



**Later careers:**  
Stemming the  
drain of expertise  
and skills from  
the profession

## Contents

Introduction.....	2
Summary of recommendations.....	3
Benefits of retaining senior doctors.....	3
Less-than-full-time working.....	3
Revalidation and appraisal.....	3
Health and long term conditions.....	3
Background.....	4
What motivates doctors to retire?.....	5
Benefits of retaining senior doctors.....	6
Mentoring.....	6
Recommendations.....	6
Less-than-full-time working.....	7
Annualised activities.....	7
On call.....	7
Job share.....	7
Recommendations.....	8
Revalidation and appraisal.....	9
Revalidation requirements for appraisal.....	9
GMC contact for revalidation queries.....	9
Recommendations.....	10
Health and long term conditions.....	11
Recommendations.....	11
References and acknowledgments.....	12

## Introduction

We are facing a workforce crisis: the Royal College of Physicians' (RCP's) 2016–17 census<sup>1</sup> showed that 45% of advertised appointments to consultant posts were unsuccessful, primarily due to a lack of applicants. At the same time, pension rules are prompting consultants to retire sooner rather than later.

At a time of low morale,<sup>2</sup> less-than-full-time (LTFT) working at a later stage of a consultant career can be of benefit to patients, the individual doctor, the hospital and the wider medical community. But it must be properly planned so everyone in the team understands and appreciates their role.

This guidance will help doctors, NHS leadership and policy makers stem the drain of expertise and skills from the profession. While focused on doctors at a later stage of their career, it may also be relevant to other healthcare professionals.

The guidance aims to

- develop a sustainable model of working that enables a satisfactory work–life balance for doctors prior to retirement
- enable doctors working LTFT to be fully integrated and valued within the team in which they are working, to the benefit of that team and patients
- develop resources and mechanisms to support revalidation and appraisal.

The quotes in this document are personal communications from individual consultants at a later stage in their careers.

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## Summary of recommendations

The RCP supports flexible working to retain consultants in the later stages of their career. Their continued involvement enhances quality and patient care.

### Benefits of retaining senior doctors

1. Make flexible or part-time working options available to senior doctors where possible.
2. Mentoring of newly appointed or trainees should be included in a senior doctor's job plan.

### Less-than-full-time working

3. Senior doctors and clinical leads should begin a discussion at age 55 about intentions for the next 10 years.
4. Job planning should be done as a department to make sure roles are complementary.
5. The hospital and consultant should agree an annual total of programmed activities.
6. Past the age of 60, a consultant should opt into on-call only if they wish to, after discussion with the clinical lead.
7. The hospital and consultant should consider job sharing.

### Revalidation and appraisal

8. The RCP should review its CPD requirement for senior doctors.
9. Appraisal of senior doctors should be sensitive and proportionate to their working arrangements.
10. Investment in IT systems or administrative support teams should be provided to support the consultant with collection of information for appraisal.
11. Mandatory training should be appropriate to the clinical role. The Responsible Officer should show judgement on requirements.

### Health and long term conditions

12. More research is needed into the number of doctors with long term conditions and the impact on their working lives.
13. The RCP should take a lead in a positive, proactive approach to finding solutions that will help doctors who are disabled or have a long term health condition have the best chance of continuing to work.
14. Departmental job planning is vital to ensuring that doctors with ill-health or disability have work commensurate with their capacity and make a valuable contribution to their teams.
15. Issues of revalidation and 'fitness to practice' may need bespoke solutions when there have been extended periods of ill-health. Retention of skilled individuals with the best health possible should be the guiding principle.
16. The establishment of regional occupational health departments with experience of individuals with complex conditions should be considered.

## Background

The 2016/17 RCP census<sup>1</sup> highlighted that 45% of advertised appointments to consultant posts were unsuccessful, primarily due to a lack of applicants. This means significant vacancies at both trainee and consultant level.

The lack of trainees has resulted in 55% of consultants reporting gaps in trainees' rotas frequently or often. In 22% of these cases, rota gaps were causing significant problems with patient safety.

The number of consultants reaching 60 years will continue to rise. Currently 8% of consultant doctors are over 60, of which 47% work LTFT.

