# Working as a specialist secondary care doctor in the NHS

TPG-IHA England Educational Summit 24th October 2023

**Prof David Oliver**

Consultant Physician in Geriatrics and General Internal Medicine

# I: My own current day job

# My place of work since 2004 – Royal Berks NHS Hospital

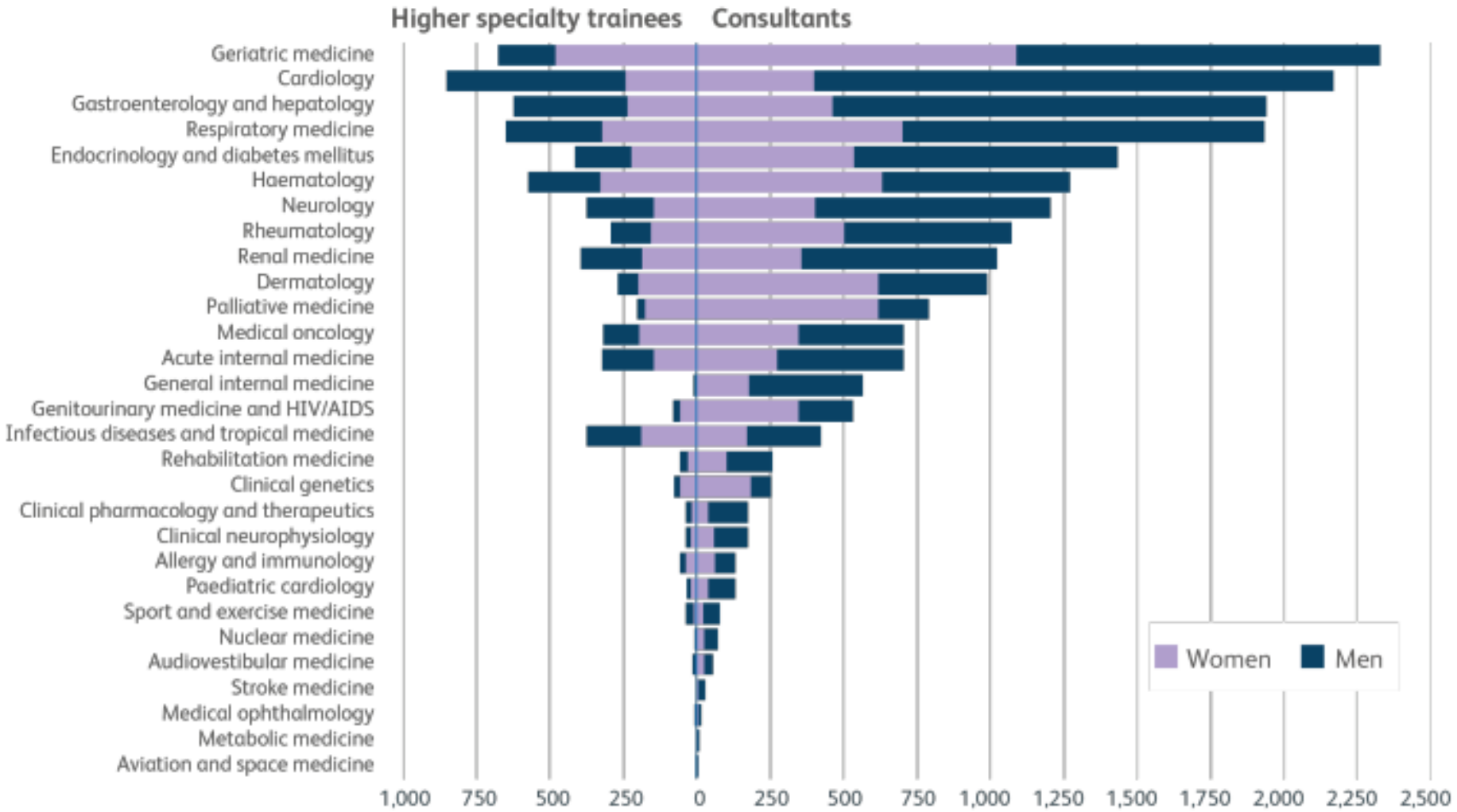

# Royal Berks

- 813 bed hospital trust
- 5,500 staff
- c £400m annual budget
- 400 consultants
- All services except regional neurosurgery & vascular surgery
- 40 miles west of London (can impact recruitment/retention)
- Catchment area c 400,000 (several local authorities)
- 450-500 Emergency Attendances each 24 hours
- c 100 admissions through Acute Medical Unit (AMU)

# My own current day job

- Year round responsibility for 28 bed inpatient ward (acute geriatric medicine – "whole stay clinician"
- 1000+ finished episodes a year
- Strong multidisciplinary team at ward level
  - *Nursing/PT/OT/SALT/Rehab Assistants & visiting ACPs/Medical teams*
  - *Including palliative care and old age psychiatry*
- **Consultant for a hot "All-Covid" ward** throughout all pandemic waves
  - ***Plenty of experiences to relate and plenty I wrote and spoke about in media***
- Regular work on acute medical unit for acute geriatric medicine take (12 hour shifts usually 30-35 patients)
- Regular Rapid Access Outpatient Clinic
- Our department has grown to 21 consultants (12 part time)
- Including stroke unit, hyper-acute stroke on call,  stroke discharge team
- Geriatricians see c 50% of acute medical intake 7/7 (and much of younger AIM)
- 8 consultants doing front door Acute Internal Medicine 50/50
- 1 in 17 rota for evening I.M. (till 10pm) from dually registered "ologists"

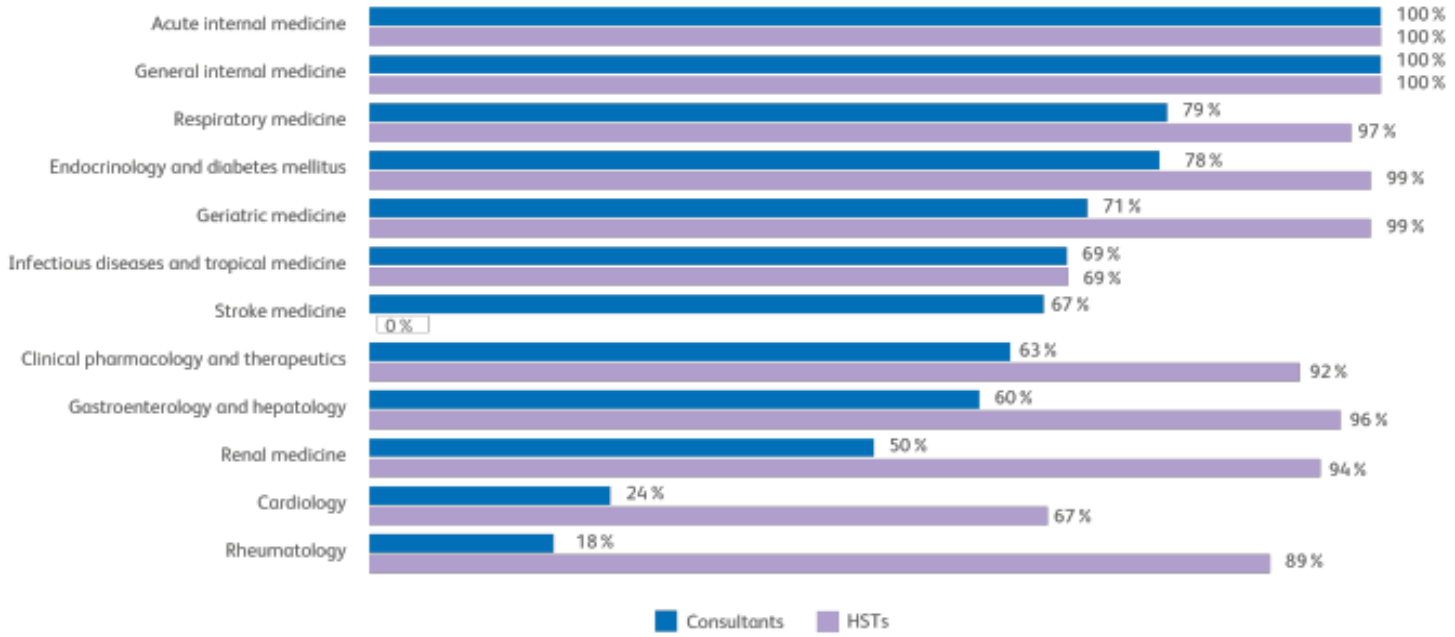
# The number of doctors by specialty



# In addition to own speciality acute on call rota 43% care for GiM inpatients and 34% on acute GiM take

## Highest-contributing specialties to acute/GIM work

(based on % of doctors undertaking work, not specialty size)




No values for HSTs in stroke medicine

# Roles geriatricians play & services we work in

Future Hospital Journal 2016 Vol 3, No 1: 49–54



## Geriatric medicine and geriatricians in the UK. How they relate to acute and general internal medicine and what the future might hold?

