GMC. Adequate time should be included in a senior doctor's job plan where they wish to contribute.[11,12]

Recommendation 4:

Include mentoring of newly appointed colleagues in the job plan discussion with senior doctors.

Sources of information

For retirement planning, doctors most frequently consulted colleagues (75 %; Fig 3), and 55 % said that they would like more advice from trusts / health boards.[1] Trusts / health boards could help to retain their senior workforce by providing information and network support.

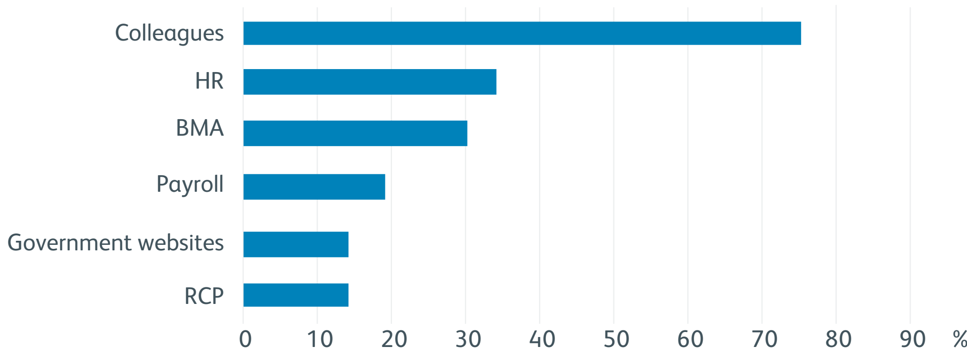


Fig 3. Resources used for career planning.

Recommendation 5:

Employers should provide formal information and support for doctors nearing retirement.

Concerns for working around retirement

'Cherry picking' and blocking colleague recruitment

While doctors are likely to stop doing on-call shifts at age 60, this should not result in younger consultants being adversely impacted.[13]

It is advised that there should be a discussion with the clinical lead by age 55 regarding future plans. This should enable proper recruitment and succession planning, so that skills for a replacement post can be retained and a junior colleague mentored by a senior colleague prior to retirement. Given the increasing demand for medical services, group job planning should allow complementary roles to be discussed and all members of the team to be included.

Recommendations:

6 Clinical leads should begin discussions about doctors' intentions for the next 10 years as early as felt necessary, but by age 55.

7 Team job planning should be done as a department to ensure that roles are complementary.

8 Employers should consider whether a requirement of a full licence to practise is needed to continue to work in a teaching/examining role in their trust / health board.

Health issues

8 % of physicians reported a long-term health condition that required them to take time off work intermittently, more commonly in an older age group.[4] For the general population, by 2030 one in three people of working age will have a long-term condition that will affect their ability to work. That proportion rises to 40 % in those over 50.[14]

The GMC requires doctors to remove themselves from work (until treatment is successful) if they feel that their health is detrimentally affecting their work. If a doctor cannot return to the same work, enabling a transfer to different duties that use their medical skills in another way reduces loss of experience from the workforce.

This sort of redeployment may require an organisation-wide, or even a regional, search for suitable work. In whatever setting, the return to work needs to be organised so that it maintains patient safety, and works for the doctor and their colleagues. It must be based on the individual and their needs, and regularly reviewed.[14]

Requirements are likely to include a predictable workload, a consistent level of demand and some control over timetable. As with a move to LTFT working, it is therefore important that planning is done as a department. Individuals and organisations should seek advice from occupational health professionals. Where they are not available locally, they may be found in other NHS organisations.

Recommendations:

9 Departmental job planning is vital to ensure that doctors with ill health or disability have work commensurate with their capacity, to support their valuable contribution to their teams.

10 Issues of revalidation and fitness to practise may need bespoke solutions when someone has had extended periods of ill health. Retaining skilled people by optimising their health and wellbeing should be the guiding principle.

11 Establish regional occupational health departments with experience of individuals with complex conditions.

Appraisal and revalidation

Doctors have cited concerns around personal clinical competence and becoming 'out of date', and CPD continues to be of importance.[9] They have also said that a simplified appraisal and revalidation process would help them remain at work.

