British Geriatrics Society
Improving healthcare for older people

The state of the older people's healthcare workforce: A report from the BGS membership survey

Foreword

We last surveyed the BGS membership in the midst of the COVID-19 pandemic. The survey was designed to gather intelligence specifically about our members' experiences during the pandemic – the challenges they faced and how the services they worked in were meeting these challenges. While COVID is very much still present in our healthcare systems, the emergency posed by the virus has passed. We are aware, however, that the situation faced by our members daily is still incredibly tough.

In 2023 there was industrial action across a number of professional groups, including the first time ever that consultants have walked out. At the time of writing, these industrial disputes remain unresolved for several disciplines. The workforce continues to be under immense pressure with high vacancy rates across the system and patients facing long waits for care. Winter 2022-23 was extremely challenging for BGS members and the older people they care for and, even as we wait for formal statistics, the indications are that winter 2023-24 has been every bit as challenging.

This report gives us an insight into how our members are feeling about their work and the services they work in. For the most part, it paints a bleak picture. It tells of a workforce who are frustrated and exhausted by the system that they are working in and the desperation they feel at not being able to provide the high quality care they aspire to. Too often we talk about healthcare being a vocation, which is an unhelpful narrative; people who work in healthcare roles are professionals who deserve to be paid fairly for their time and expertise. However, it is noteworthy that very few of our respondents mentioned pay when asked what would make the biggest difference to their mental and emotional wellbeing. Far more respondents simply said that having more staff would improve their wellbeing. Healthcare professionals should receive fair pay for the crucial work that they do but they are generally not motivated by money. Rather, they want a resolution to workforce shortages so that, with their colleagues, they can achieve more for their patients.

There is however some cause for optimism. Members told us that their services have implemented innovative solutions to the workforce crisis locally, ensuring that older people can still access the care they need. While more staff are plainly needed, we applaud those services that have managed to find creative ways of working to make the most of the staff they do have. Here at BGS, we would like to be able to share those stories so that colleagues can learn from each other.

We publish this report at the beginning of what will almost certainly be an election year. Older people use the NHS and social care more than any other population group. It is imperative that political parties consider the needs of this age group, and the views of the healthcare professionals who care for them, when planning their health policies. This is vital in solving current pressures on the healthcare system but also fundamental to planning for our ageing society.

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Chaper 1: Introduction

During summer and autumn 2023, the British Geriatrics Society (BGS) surveyed members via SurveyMonkey. Our aim in doing this was twofold. Firstly, we wanted to gather workforce information from across our multidisciplinary membership. We knew that through the annual census conducted by the Royal College of Physicians[1] we had access to rich quantitative data about our physician members. We understand from this census how many geriatricians there are across the country, where they are and some information about how they feel about their work. This is useful data and we used this in our *Case for More Geriatricians*[2] report. However, we do not have equivalent data for our multidisciplinary members and this survey was, in part, an attempt to gather some of this data.

Our second reason for surveying the membership was to understand more about what is happening in their services around the country. While we will not claim that this survey gave us as much data on the multidisciplinary team as we were hoping for, it did give us an insight into how our members are feeling about the services they work in and the care they are currently providing for their patients.

The survey was open from 31 July 2023 until 9 October 2023 and was promoted to members through email and posts on X (formerly Twitter). At the time of the survey, BGS had 4,600 members across the multidisciplinary team; 359 people responded to the survey, representing around 8% of the total membership.

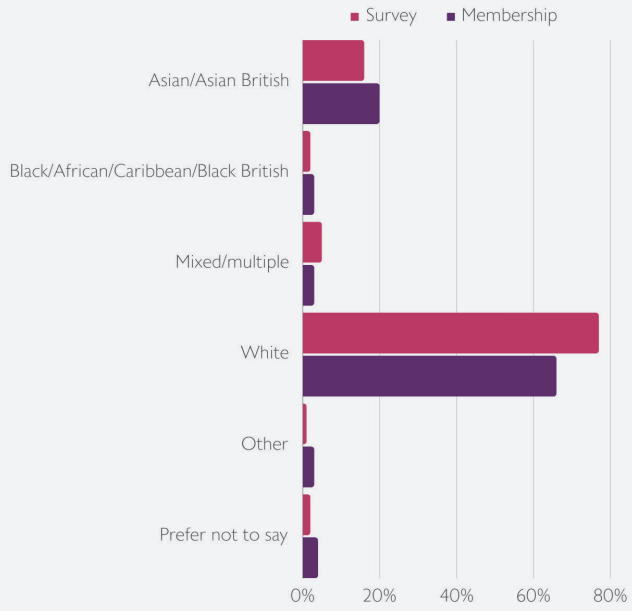
We regularly analyse data from the RCP census from the perspective of geriatric medicine and publish this analysis.[3] Our latest analysis of the RCP data will be published shortly after this report is published. We have cross-referenced some of the findings from the census into this report where relevant.