**Authors:** David Oliver[A] and Eileen Burns[B]

ABSTRACT

**The Royal College of Physicians and its Future Hospitals Commission has a renewed focus on general internal medicine. But in 2015, most is in effect either acute medicine or geriatric medicine. Acute physicians and 'organ specialists' looking after inpatients on specialty wards or at the acute hospital 'front door' will need sufficient skills in geriatric medicine, rehabilitation, discharge planning and palliative care, as frailty, dementia and complex comorbidities may complicate the care of older patients with predominant speciality-defining complaints. In an era where we are urged to focus on patient-centred care, patients' preference for continuity and 'whole-stay', consultants must be recognised and respected. Ideally, this will require increasing numbers of geriatricians and acute physicians, more age attuned training for all; a shift in values and status. This should be backed by adequate capacity and rapid access to social and intermediate care services outside hospital, as well as adequate multidisciplinary staff and skills within the acute hospital to ensure that older patients' needs beyond the immediate complaints are not neglected. Meanwhile, geriatric medicine itself has diversified into specialised, community and interface roles, aligned with the integration agenda, and continues to contribute substantially to acute, general and stroke medicine. These developments are described here.**

**KEYWORDS:** Geriatrics, general, acute medicine and workforce

Medical specialities in those early post-war years tended to focus on short-lived, infectious or 'single-organ' diseases generally affecting people below retirement age. This has indirectly coloured the way our services, training and specialities are configured to this day.

UK geriatric medicine came to prominence in the 1940s with the pioneering work of Warren, Amulree, Howell and Exton-Smith among others, and with the founding of the British Geriatrics Society (BGS).[5] Its pioneers demonstrated the value of specialised and skilled assessment of older patients both to those individuals and to hospitals. Back then, geriatricians were far from the mainstream of acute adult medicine and centred in long-stay facilities.[6] We are now the largest UK internal medicine speciality with at least 1,350 consultants, with most consultants dually accredited in general internal medicine (GiM) and many also in stroke or acute medicine.[7]

The BGS has defined geriatric medicine thus: 'a branch of GiM that is concerned with the clinical, preventative, remedial and social aspects of illness in old age. The challenges of frailty, complex comorbidity, different patterns of disease presentation, slower response to treatment and requirements for rehabilitation or social support require special medical skills'.[8] This is explored in more detail in the Royal College of Physicians' *Consultant physicians working for patients* resource on the speciality.[9] A recent article in this journal[10] discussed how we identify older people with frailty and

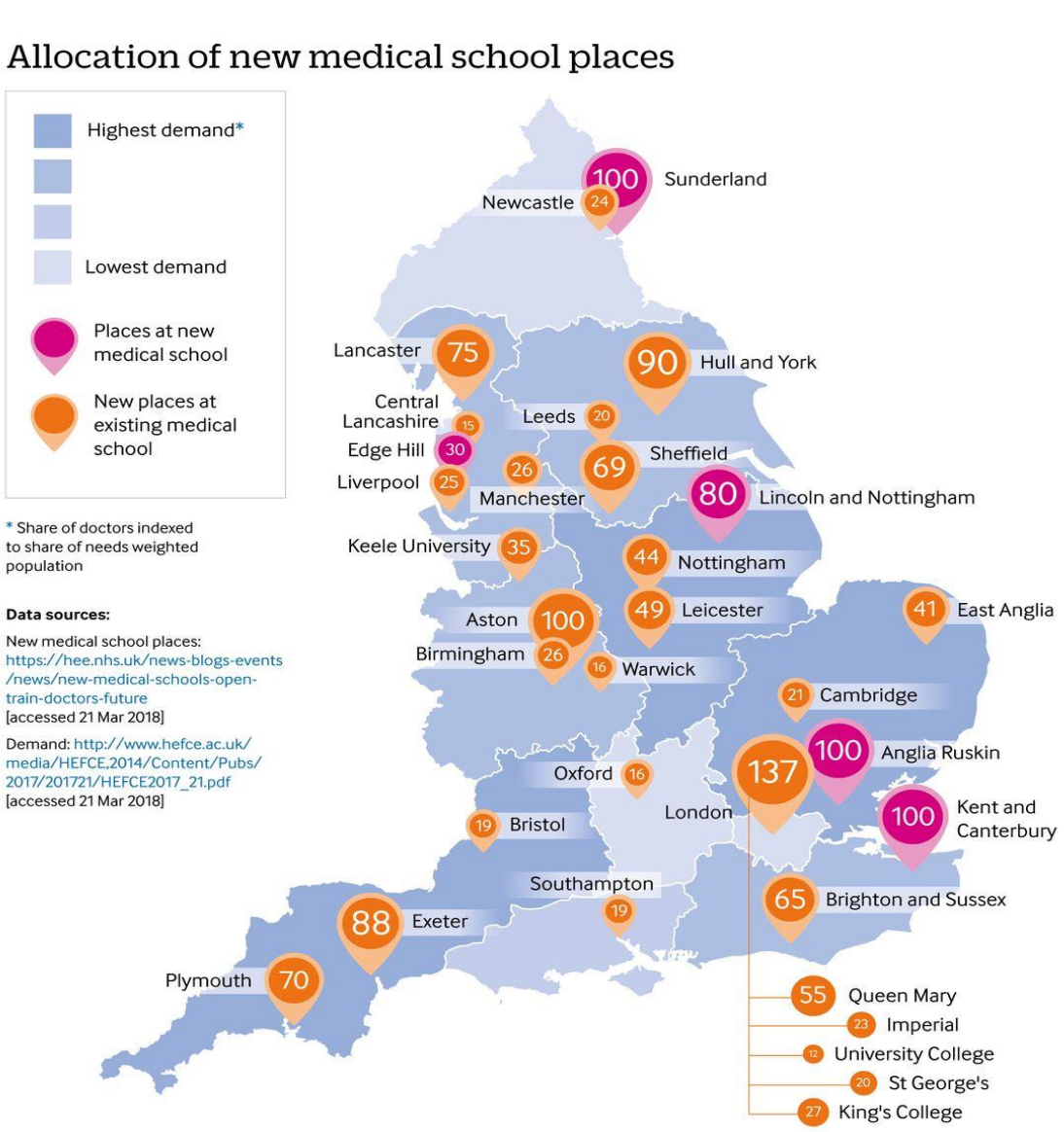
# Some roles geriatricians now play (Oliver & Burns 2016)

## We do all of this locally

- Acute  front door
- Including younger AIM
- And SDEC/Ambulatory Care
- End  of life care
- Stroke
- Community/Interface
- Care Homes
- Community Hospitals
- Community Teams
  - e.g. Hospital at Home. Virtual Wards, CRT
- Domiciliary Assessment
- Ward-based inpatient geriatrics/GiM
- Joint work with old age psychiatry
- Orthogeriatrics
- Surgical Liaison/Oncology
- Speciality clinics e.g. movement disorder/falls
- Specialist services for delirium, dementia
- Population health input
- Safety, Audit & Improvement
- System leadership
- Education
- Research
- Upskilling others/Good Practice Resources