The process therefore needs to be tailored to the needs of those working around retirement, as recommended by Sir Keith Pearson in 2017. As independent chair of the former Revalidation Advisory Board, he carried out a review of the operation and impact of revalidation throughout 2016. The report was published in January 2017.[15] The GMC published guidance in response to this report,[16] which highlighted the need to:

- reduce unnecessary burdens and bureaucracy for doctors so that registration and licence to practise can be maintained
- improve local information systems so that doctors can more easily access and collate the information they need to reflect upon at appraisal.

The RCP has produced guidance for appraisal and revalidation.[17]

GMC contact for revalidation queries:
Revalidation – GMC (gmc-uk.org)
0161 923 6277 (or +44 161 923 6277 from outside the UK)
Email: revalidation@gmc@uk.org

Recommendations:

12 Appraisal of senior doctors should be sensitive and proportionate to their working arrangements.

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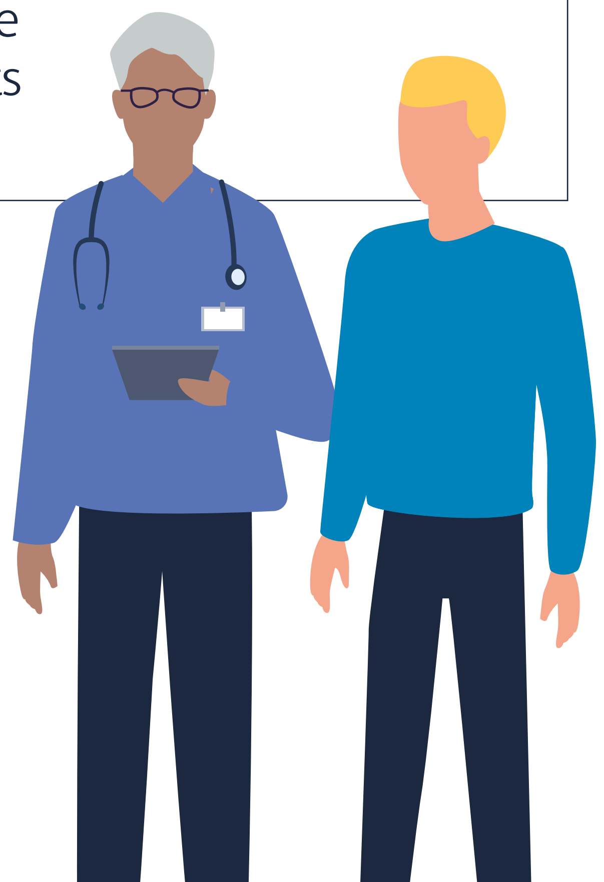
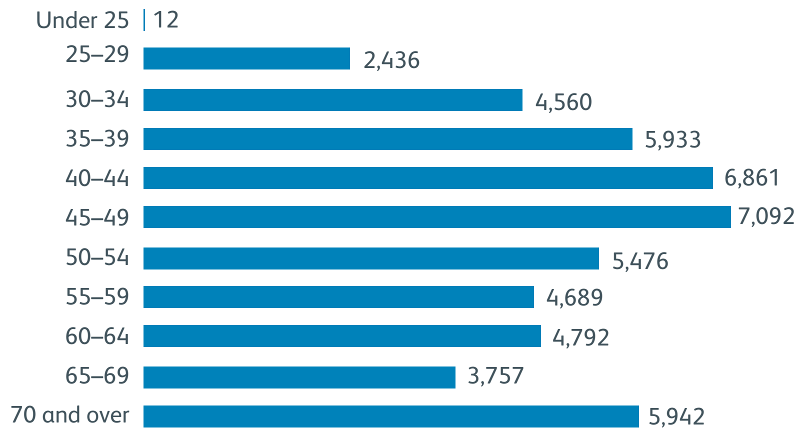