Chapter 2: Who responded

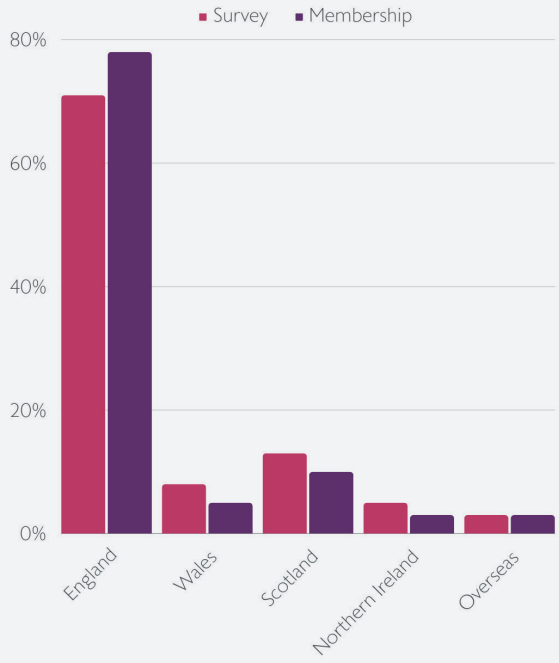
Demographics

Approximately two thirds (66%) of those who responded identified as female, 33% identified as male and 1% preferred not to say. This matches closely with the gender make-up of our membership. More than 60% of respondents were aged between 40 and 59. When asking about ethnicity, we used categories used by the Government for the census[4] which break down common ethnic groupings into more specific ethnicities. The majority of respondents told us they were white (English, Welsh, Scottish, Northern Irish or British) with 68% of respondents placing themselves in this category. In total, 77% of respondents told us that they were from white ethnic groups. The second largest ethnic group was Asian or Asian British (Indian) with 7% of respondents identifying with this ethnicity. When added together, those from all Asian and Asian British ethnicities comprised 16% of respondents. Only 2% of respondents told us they were from Black ethnicities, making this the smallest ethnic group. We do not hold full ethnicity data on all our members. However, from what we do hold, it appears that members from white ethnic groups are slightly overrepresented in our survey responses when compared to members from other ethnic groups.

Ethnicity of BGS membership and survey respondents



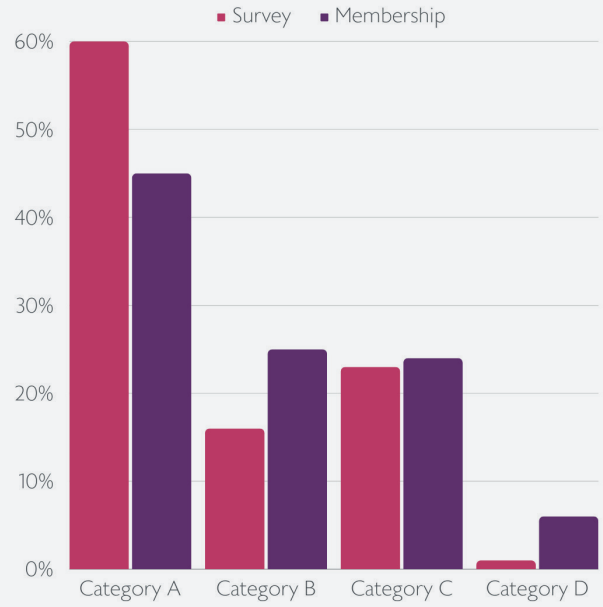
Proportion of membership and survey responses by nation



Just over 70% of respondents were based in England with 13% in Scotland, 8% in Wales, 6% in Northern Ireland and 3% outside of the UK. When compared to our membership distribution, it appears that members in England are slightly underrepresented in this survey as 78% of our membership is based in England. The devolved nations are each slightly overrepresented when compared to their share of the BGS membership.

