Academy of
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Colleges

Blogpost:

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Medical careers:

A flexible approach in later years

The workforce ‘time bomb’

There are just under 12 million people over the age of 65 in the UK. With health and social care providers already struggling to cope with the demands of this increasingly ageing population, projections for future years are even more daunting.

The government has announced a welcome increase in medical school places, but these additional doctors will not be fully qualified in most specialties for 10 to 12 years at the earliest. In some specialties nearly 30% of the incumbents are due to retire within the next five to ten years and for GP’s this figure rises to 41%. The situation could be made worse by Brexit because of an anticipated fall in the number of European doctors in the workforce.

Manpower planning is vital and to be successful needs a strong evidence base. Our survey was designed to identify the drivers for early medical retirement and to identify any enablers that would encourage older clinicians to remain in the medical workforce. Retention is driven more by the features of the job than the capabilities of the individual, so supporting an ageing workforce to work longer requires changes to the working environment to fit circumstances and a job design which facilitates staff retention. Multi-generational teams comprising a mix of age ranges have greater strengths than single-age teams, but, require more careful management. Older workers bring a range of benefits to the workforce and employers tend to underestimate the cost, financial and otherwise, of failing to retain experienced staff. The cultural attitude towards redeployment within the service needs to change so that movement into new roles is considered positively.

The intensity of workloads, chronic fatigue associated with excessive work hours and staff shortages was a recurrent theme in our survey. We also found a high level of support for older clinicians who want to stop working at night or come off on-call completely; this must be given much higher priority if clinicians are to work longer. Other specialty specific surveys by the Royal College of Physicians, Association of Anaesthetists of Great Britain and Ireland, and British Medical Association (BMA) survey of more than 5,000 GPs echo our results.

Other useful measures would be an effective user-friendly IT system; one which supports rather than hinders the efficiency of the clinical workforce. This would reduce a clinician's workload and would go a long way to cutting the administrative bureaucracy that is attached to clinical activity. All permanent members of NHS staff should be able to maintain system security by login to the various computer medical databases by finger print recognition rather than repeatedly having to change passwords. Referrals from primary care to secondary care, and secondary care to tertiary care, should be in template form, with automatic population of the referral letter with significant past medical history details, current medication, allergies and lifestyle issues such as smoking, alcohol, cholesterol and weight/BMI (all already held on databases), thus preventing repetitive questioning of the patient, saving time and allowing the consultation to concentrate on the current medical issue.

The current pension caps are a driver for early retirement. Many clinicians would like to retire to discontinue their pension payments and return to work. Unfortunately, from our survey findings, this seems to only be a viable option in shortage specialties. This is surprising since these highly trained individuals lose their distinction award payments and return to basic salaries, do not require pension contributions from the employer, and generally have already completed the maximum 37 years of national Insurance payments all of which makes them cost effective to employ.

There are many studies that show more experienced doctors are also more likely to order fewer tests, make diagnoses more rapidly and avoid unnecessary repetition of investigation - making them ideal candidates for provision of local outreach care.

Older doctors can free up younger colleagues work schedules by taking on local managerial roles, training roles and mentoring young consultants. They are invaluable for Trustee roles for Colleges, advising the GMC and BMA, Postgraduate Education and Examiners. Finally, with the increasing number of doctors training and working flexibly, older clinicians could be attractive job share partners affording additional flexibility in school holidays.

With a self-evident workforce time-bomb on the horizon, our survey adds weight to what many of us already long-suspected. Employers and those responsible for the delivery of health and social care need to think differently about how doctors are treated towards the end of their careers. Only then will stand any chance at all of dealing with the challenges we face now and which will surely only get worse in the future.

Miss Elaine Griffiths
Chair, Flexible Careers Committee