Returning to work

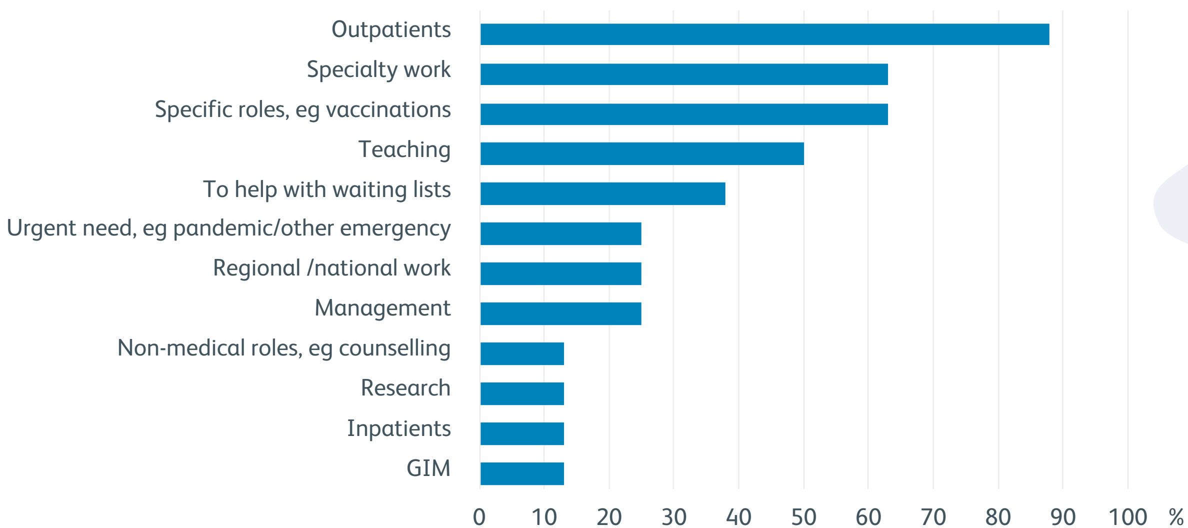
GMC registration shows that 42,000 doctors under 65 years of age are on the GMC register, but do not hold a licence to practise.

Fig 4. Age ranges of doctors on the GMC register not currently with a licence to practise.[18]



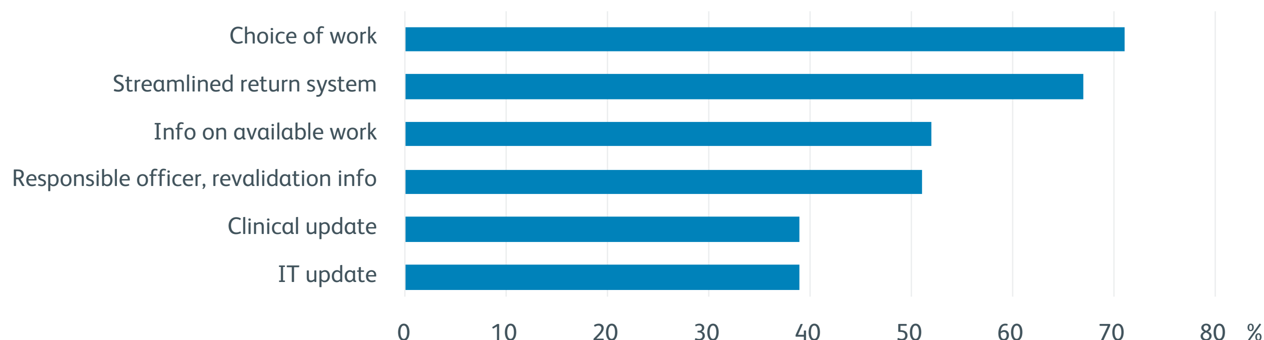
At present there is no clear process for physicians to register an interest in returning to work, to maintain skills after retirement or to return easily in time of need. If those aged 50+ returned in the future, there is considerable interest in specialty elective work, which may be timely in the current context.

Fig 5. Options that physicians currently not working would consider returning to do.[1]



Data from both the three UK royal colleges of physicians and the GMC show that a reduction in bureaucracy will enable returning to work.[1,18]

Fig 6. Enablers to return to work.[1]



Newly retired specialists will soon be able to use a digital platform, the NHS Emeritus Doctor Scheme, to offer their availability to trusts in England to deliver outpatient appointments virtually or in person. The platform aims to provide trusts with an alternative to using expensive agency staff.

Recommendations:

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20 Offer proactive and confidential occupational health support to late-career physicians.

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Resources

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NHS England. Retaining doctors in late stage career guidance
NHS Employers. The working longer group
AoMRC. Medical careers: a flexible approach in later years
BMA. Supporting an ageing medical workforce
BMA. Consultant part-time and flexible working
GMC. Caring for doctors. Caring for patients

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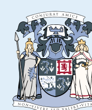
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