Already 5% of consultant doctors are people who have retired and then returned to work, 81% on a LTFT basis. But 69% of those aged over 55–60 would like to do the same.<sup>3</sup>

The NHS Working Longer Group cites a number of motives employees have for extending their working life, including

- financial need
- benefits to health and vitality from the physical activity involved in working, particularly from maintaining routines and obligations
- increased psychological wellbeing by maintaining professional identities and meeting challenges
- continuing personal development
- continuing social affirmation and friendships at work.<sup>4</sup>

Since 2015, the Normal Pension Age at which NHS employees can receive their pension without reduction for early payment is the same as their State Pension Age. In response, the NHS pension scheme described flexible retirement options, including 'winding down', and 'retire and return'.<sup>4</sup> In 2017 these options were further described in *Retaining your clinical staff: a practical improvement resource*.<sup>5</sup>

If these motivations and options can be explored for all doctors approaching retirement, it will be of great benefit to the workforce. Taking a flexible approach will increase the number of available doctors, and make sure their skills and experience remain available and up-to-date.

## What motivates doctors to retire?

In the 2015/16 RCP census,<sup>6</sup> consultants were asked what motivates them to retire. The main reason was 'pressure of work', followed by 'dissatisfaction with the NHS' and 'length of hours'.

For the first time we also asked about pensions, and the fourth most common reason given was 'changes in pension arrangements'. Anecdotally, an increasing number of doctors are citing the arrangements as a motivation to retire. It may be necessary for the BMA to explore their impact.

With regard to working conditions, doctors have raised various issues that prompt them to consider retirement. They include

- revalidation and appraisal
- department dynamics and accusations of 'cherry picking'
- concerns about performance competency
- long-term conditions (6% all consultants have a long-term condition which may necessitate time off work).

## Benefits of retaining senior doctors

11% of doctors over 60 working LTFT are still contributing to the acute unselected medical take.<sup>1</sup> In an ageing population with multiple co-morbidities, the value of general medical skills is of increasing benefit in patient care, particularly inpatients, and should be valued.

Ambulatory care, an increasingly important part of emergency care provision, provides an opportunity for utilising senior medical experience in a planned environment.<sup>7</sup> It is likely that this type of service provision will increase in the future.

Hospitals need to retain senior doctors to provide clinical services and other roles. The RCP recommends hospitals 'make flexible or part-time working options available to older doctors where possible'.<sup>8</sup>

*I believe my experience makes me quicker in clinic (they rarely over-run), and I perform fewer and more targeted investigations.*

For example, rota gaps have compromised teaching, management and research at the expense of maintaining emergency services. The RCP wellbeing survey 2017 showed consultants clearly wanted more time for these activities.<sup>3</sup> Doctors working LTFT could help ease the pressure.

### Mentoring

Senior doctors have a key role to play in mentoring, such as that offered through the RCP mentoring scheme. As well as passing on what they have learned during their career, senior doctors can act as an exemplar and an ambassador for the specialty.

Mentoring is of particular benefit to trainees as they develop their career goals, but it should also be of benefit to the mentor in terms of job satisfaction. The wider team benefits too, as the skills and experience of their senior colleagues are retained.

### Recommendations

1. Make flexible or part-time working options available to senior doctors where possible.
2. Mentoring of newly appointed or trainees by senior doctors should be included in their job plan.

## Less-than-full-time working

LTFT working enables someone to continue working, but less intensely. With proper planning it will be of benefit to the department or unit as a whole.

In 2017 NHS Improvement published *Retaining your clinical staff: a practical improvement resource*.<sup>5</sup> It lists four options as a doctor approaches retirement:

- wind down: working fewer days
- step down: less demanding role with fewer responsibilities
- draw down: staff at minimum pensionable age take between 20% and 80% of their pension while continuing as NHS employees
- retire and return: retire, claim pension benefits and then return to work.

Senior doctors and clinical leads should begin a discussion at age 55 about intentions for the next 10 years. That will allow for planning of appropriate recruitment, training and mentoring of incoming staff.

Job planning should be done as a department to make sure roles are complementary. It will also make sure everyone understands who will be doing what and why.

At the time of retirement it is likely a consultant is at their professional best in subspecialties developed over their career. It is natural to want to continue those areas of interest. A department- or unit-wide discussion will aid understanding and help avoid accusations of 'cherry picking'.

### Annualised activities

The hospital and consultant should agree an annual total of programmed activities. Alternatively they could agree a number of specific activities to be delivered over the year, such as outpatient clinics. For more information, see *A guide to consultant job planning* from NHS employers and the BMA.<sup>9</sup>

### On call

The stamina for out-of-hours work may reasonably have deteriorated during a consultant career. The Academy of Medical Royal Colleges' later careers survey identified on-call commitments as the main influence to retire after pension arrangements.<sup>10</sup>

The 2016/17 RCP census shows that participation in acute medical on call drops through a career, from 44% at the start to 18% at the end.<sup>1</sup> Participation in specialty out-of-hours work drops from 80% at the start of a consultant career to 57% at the end. In the RCP wellbeing survey 2017, on-call came second to personal life as the driver for retirement planning.<sup>3</sup>

The Academy of Medical Royal Colleges recommends that past the age of 60 a consultant should opt into on-call only if they wish to.<sup>10</sup>

### Job share

One way of reducing a senior doctor's hours is to introduce a job share, dividing a full time role between two people. As well as facilitating LTFT working, it can be a beneficial learning experience.