Responses were received from each of the English regions of membership. The fewest responses were received from Mersey with 1.2% of responses, while the region with the most responses was the South East with 11.8% of responses.

Proportion of membership and survey responses by membership category



Work

More than half (60%) of respondents are in Category A of BGS membership which includes senior doctors – post CCT[i] or CESR CP.[ii] Category B members (pre CCT or CESR CP doctors) represent 16% of respondents. Just under a quarter (23%) were in Category C which includes healthcare professionals such as nurses and allied health professionals and 1% were in Category D which is the free membership category available to students. With the exception of category C members, the distribution of responses does not closely match our distribution of our membership. Category A members are over-represented in the survey response as they comprise 45% of our membership. Category B members are underrepresented as they comprise 25% of our membership. As mentioned, category C members almost match as they comprise 24% of our membership. Category D members are underrepresented as they comprise 6% of our membership.[iii] The vast majority of those responding from category A were consultants in geriatric medicine with 80% of category A respondents giving this as their job title. The second largest profession within this category were GPs who comprised 6% of respondents from category A.

More than half (56%) of those from category B said they were Specialty Registrars followed by 26% who told us they were Associate Specialists or SAS grade doctors.

Within category C, the largest group was Advanced Clinical Practitioner (ACP) at 30% followed by Consultant Practitioner (CP) and physiotherapist, both at 19%. Within the ACP and CP groups, we asked respondents to specify their profession by registration, and nurses were the most represented profession in both categories.

i. Certificate of Completion of Training
ii. Certificate of Eligibility for Specialist Registration via the Combined Programme
iii. Membership data correct as of 31 December 2023.
iv. We were advised by members of our Trainees Council to use this terminology instead of 'junior doctors'.

The people who responded in category D were undergraduate medical students and foundation year doctors. However, the numbers responding in this category were very low and because of this, we have avoided making generalisations about this group in the analysis.

The majority of respondents (60%) work in an acute hospital setting. Nine per cent told us they work in blended working roles and 8% said they work in a community including hospital at home and virtual wards (excluding community hospitals which were a separate category). Six per cent told us they work in primary care and 5% said they work in community hospital.

Almost two thirds (62%) of respondents work full time with 28% working less than full time. Analysis of the RCP census shows that 31% of consultant geriatricians work flexibly or less than full time. Of those within the BGS membership who work less than full time, 83% told us that they identify as female. The vast majority (93%) of respondents work in a role that is clinical at least part of the time.

Chapter 3: About their service

Short-staffing

We asked our members a series of questions to understand more about the situation in the services they work in. Four fifths (81%) of respondents told us that their service is short-staffed at least weekly with 51% saying that the service was short-staffed on a daily basis. Analysis of the RCP census suggests that this aligns with the views of consultant geriatricians although consultants across all specialties report lower levels of short-staffing than seen in geriatrics. There was some variation in answers to this question depending on nation, work setting and profession. Around two thirds (67%) of respondents in Northern Ireland said that their service was short staffed on a daily basis compared to 49% in England. Around half (52%) of those working in acute hospitals said their service was short staffed daily compared to 43% of those working in community hospitals and other community settings. Respondents from category A of BGS membership (senior doctors) reported services being short staffed more frequently than other groups. More than half (56%) of category A members reported their service being short staffed on a daily basis compared to 41% of category B members (Specialist Registrar or SAS grade doctors) and 46% of category C members (healthcare professionals).

Respondents were then asked where in the multidisciplinary team the gaps occur. A list of professions was provided with respondents able to tick as many as were applicable. Respondents said that gaps occurred across the team with nursing roles and trainee doctor roles most commonly identified at 65% and 61% respectively.

Gaps occur among:

- **Nursing staff:** 64.7%
- **Trainees and doctors in training:** 61.3%[iv]
- **Therapy staff:** 55%
- **Consultant physicians:** 46.7%
- **Pharmacists:** 26.3%
- **All/combination:** 24.7%
- **Consultant practitioners/ACPs:** 14%
- **GPs:** 8.3%
- **Other:** 4.3%

Vacancies

Nearly three quarters of respondents said that they were aware of vacancies being advertised but not recruited to. More than one in ten (13%) said they were not aware of this and another 13% said they are often not aware when vacancies are advertised so were unable to answer this question. More than four in ten (43%) of respondents told us that they were aware of vacancies not being advertised because there was no expectation of being able to recruit to the post. More than a third (39%) said they were not aware of this happening with 18% saying that they are often not aware of vacancies being advertised at all so were unable to say whether this happened.