# III: Undergrad and postgrad training

# UK med schools and planned (England) expansion



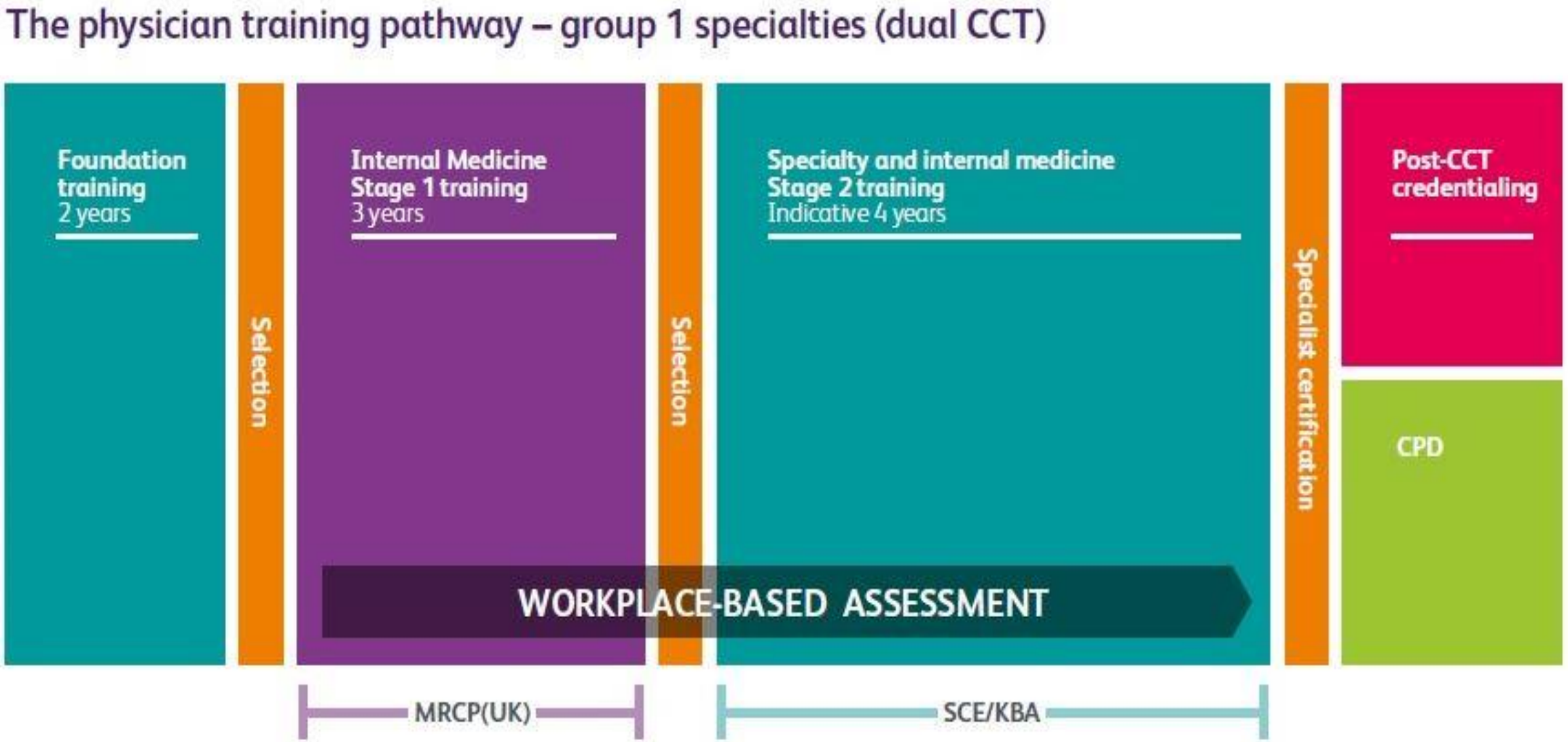

# UK Medical schools

- 10,000 places
- After expansion from 7,500 (with two waves of new medical schools)
- NHS England 2023 Workforce Plan aims for 15,000 (England)
- Aim for 60,000 more doctors by 2036
- More training places in most doctor-deprived areas
- Less reliance on IMGs
- Expansion of PA/ACP/NA roles (at expense of medics?)
- More (socioeconomically) diverse access to training
- And increase in vocational GP training places from 4,000 to 6,000
- Acceptance rate 8-20% (lots with high grades rejected)
- Graduate debt c £100,000 since tuition fees introduced (formerly free)
- 5-6 year course (4 years for graduate entry – still a small %)

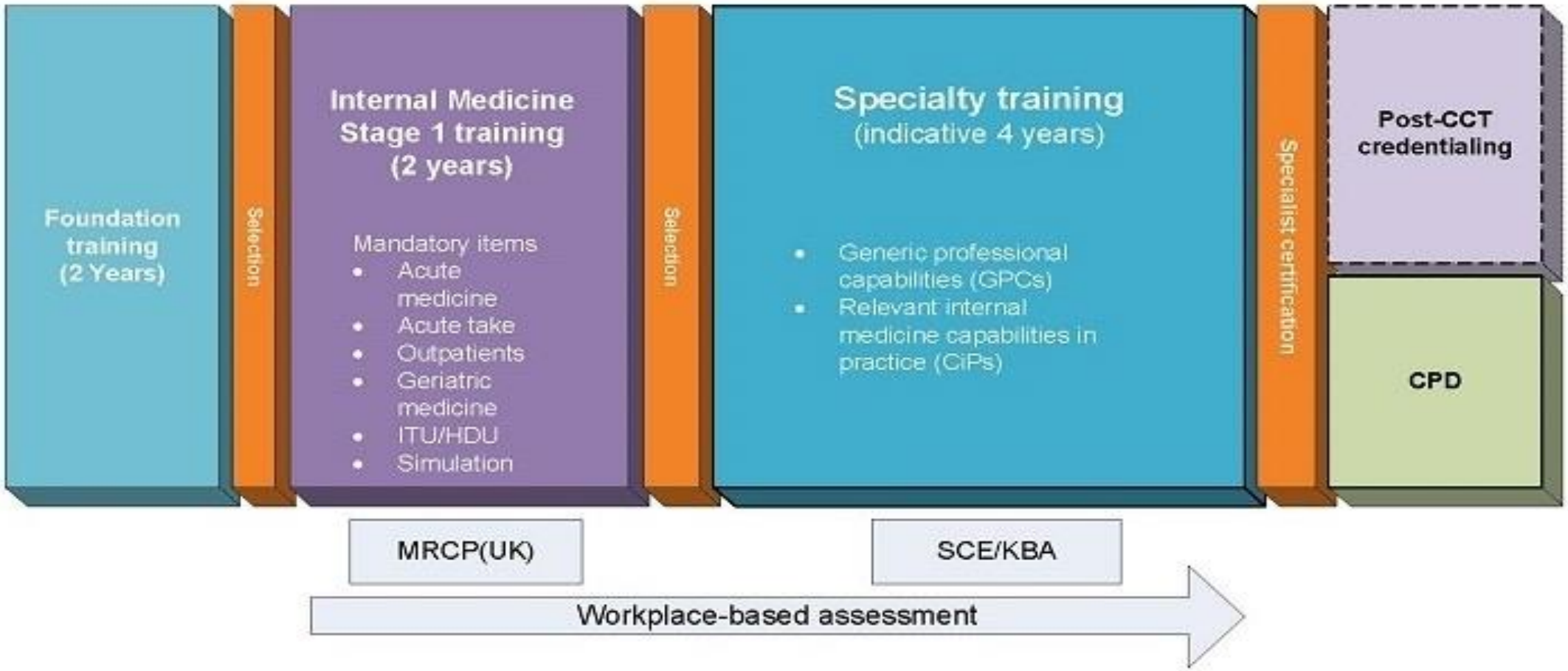
# Postgrad training

- Foundation years 1 and 2 ( 6 x 4 month rotations)
- Plenty take time out of programme (overseas or FY3/fellowship etc)
- Then option of GP Vocational Training (3 years)
- Or into 2-3 years core training (e.g. surgical, internal medicine, acute common stem, paeds, psych)
- Multi-stage Postgrad exams
- Then entry to higher speciality training (HST) (3-4 years but option of credentialing)
- Usually several hospitals in one region
- Competitive entry to core training/higher speciality training
- Some specialties oversubscribed and some struggle to fill… (often the ones we need most)
- Annual review of competencies and progression
- Exit exams
- Award of Certificate of Completed Training
- Some doctors work as speciality doctors (SAS) without becoming consultants
- And CESR route is available to CCST for some experienced international graduates