*I have returned to work doing a job share with a former trainee. We both work three 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.*



### Recommendations

3. Senior doctors and clinical leads should begin a discussion at age 55 about intentions for the next 10 years to allow for planning of appropriate recruitment, training and mentoring of incoming staff.
4. Job planning should be done as a department to make sure roles are complementary.
5. The hospital and consultant should agree an annual total of programmed activities.
6. Past the age of 60 a consultant should opt into on-call only if they wish to, after discussion with the clinical lead.
7. The hospital and consultant should consider ways of facilitating LTFT working, including job sharing.

## Revalidation and appraisal

Consultant concerns regarding appraisal and revalidation have centred on the workload and requirements of the process.

*There must be many like myself who are planning to retire from their main occupation in their 50s, but who for reasons more professional than financial would like to continue to offer their skills on a much more part time basis. One of the main barriers to this is appraisal and revalidation. This is burdensome enough when in full time work but becomes much harder as the clinical activity reduces and the opportunity to document and collect the evidence demanded becomes more difficult. After 30 years as a doctor I would have thought that I had demonstrated my competence and experience sufficient to be permitted to work a couple of sessions a week, and being forced to go through this process seems like a slap in the face when all I want to do is help out at a time of national shortage.*

Sir Keith Pearson, independent chair of the former Revalidation Advisory Board, carried out a review of the operation and impact of revalidation throughout 2016. The report was published in January 2017.<sup>11</sup> Key recommendations were:

- Regulators should remove unnecessary burdens and look at practical ways they can reduce the time and effort needed to prepare for appraisal.
- The GMC should continue its work with partners to update guidance on the supporting information required for appraisal for revalidation to make clear what is mandatory (and why), what is sufficient, and where flexibility exists. They should also ensure consistency and compatibility across different sources of guidance.
- Healthcare organisations should explore ways to make it easier for their doctors to pull together and reflect upon supporting information for their appraisal. This might occur through better IT systems or investment in administrative support teams.

The GMC has published guidance in response to this report.<sup>12</sup> They have highlighted the need to

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

### Revalidation requirements for appraisal

The GMC is updating its guidance on the supporting information doctors must collect and reflect upon at their appraisal.<sup>13</sup> The aim is to make the requirements clearer so that doctors can see what is needed for revalidation, as distinct from other appraisal requirements set by their employer or organisation.

Continuing professional development (CPD) is a key part of revalidation. The requirement to undertake a minimum average of 50 hours CPD per year is set by the RCP.<sup>14</sup>

The RCP has produced guidance for appraisal and revalidation,<sup>14</sup> and *Mythbusters: addressing common misunderstandings about appraisal and revalidation*.<sup>15</sup>

Mandatory training should be appropriate to the clinical role. The Responsible Officer should show judgement on requirements.

### GMC contact for revalidation queries

- [www.gmc-uk.org/doctors/revalidation/contact\\_us\\_doctors\\_reval.asp](http://www.gmc-uk.org/doctors/revalidation/contact_us_doctors_reval.asp)
- 0161 923 6277 (or +44 161 923 6277 from outside the UK)
- [revalidation@gmc-uk.org](mailto:revalidation@gmc-uk.org)

## Recommendations

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## Health and long term conditions

In the RCP wellbeing survey 2017, 6% of doctors reported a long-term health condition that required them to take time off work intermittently.<sup>3</sup> 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.<sup>16</sup>

The GMC requires doctors to remove themselves from work (until treatment is successful) if they feel 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.<sup>16</sup>

Requirements are likely to include a predictable work load, 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

- 12.** More research is needed into the number of doctors with long-term conditions and the impact on their working lives.
- 13.** The RCP should take a lead in a positive, proactive approach to finding solutions that give doctors who are disabled or have a long term health condition the best chance of continuing to work.
- 14.** Departmental job planning is vital to ensuring that doctors with ill-health or disability have work commensurate with their capacity and make a valuable contribution to their teams.
- 15.** Issues of revalidation and 'fitness to practice' may need bespoke solutions when there have been extended periods of ill-health. Retention of skilled individuals with the best health possible should be the guiding principle.
- 16.** The establishment of regional occupational health departments with experience of individuals with complex conditions should be considered.

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