There was significant variation between the four nations with members in Scotland more likely than those in the other nations to report difficulties recruiting. The vast majority (85%) of respondents in Scotland told us that they are aware of vacancies being advertised but not recruited to. This compares to 75% in England and 67% in both Wales and Northern Ireland. Nearly two thirds (64%) of respondents in Scotland also told us that they are aware of vacant posts not being advertised because there is no expectation of filling them. Again, this is higher than the other nations with 47% of respondents from Northern Ireland telling us the same and 41% and 29% from England and Wales respectively. Within England there also appears to be some geographical variation in recruitment. We compared responses for these questions from the five English regions with the highest response rates to the survey.[v] Proportions of respondents who were aware of vacancies being advertised but not recruited to ranged from 67% in the South East to 89% in the North West. There was less variation in answering the question about roles not being advertised. More than a third (36%) of respondents from the South West responded yes to this question, the lowest of the five regions. This compares with 48% in the West Midlands, the highest rate across the five regions.

Respondents were asked what roles are vacant in their services and the responses showed vacancies across the multidisciplinary team with the highest number of vacancies occurring among consultant physicians, nursing staff and therapy staff. Interestingly, a low number of respondents reported vacancies occurring in consultant practitioner and advanced clinical practitioner roles, suggesting that these roles may not be in use in all services.

Solutions

The survey asked members if their service had implemented innovative solutions to short staffing and 33% said they had. Under half (40%) said they had not and 26% didn't know. Respondents were given the option to provide more detail about their innovative solution in a free text box. Many of the responses to this focused on using the multidisciplinary team and particularly advanced clinical/nurse practitioners.

v. South East, South West, West Midlands, Yorkshire, North West

vi. Falls cars are used to enable healthcare professionals to provide care at home for people who have fallen but may not need to be transferred to hospital. Services vary around the country but details of one example can be found at: https://healthinnovationwessex.org.uk/img/projects/HHFTSCAS%20first%2018days.pdf

'We have invested in Physician Associates and ACPs in frailty. We have also recruited a GP with an interest in frailty to support consultant/registrar gaps.'
– Consultant geriatrician, Wales

'We work as MDT in day hospital and constantly prioritise workload, and where possible help other staff groups when roles overlap.'
– Consultant geriatrician, Scotland.

'Employing ANPs. Enhancing the role of more senior nursing staff and giving better development and career opportunities. Developing a new band 4 practitioner role to help with high level of band 5 gaps, means more hands-on staff on the ward and training development opportunities for the band 4.'
– Clinical director, Scotland

Respondents also told us about innovative recruitment practices intended to expand the pool of potential applicants for vacant positions.

'Offering post as band below with training. Or readvertising a revised post at a different band where there will be candidates.'
– Consultant geriatrician, England

'We have open recruitment, so RN, RMN or AHP. Full time or part-time, various hours offered to support work life balance. Also offer apprenticeships and ACP development pathways.'
– Occupational therapist, England

'In the past – lack of applicants for vacant SAS posts so medical staffing restructured to have clinical fellows working on wards with senior SAS (me) supervising them.'
– SAS, Wales

'Created integrated roles across urgent care community, ambulance service (falls car)[vi] and ED frailty team.'
– Consultant Practitioner, England

However, some respondents highlighted what they considered to be the negative effects of innovative recruitment practices including taking staff from other areas of the service, non-specialist staff caring for older people with frailty and complex needs and lack of funding.

'Staff redirected to the front door services compromising ward cover.'
– Consultant geriatrician, Wales

'Community hospitals are manned by GP/ overseas geriatric/overseas physicians to oversee ACPs. One of the acute hospital sites has no geriatricians and the so-called frailty wards are under general medics.'
– Consultant geriatrician, England

'The local service is implementing innovative solutions but there is 'no funding' for GP frailty roles. I am an experienced GP who has done a year in frailty. I have had verbal support for a frailty role but it has not translated into work. I am trying to understand the barriers.'
– GP Locum, Wales

Use of locums

More than a third (38%) of respondents told us that their service uses locums more than half the time, with more than a quarter of respondents saying that locums work in their service between 75 and 100% of the time. Less than a quarter (17%) told us that locums are never used in their service and a further 20% said that locums are used less than 25% of the time. This aligns with findings from the RCP census for both consultant geriatricians and consultants across specialties. There was not a significant difference between the four nations regarding the use of locum staff. More than a third (37%) of respondents in Scotland reported use of locums at least half of the time. This figure was 38% in Wales and 40% in both England and Northern Ireland.