# For IM Specialities ("Physicians" or "Medicine") which dually accredit in ology + GIM



# For IM Specialities (Group 2) only accredit in their “ology” & not GIM



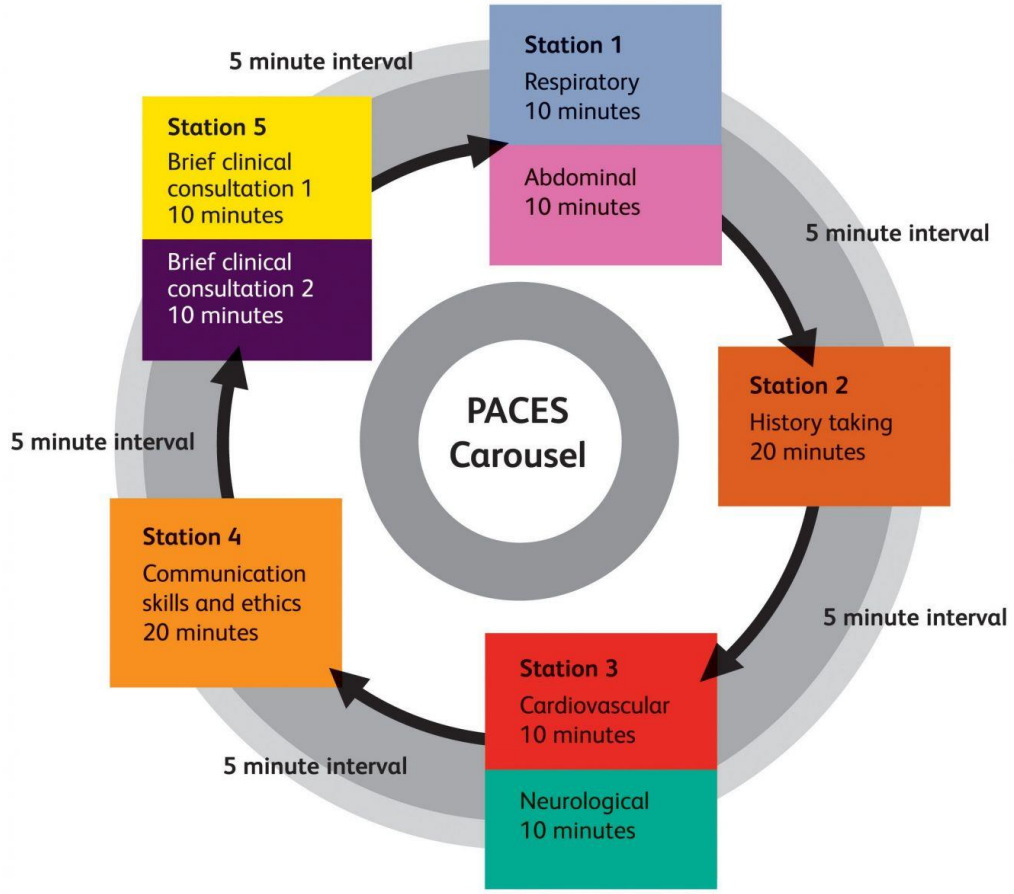
# MRCP UK exam (before entering HST)

**Written Part 1 and 2**

- **Part 1** – two x 3 hour papers
- 100 MCQs
- Testing basic clinical knowledge

- **Part 2** – two 3 hour papers
- Testing application of clinical reasoning and skills

**PACES – Clinical Exam**



# Nuffield Trust. Doctors' Pay 2023

| | Number employed in NHS, headcount | Latest pay deals | | Full-time equivalent earnings, 2023-24 (unless stated otherwise) | |
|---|---|---|---|---|---|
| | | 2022/23 | 2023/24 | Basic salary | Estimated average earnings |
| **Doctors in training ('junior doctors')** | | | | | |
| Foundation year 1 | 7,078 | 2% | 6% plus £1,250 | £32,397 | £41,300 |
| Foundation year 2 | 6,517 | | | £37,303 | £48,800 |
| Core training | 20,113 | | | £43,922 | £62,300 |
| Specialty registrar | 43,140 | | | £55,328 - £63,162 | £71,300 |

# IV: Composition of medical workforce

GMC 2022

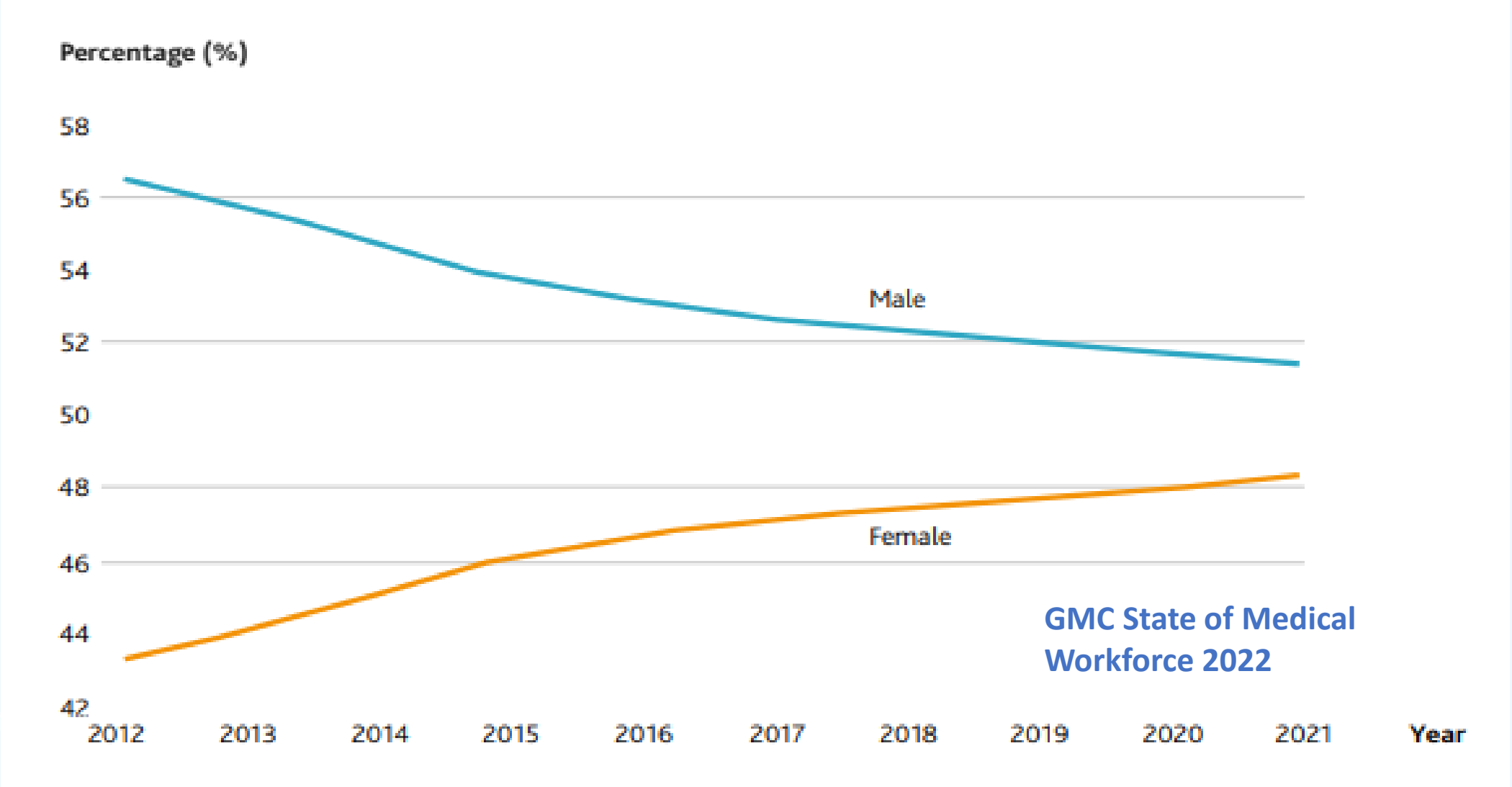
## Figure 12: Number of licensed doctors by register type

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2017–2021 |
|---|---|---|---|---|---|---|
| GP | 60,690 | 61,313 | 62,256 | 63,741 | 65,160 | +7% |
| GP and specialist | 1,241 | 1,241 | 1,249 | 1,295 | 1,289 | +4% |
| Specialist | 75,282 | 77,257 | 79,041 | 81,838 | 83,513 | +11% |
| SAS and LE doctors | 45,578 | 48,199 | 53,432 | 58,760 | 63,740 | +40% |
| Doctors in training | 59,851 | 62,200 | 64,342 | 66,621 | 69,961 | +17% |
| **Total** | **242,642** | **250,211** | **260,320** | **272,257** | **283,663** | **+17%** |

# The future is increasingly female.

## But gender pay gap & presence in senior leadership still significant

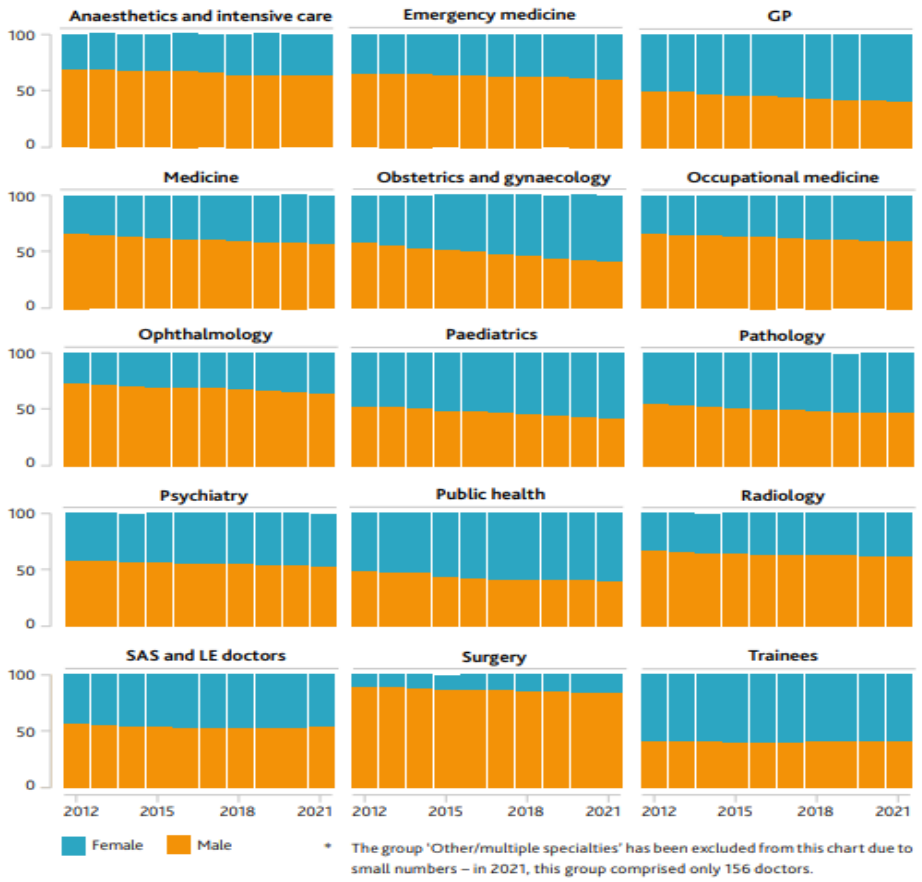
**Figure 19: Proportion of licensed doctors by gender, by year**



# M vs F by Speciality/Training Prog

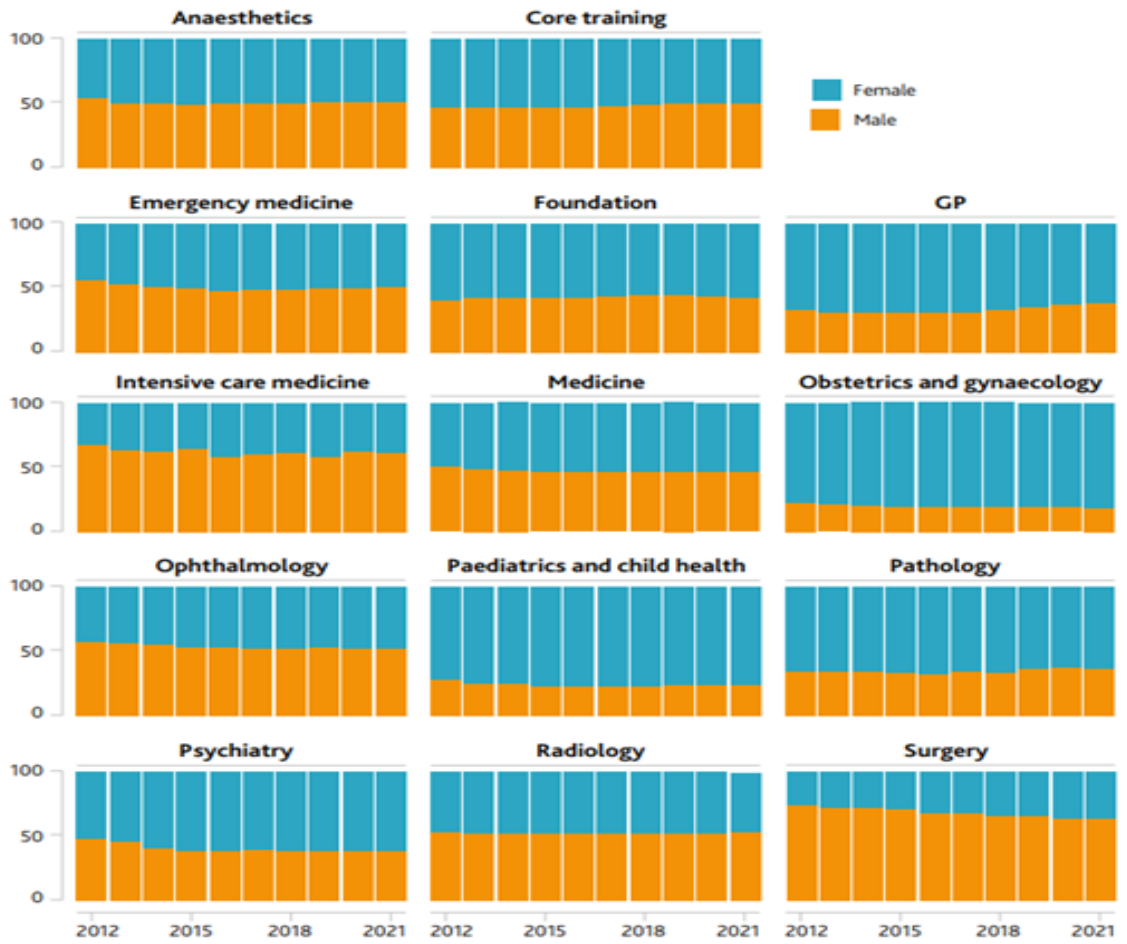
*(GMC 2022)*

Figure 20: Proportion of licensed doctors by gender, specialty and year




The group 'Other/multiple specialties' has been excluded from this chart due to small numbers – in 2021, this group comprised only 156 doctors.

Figure 37: Gender proportion by postgraduate training programme, by year



# International Medical Graduates – growing

*(GMC 2022)*

Figure 3: Workforce size in 2017 and 2021 by register type and for IMGs

| | Licensed doctors | | | IMGs | | |
|---|---|---|---|---|---|---|
| | 2017 | % change | 2021 | 2017 | % change | 2021 |
| Doctors in training | 59,851 | 17% | 69,961 | 6,956 | 98% | 13,035 |
| SAS and LE doctors | 45,578 | 40% | 63,740 | 23,268 | 60% | 37,132 |
| GP | 60,690 | 7% | 65,160 | 9,653 | 10% | 10,579 |
| Specialist | 75,282 | 11% | 83,513 | 18,602 | 11% | 20,594 |
| Total | 242,642 | 17% | 283,663 | 58,119 | 40% | 81,340 |

Figure 30: IMGs joining the workforce each year by world region of PMQ

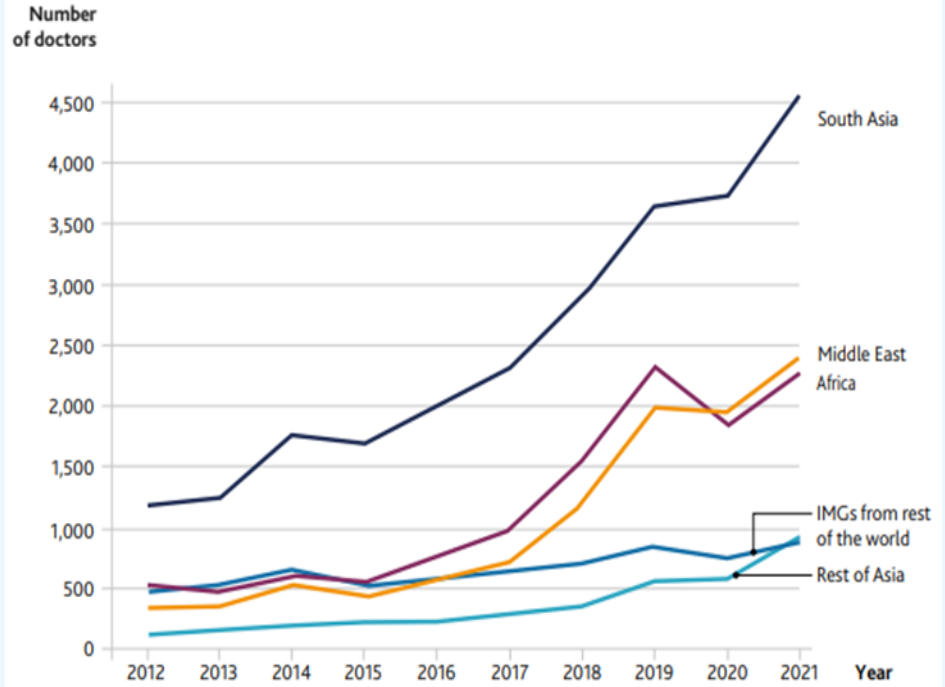


Figure 15: Number of licensed doctors on the specialist register

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2017–2021 |
|---|---|---|---|---|---|---|
| Medicine | 19,807 | 20,483 | 21,157 | 22,015 | 22,625 | +14% |
| Emergency medicine | 2,175 | 2,300 | 2,413 | 2,581 | 2,737 | +26% |
| Anaesthetics and intensive care medicine | 10,236 | 10,420 | 10,586 | 10,897 | 11,125 | +9% |
| Obstetrics and gynaecology | 3,904 | 4,005 | 4,131 | 4,323 | 4,429 | +13% |
| Occupational medicine | 583 | 569 | 565 | 547 | 528 | -9% |
| Ophthalmology | 2,270 | 2,359 | 2,378 | 2,451 | 2,446 | +8% |
| Paediatrics | 5,699 | 5,925 | 6,146 | 6,422 | 6,586 | +16% |
| Pathology | 2,976 | 3,014 | 3,041 | 3,073 | 3,104 | +4% |
| Psychiatry | 8,123 | 8,203 | 8,269 | 8,432 | 8,516 | +5% |
| Public health | 1,063 | 1,053 | 1,016 | 1,033 | 1,014 | -5% |
| Radiology | 5,795 | 5,976 | 6,153 | 6,406 | 6,584 | +14% |
| Surgery | 13,731 | 14,030 | 14,273 | 14,791 | 14,952 | +9% |
| Other specialty or multiple specialty groups | 161 | 161 | 162 | 162 | 156 | -3% |
| **Total** | **76,523** | **78,498** | **80,290** | **83,133** | **84,802** | **+11%** |