Multidisciplinary team meetings

More than three quarters of respondents said that MDT meetings are held daily in their service with a further 16% saying that these meetings are held weekly. We asked respondents if they feel empowered to speak up in MDT meetings and 94% said yes. More doctors felt empowered to speak up than other healthcare professionals – 96% of both Category A and B members answered yes to this question compared to 88% of Category C members. Those who said that they did not feel empowered to speak up were asked to share the reasons why.

'As a rotating doctor, it is sometimes hard to be honest in a department where you are only there for a max of 6 months.'
– Specialist registrar in geriatric medicine, England

'Often the views of therapists are skimmed over quickly.'
– Physiotherapist, Wales

'High stress environment, board rounds are tense with every decision out to committee meaning it changes every day and you can't make a plan and expect it to happen.'
– Advanced clinical practitioner, England

Chapter 4: Work and you

Work/life balance

Three quarters of respondents told us that they work more clinical hours than are set out in their job plan with 32% saying that this occurs every day. This varied slightly depending on profession and seniority with 79% of Category A members answering either daily or weekly to this question compared to 70% of both Category B and C members. When asked to comment on this, respondents regularly pointed to staff shortages and the need to provide supervision and support to more junior colleagues as reasons for working longer hours than contracted to do so. There was also variation across the four nations with 87% of respondents in Northern Ireland saying they work more clinical hours than their job plan states either daily or weekly, compared with 63% of respondents in Wales. In England and Scotland this figure was 76% and 73% respectively.

'I am the only substantive geriatrician in frailty. Our trust doesn't prioritise recruiting the right people to the job.'
– Consultant geriatrician, England

'I should be clinical 1/3 of my week, but currently work either full time clinical or at least 2/3 clinical due to staffing gaps and inability to recruit. Locums are used in other teams but I don't have the budget to do this.'
– Physiotherapist, England

'Quite often work more clinically on ward to support junior doctors during times of short staffing – else there is risk to delays and harm with patients.'
– Specialist registrar in geriatric medicine, England

'Because of the lack of substantives, things like supervision, supporting trainees and references usually fall on the few substantives. For instance, in my hospital 6 consultants do all the supervision and training references covering the work of 10 substantives.'
– Consultant geriatrician, England

However, there were a significant number of responses highlighting that individuals have changed their priorities in recent years and are less likely than before to work longer hours. While we didn't ask for the reasons for this, member surveys[5,6] conducted during the COVID-19 pandemic suggested that the pandemic had caused members to re-evaluate their lives and were placing a higher value on work-life balance.

'I encourage the whole team to work to contracted hours to prevent work-based stress and subsequent unplanned absence.'
– Consultant practitioner, Wales

'It would be so easy to do but I've got more ruthless with my work life balance over the years.'
– Consultant geriatrician, England

'Now more likely to hand over or leave non-urgent jobs incomplete whereas previously used to stay late much more frequently.'
– Specialist registrar in geriatric medicine, England

'It would be so easy to always work extra hours, as many colleagues do. I tend to have a fairly ruthless attitude to my work life balance, not always easy but it does mean at work I am full on. Out of hours I generally don't look at emails and I avoid work WhatsApp groups.'
– Consultant geriatrician, England

'I used to work much more than my job plan but after a near breakdown I now do only what my job plan says.'
– Consultant geriatrician, England

Time spent on non-core activities

We asked members how much time they spend on non-core activities which were described in the survey as administrative tasks, acute geriatricians doing general medicine or community nursing staff chasing test results or following up referrals. More than half (59%) of our respondents told us that less than a quarter of their time is spent on this type of activity with a further 34% saying that they spend between a quarter and half of their time in this way.

Training and support

When asked if they have the training and support they need to do their jobs, more than three quarters of respondents said yes. This varied slightly across professions ranging from 70% for Category C members to 83% for Category B members. This also varied slightly across the four nations ranging from 73% for respondents from Northern Ireland to 83% for those from Wales. When asked to comment on this, several respondents commented on the lack of time made available for training.