Figure 16: Number of doctors joining specialist register by specialty group

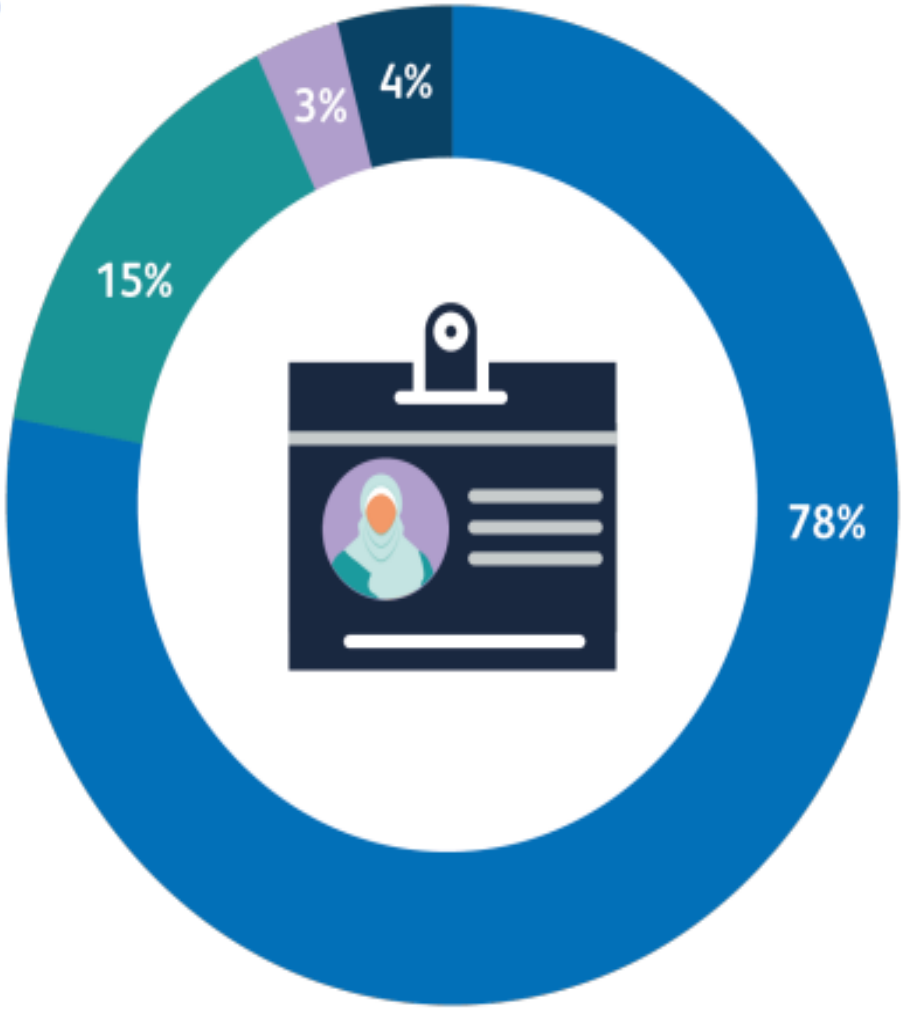
| | 2017 | 2018 | 2019 | 2020 | 2021 | 2017–2021 |
|---|---|---|---|---|---|---|
| Medicine | 1,214 | 1,263 | 1,339 | 1,274 | 1,226 | +1% |
| Emergency medicine | 163 | 153 | 182 | 209 | 229 | +40% |
| Anaesthetics and intensive care medicine | 548 | 517 | 539 | 545 | 581 | +6% |
| Obstetrics and gynaecology | 255 | 266 | 269 | 294 | 254 | 0% |
| Occupational medicine | 18 | 16 | 22 | 10 | 15 | -17% |
| Ophthalmology | 161 | 173 | 156 | 156 | 135 | -16% |
| Paediatrics | 402 | 433 | 446 | 388 | 380 | -5% |
| Pathology | 131 | 134 | 125 | 112 | 115 | -12% |
| Psychiatry | 322 | 381 | 375 | 353 | 361 | +12% |
| Public health | 43 | 44 | 26 | 34 | 38 | -12% |
| Radiology | 353 | 351 | 367 | 398 | 400 | +13% |
| Surgery | 950 | 827 | 836 | 846 | 734 | -23% |
| Other specialty or multiple specialty groups | 7 | 6 | 8 | 3 | 5 | -29% |
| **Total** | **4,567** | **4,564** | **4,690** | **4,622** | **4,473** | **-2%** |

# V: Life as a consultant specialist

(employed secondary/tertiary/community/mental health trust/university)

# Who employs consultants?

- NHS
- Academic (+/- NHS contract)
- Joint NHS-other (eg hospice)
- Other (incl hospices, royal colleges and specialist societies, etc)

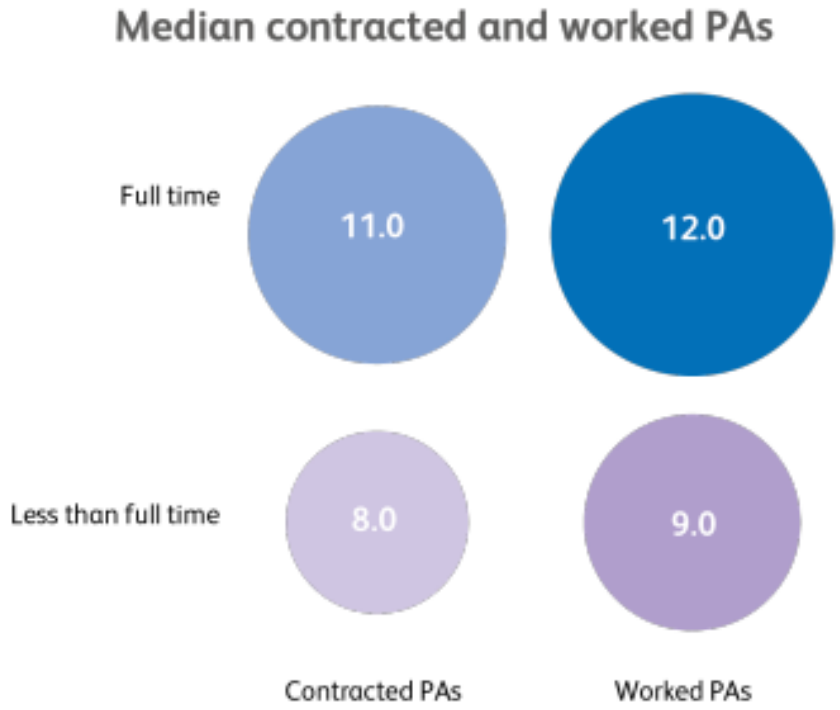



RCP Census 2022

# Consultant Contract *(BMA)*

- Based on 10 x 4 hour “Planned Activities” (PAs)
- Ideally – balance of 7.5 “Direct Clinical Care” PAs
- And 2.5 “Supporting professional activities”
- This could be more if in formal medical management or educational role or seconded to a national organisation
- Can negotiate external activities (either paid or unpaid)
- Or less than full time
- Supplements for frequency and intensity of night time/weekend on call work
- Can negotiate more than 10 PAs (e.g. for elective weekend lists/clinics)
- Clinical Excellence (now “Clinical Impact”) awards for work above and beyond
- 14% employee contribution (matched by employer) to defined benefit pension scheme
- 30-34 days’ annual leave
- 30 days over 3 years study and special professional leave
- 6 months full pay and 6 months half pay for sickness
- Enhanced early retirement sickness pension
- NHS Indemnity (though many people also take out private legal indemnity)
- Annual Appraisal
- (And every 5 years, revalidation to stay on GMC register)
- Most consultants are members of royal college and speciality society and also get CPD points and diary through their events