'I have access but not the protected time to do it.'
– Physiotherapist, England

'Training opportunities often limited by expectation to carry out daily clinical duties, eg, no time to attend clinics or teaching, no time to be taught new procedural skills.'
– Trust grade SHO, England

'Very difficult to get to offline training. Most CPD carried out in own time.'
– Consultant geriatrician, England

'Training opportunities yes, but not the time often to look into and do it. Support no, everyone so stretched, so not from lack of wanting to support just inability to.'
– Physician Associate, England

'There is no time in job plan for training, other than mandatory training. Any other training is done in own time.'
– Advanced clinical practitioner, England

Others commented on the lack of support from management and senior colleagues and the difficulty this causes in accessing training.

'Employer does not understand the role of the ACP or the network required to support and train them.'
– Advanced clinical practitioner, England

'My department are really supportive and I have had support, time and teaching to help me submit my CESR application, which is something colleagues in other departments haven't had in similar positions to me.'
– SAS, England

'Trainees given priority over SAS colleagues. Staffing issues, rota gaps and expansion of services made it vital for SAS and locum doctors to manage and maintain services. Support and training variable.'
– SAS, Northern Ireland

Impact of work on mental and emotional wellbeing

More than half of respondents told us that their work had a negative (46%) or very negative (5%) impact on their mental and emotional wellbeing with around 30% saying it had a positive or very positive impact and 20% saying it had no impact at all. There was a slight difference across professions with 58% of Category C members saying work had a negative or very negative impact compared to 51% of Category B members and 48% of Category A members. There was a difference across the nations as well. Respondents from England matched the overall response. However, only 33% of respondents from Wales told us that work had a negative impact and no respondents from Wales selected the 'very negative' option. More than half (54%) of those from Scotland said work has a negative impact and 3% said very negative while in Northern Ireland 53% said negative and 20% said very negative. However, it should be remembered that there were fewer responses from Northern Ireland and it is therefore more difficult to make generalisations about this group.

This is not directly comparable with results from the RCP census. However, the census did ask whether respondents felt they were at risk of burnout. Nearly a quarter (23%) of

consultant geriatricians reported that they were at risk of burnout – a higher proportion than other specialties.

Respondents were given a free-text box and asked to suggest changes at work that would make a difference to their mental and emotional wellbeing. Around half of respondents (178 people) chose to answer this question and the most common theme to emerge was the need for more staff. More than a third of those who chose to answer (67 people) specify that more staff would improve their mental and emotional wellbeing. While shortages were identified across the multidisciplinary team, several people highlighted a shortage of junior doctors in particular.

'Regular staffing. Some days will have no staff and the next will be loads more people available.'
– Advanced clinical practitioner, Wales

'Fixing the workforce issues and strikes. As patient complaints and shortfalls in care are a daily occurrence.'
– Consultant geriatrician, England

'Being able to recruit to vacant posts. Mental health challenges that some of my team suffer with can at times be a burden on me emotionally and mentally.'
– Physiotherapist, England

'Not being constantly under pressure due to lack of staff or lack of adequately trained staff. Feels like any positives are just a drop in the ocean.'
– Physician Associate, England'

'Having better staffing would help enormously. People ask me if I like my job and I say I love my job when I get to do it properly, but I spend so much of each day firefighting, trying to just get the basics done, that I struggle to find time for the things that make my job, and geriatrics as a whole, meaningful – things like long conversations with patients and relatives, and ACP [advance care planning] conversations.'
– Physician Associate, England

'Having more continuity with junior staffing, so they aren't pulled between wards, and really become part of the team and can learn/work accordingly, would also benefit as know the team better and where to focus on for training. Knowing that the nursing and therapy staffing levels were better would be significantly helpful, it is hard asking for things when you know how stretched they are. They do an amazing job, despite this!'
– Consultant geriatrician, England

Some respondents mentioned that their mental and emotional wellbeing has already improved through changes to working hours and through initiatives such as 'retire and return' where they have more control over their working hours. This is consistent with trends across medicine and the three Royal Colleges of Physicians have recently published guidance aimed at supporting doctors approaching traditional retirement age to remain in practice. [7]