# Median contracted and programmed activities (PAs) of consultants

# Private practice in non-NHS time

- Only c 1 in 3 do private work
- Whole swathes of practice offer none
  - Acute/urgent/critical/frailty
- Must ensure no detrimental effect from private on NHS work
- Must disclose to employer
- Must first offer additional PA to employer

# Pay scales and awards – Consultants

*Assuming 10 PAs worked*

*And before on call supplements or private practice income*

## Consultants on the 2003 contract

| Threshold | Value £ |
|---|---|
| 1 (starting salary) | 93,666 |
| 2 (after 1 year completed as consultant) | 96,599 |
| 3 (after 2 years completed) | 99,532 |
| 4 (after 3 years completed) | 102,465 |
| 5 (after 4 years completed) | 105,390 |
| 6 (after 9 years completed) | 112,356 |
| 7 (after 14 years completed) | 119,323 |
| 8 (after 19 years completed) | 126,281 |

## Clinical excellence awards 2021 (existing LCEAs)

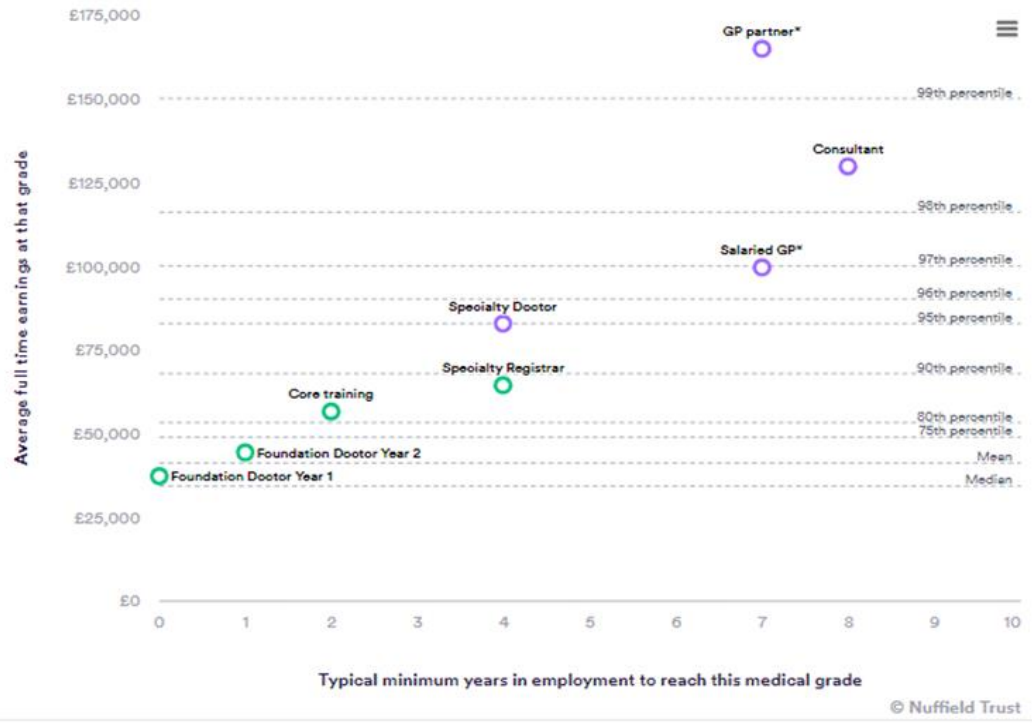
| Level | Value £ |
|---|---|
| Level 1 | 3,016 |
| Level 2 | 6,032 |
| Level 3 | 9,048 |
| Level 4 | 12,064 |
| Level 5 | 15,080 |
| Level 6 | 18,096 |
| Level 7 | 24,128 |
| Level 8 | 30,160 |
| Level 9 | 36,192 |

# Pay comparisons. *Nuffield Trust 2023*

Chart

**Figure 2: Average estimated NHS earnings of doctors compared to all jobs in England, 2021/22**

24/08/2023




Chart

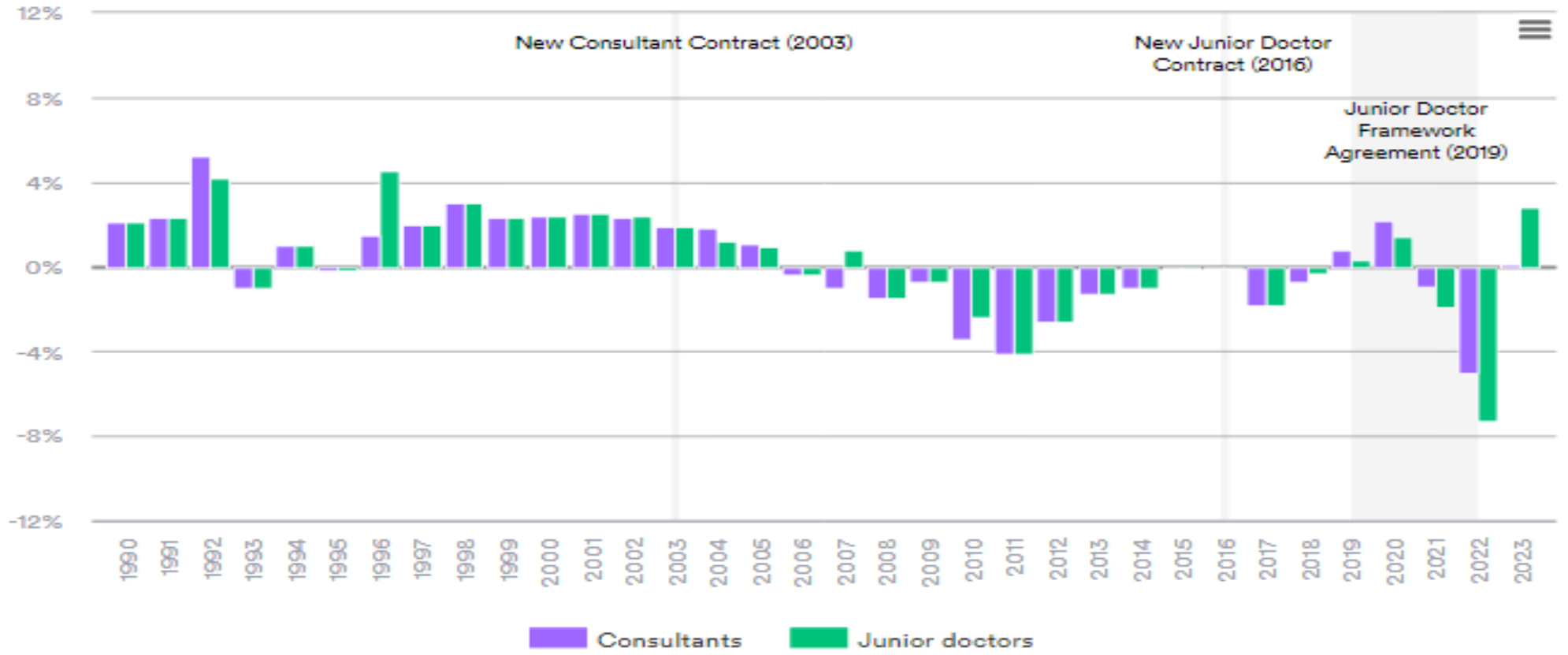
**Figure 3: How specialist doctors' pay compares internationally**

24/08/2023

# Real terms pay erosion. *Nuffield Trust 2023*

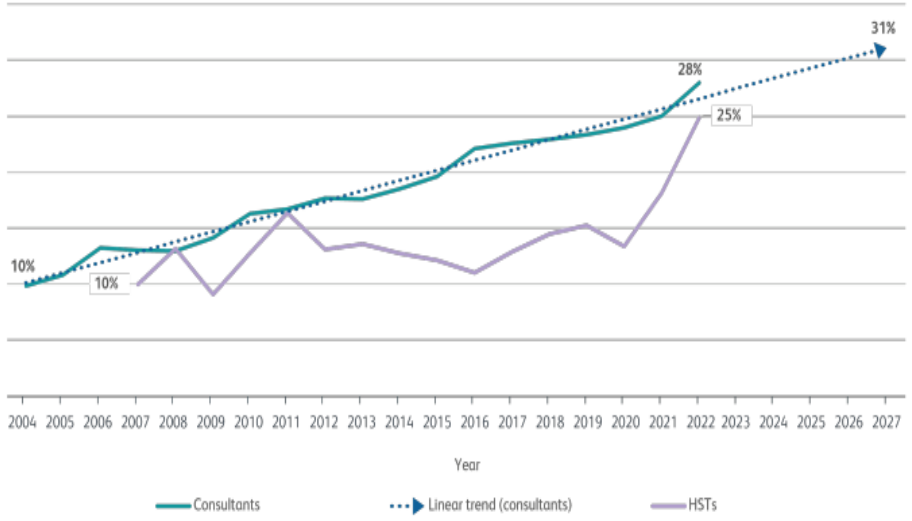
**Figure 1: Real-terms changes in pay for consultants and junior doctors since 1990**