'I reduced my working hours significantly one year ago, which has had clear positive impact on my emotional/mental and physical wellbeing.'
– Consultant geriatrician, Scotland

'I retired and returned, dropped a day, and hope this will make a difference.'
– Consultant geriatrician, England

'I have chosen to reduce my clinical commitment to maintain my mental health. The level of pressure feels unsustainable.'
– GP, England

'Reduced hours, reduced workload. Support managing workforce, support supervising trainees. Flexible working hours.'
– Consultant geriatrician, Northern Ireland

'Better junior doctor staffing and training. As a consultant, I feel I am often 'acting down' and doing the same jobs/roles that I was doing when I was an SHO or SpR because I am either filling in gaps in the rota or providing extra support for the SHOs/SpRs who are struggling or finding it difficult to do their roles/tasks.'
– Stroke consultant, England

'I've dropped my hours partly to give me more flexibility with doing the admin, but of course this means I'm just doing more on my non-working days!'
– Consultant geriatrician, England

Many respondents expressed frustration at the level of care currently being provided to older people, acknowledging that in many cases the care falls below the standard that they would wish to provide.

'I get so frustrated witnessing poor care and massive delays for older patients in my trust, and across the country. We need all staff to have basic skills, we must speed up discharges. Despite the complexity there are lots of things within 'our gift' as ICSs to improve but the unwieldy bureaucracy gets in the way – drives me nuts! It could be so much better.'
– Consultant geriatrician, England

'Staff need to take more ownership when looking after elderly patients, training and education is required to all staff on a regular basis to deliver high standards of care. I do get frustrated not working to full potential (as a team).'
– Physiotherapist, Scotland

'No corridor care, no boarding of patients, patients move to community hospital when needed rather than weeks later. Care capacity to get people home.'
– Consultant geriatrician, Scotland

Many highlighted issues with culture and attitudes from senior management, including the acknowledgement of older people's healthcare as a specialism particularly among non-medical staff.

'Some senior managers doing their jobs. Planning ahead better and communicating more effectively and honestly. Reduction in unnecessary bureaucratic tasks.'
– GP, England

'If everyone would treat each other with dignity and respect that would make my job more enjoyable.'
– Professor, Scotland

'Appropriate recognition of the specialism (older people's mental health) with a workforce model and staffing comparable to other services.'
– Advanced Clinical Practitioner, England

'More flexible working hours, cultural change in behaviours from staff – just because some of us can't work like super heroes full-on all day does not mean we lack resilience – we are just human!'
– Occupational therapist, England

Some respondents highlighted infrastructure issues including physical spaces within clinical settings, IT facilities and integration of infrastructure between health and social care services.

'Better infrastructure: top priority IT hardware and software, next more coherent social care liaison for discharges, next phlebotomy services, lastly better HR for appointments.'
– Consultant geriatrician, England

'Better office facilities, better access to admin support, improved ward environment with space for sensitive conversations and telephone calls. Access to space and refreshments (tea/coffee/biscuits) for post ward round catch ups with the ward team for both clinical support and wellbeing/morale.'
– Consultant geriatrician, England

'An office to work in when concentrating. A quiet room to talk to families in.'
– Specialist registrar in geriatric medicine, England

Industrial action across the multidisciplinary team was constant throughout 2023 and, at the time of writing, was ongoing for some professions. Despite this, only two respondents mentioned strikes, both expressing a desire for industrial action to be resolved and highlighting the impact on staff morale and patient care. Three respondents highlighted pay as something that would affect their mental and emotional wellbeing with one specifically mentioning pay restoration which is the primary demand of junior doctors in the current industrial action. However, it is interesting that far more BGS members are more concerned about staffing levels and the provision of care to their patients than they are about their own financial interests.

Access to study leave

We asked members how easy they felt it would be for them to get study leave over the next year. Around half (49%) of respondents felt it would be very or somewhat easy and 22% felt it would be very or somewhat difficult. Around a quarter said it would be neither easy nor difficult. As may be expected, there was a difference between professions with around half of both category A and category B members saying it would be very or somewhat easy to get study leave, compared to 38% of category C members. The difference between respondents across the four nations was less significant with very similar figures across England, Scotland and Wales. Respondents from Northern Ireland were less likely to report that getting study leave would be easy but this was not matched by a greater number saying it would be difficult. Instead, a greater number of respondents from Northern Ireland said that it would be neither easy nor difficult to get study leave.

The next question asked whether the respondent felt that their study budget would be sufficient for them to attend meetings in person over the next year. Overall, 34% of respondents either strongly or somewhat agreed that their budget would be sufficient for this compared to 30% who strongly or somewhat disagreed. Around one fifth (19%) of respondents overall said that they don't have a study budget. Unsurprisingly, again

there was a marked difference across professional groups with 38% of category C members saying that they did not have a study budget, compared to 14% of category A members and 8% of those from category B. Around one fifth (21%) of category C members who indicated that they do have a study budget agreed that their study budget would cover this cost, compared to 38% of category A members and 37% of category B members. At BGS, we know that this is a challenge facing many of our nursing and allied health professional members. We try to counter this by offering grants for these members to attend our meetings.[8]

Chapter 5: Conclusions

Nothing in this report will have come as a surprise to anyone working in or using the NHS, or indeed anyone paying attention to the news. As we approach an election, this report provides further evidence that an incoming Government must prioritise the NHS and the people who work in it.

Public support for the principles of the NHS remains high – Health Foundation polling showed that 90% of people supported the NHS being free at the point of delivery, 89% support the provision of a comprehensive service and 84% support it being funded through general taxation. The same polling however found that the public are negative about the state of the NHS and are unsure about whether the principles underpinning the service will last.[9]

This is a sentiment echoed by BGS members in this survey – many remain dedicated to the principles of the NHS but are frustrated at their inability to provide good quality care for older people and worried for the future.

There is some cause for optimism. Many BGS members told us about the innovative solutions that they are implementing locally to help tackle the workforce crisis. The *NHS Long Term Workforce Plan* promises some substantial developments over the coming years. However, the biggest message from this report is that older people's healthcare remains dangerously under-staffed and this is having a significant on the wellbeing of our members and the care that they are able to provide to their patients. Any political party wishing to protect the principles upon which the NHS was founded must address this point first and foremost.

What you can do

1. **Help us to make the case for the older people's workforce by supporting our upcoming campaign #ChooseGeriatrics (more to follow)**
2. **Consider how staff can be better supported locally. Are there changes that can be made to job plans and rotas that would make a difference to staff wellbeing? Can improvements be made to the physical environment you work in to enable space for quiet work or confidential conversations?**
3. **Innovate – there are creative solutions out there. Look at what others have done and steal with pride. Have you done something innovative? Let us know so we can share it with other members.**
4. **Join the community. BGS SIGs and committees provide an excellent opportunity to network with colleagues and new faces are always welcome. Find out more at www.bgs.org.uk.**

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References

1. Royal College of Physicians, 2023. The UK 2022 census of consultant physicians. Available at: www.rcplondon.ac.uk/projects/outputs/uk-2022-census-consultant-physicians (accessed 3 January 2024)
2. British Geriatrics Society, 2023. The case for more geriatricians: Strengthening the workforce to care for an ageing population. Available at: www.bgs.org.uk/MoreGeriatricians (accessed 3 January 2024)
3. British Geriatrics Society, 2022. The geriatric medicine workforce 2022. Available at: fappro (accessed 23 January 2024)
4. Cabinet Office, undated. List of ethnic groups. Available at: www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups/ (accessed 3 January 2024)
5. British Geriatrics Society, 2021. Through the visor: Reflecting on member experiences of the COVID-19 first wave. Available at: www.bgs.org.uk/resources/through-the-visor-reflecting-on-member-experiences-of-the-covid-19-first-wave (accessed 3 January 2024)
6. British Geriatrics Society, 2021. Through the visor 2: Further learning from member experiences during COVID-19. Available at: www.bgs.org.uk/throughthevisor2 (accessed 3 January 2024)
7. Royal College of Physicians, Royal College of Physicians of Edinburgh and Royal College of Physicians and Surgeons of Glasgow, 2023. Later careers 2023. Available at: www.rcplondon.ac.uk/news/rcp-later-careers-guidance (accessed 3 January 2024)
8. British Geriatrics Society, undated. BGS event grants. Available at: www.bgs.org.uk/grants (accessed 3 January 2024)
9. Health Foundation, 2023. Public perceptions of the NHS: a winter of discontent. Available at: www.health.org.uk/publications/long-reads/public-perceptions-of-the-nhs-a-winter-of-discontent (accessed 3 January 2024)

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