24/08/2023



# 45% F and 18% M consultant physicians LTFT

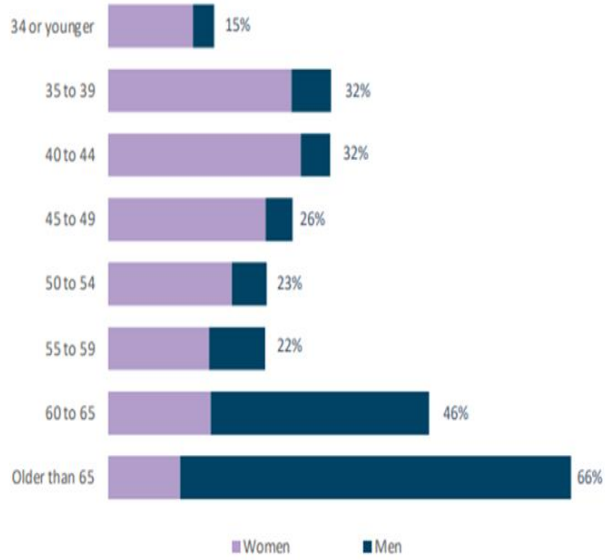
## Less-than-full-time working over time with expected trend for consultants to 2027




Less-than-full-time only: excludes full-time doctors working flexibly



## Proportion of consultants who work less than full time

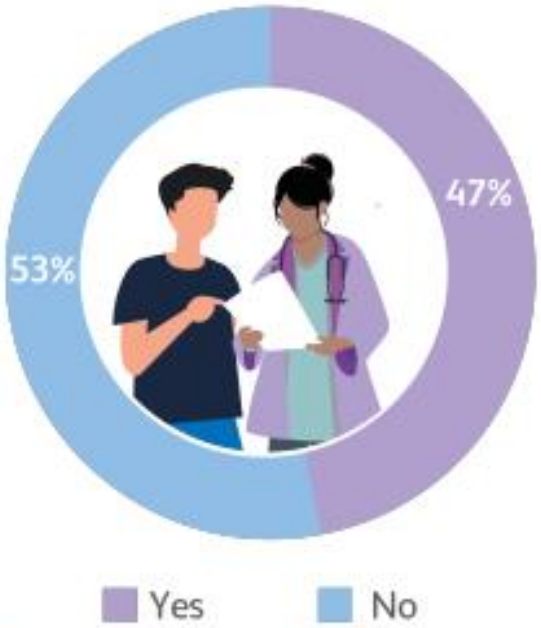




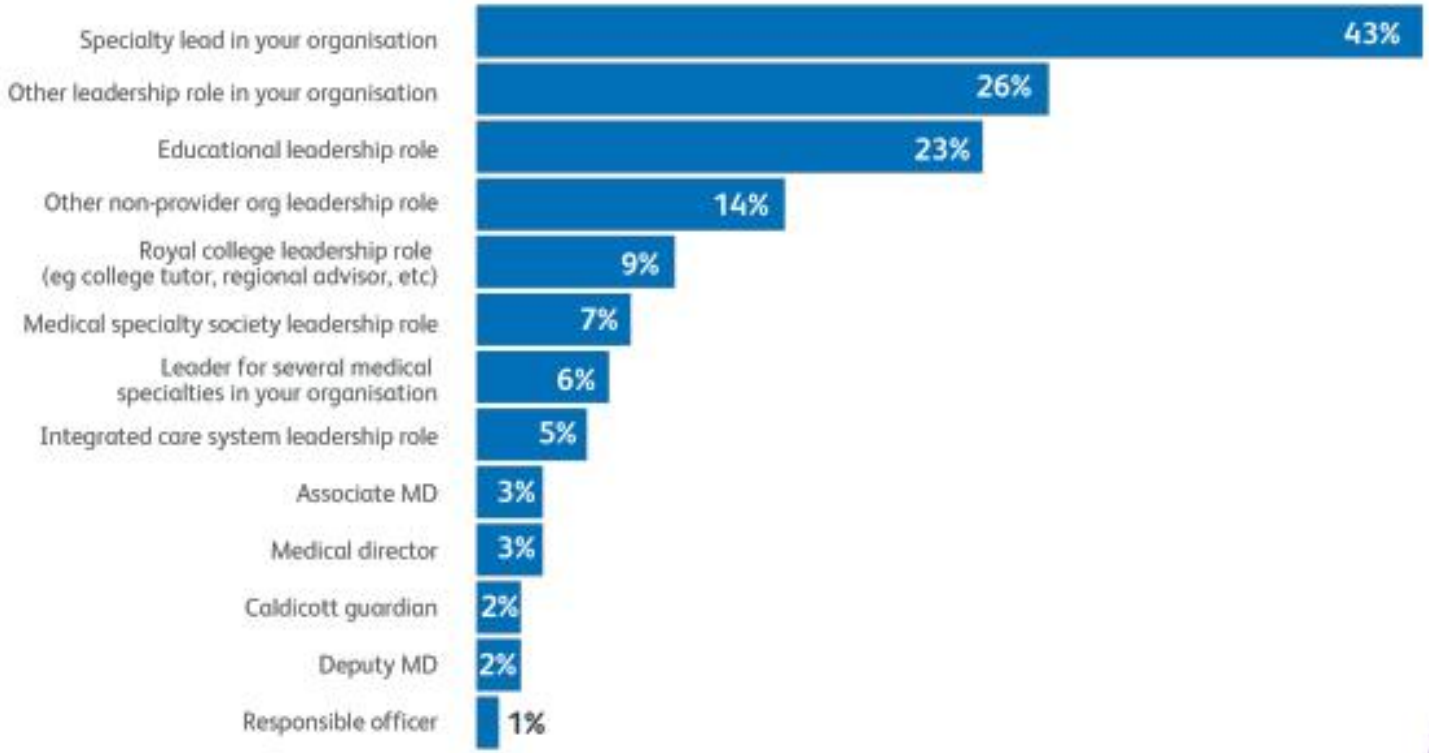

**RCP Census 2023**

# Leadership roles

## Consultants in leadership role

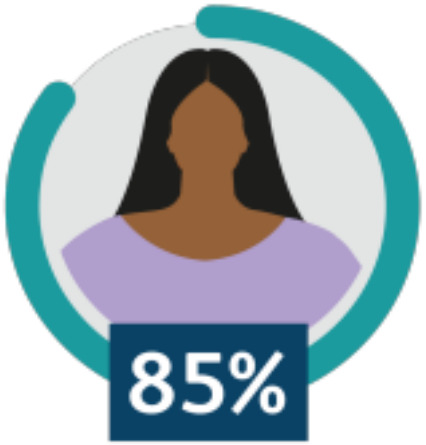



## Type of leadership role



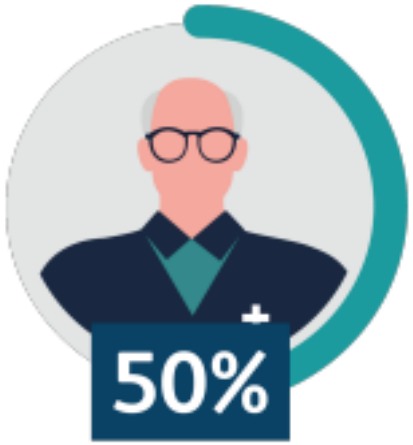
# Consultants and job satisfaction

% who said they 'always' or 'often' felt satisfied with different areas of their work




Specialty


GIM




Leadership role


Educational /training role

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# VI: Future Medical Workforce

# Some challenges

- NHS England Workforce Plan (does not cover the 3 other UK nations)
- Acknowledgement of need to train more homegrown doctors
- Rely less on overseas
- Push to create extra medical school places
- More staff in community, primary, mental health roles
- More use of non medical roles (e.g. PAs, AAs, ACPs) contentious
- Serious workforce gaps in nursing, AHPs, social care too
- But current rates of retention worsening
- More UK trained doctors leaving NHS or the Uk or wanting to
- Industrial disputes
- Dissatisfied doctors in training grades – not current getting what they want
- Older doctors burning out/leaving
- The generalist disciplines we are most in need of are the ones struggling most to recruit or train
- Have training and values caught up with reality of ageing population and multimorbidity?

# Thankyou

- Questions?
- Discussion?


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