

Caring, supportive, collaborative?



Doctors' views on working in the NHS



September 2018

Caring, supportive,
collaborative



a future
vision
for the NHS

1. Introduction

Across the UK, the NHS is facing some of the most difficult challenges in its 70-year history. More people than ever before rely on the expert care it provides every day, with the UK's population continuing to both grow and age, and an increasing number of people now living with multiple long-term conditions. But at a time when levels of patient need are rising, the NHS has experienced nearly a decade of underfunding, leaving many services under intense pressure all year round¹.

Doctors experience these challenges in their working lives every day. Many feel they are increasingly expected to provide patient care in an unsafe, unsupportive environment, where a persistent culture of blame stifles learning and discourages innovation. This is contributing to a vicious cycle of low morale and poor recruitment and retention, contributing to endemic workforce shortages.

The BMA's Caring, supportive, collaborative project² aims to understand and find solutions to these challenges. Launched in early 2018, the project is engaging doctors in an open conversation about what they want the NHS they work in to look like. It also aims to bring together the views of doctors with those of patients, managers and policymakers, to establish a vision for the future of the NHS.

In order to better understand what is currently happening at the frontline of the NHS, in May/June 2018 we conducted a major survey of doctors across the UK. We asked doctors for their views on a range of issues affecting their working lives, focusing on three themes:

Culture – How does the current environment of the NHS affect doctors' well-being? Do they feel they work in a supportive culture in which they are able to fulfil their professional duty of care to patients and are able to raise concerns in order to improve quality and safety?

Workforce – What support do doctors need in an environment of workforce shortages – including any changes in workforce skill mix – to meet the changing needs of patients?

Structures – What are doctors' views and wishes about how the NHS is structured with regards to collaborative working and promoting innovation?

Summary of the results

Across the UK, 7,887 doctors took part in the survey. This report sets out the responses we received, which together provide a clear picture of the challenges and opportunities facing doctors in the NHS today. The results are stark. They reveal that many doctors feel they are working in a dangerous and toxic environment, with a culture of blame and fear jeopardising patient safety and discouraging learning and reflection. They also show the damaging impact of asking doctors to provide care without enough funding, doctors, other NHS staff, beds and equipment to meet the needs of patients. Adding to this, the results suggest that poor lines of communication and lack of IT support is holding back efforts to encourage greater innovation and collaboration in our health services.

The BMA believes a new and bold approach is needed: one that prioritises patient safety over top down targets, removes barriers to collaboration and innovation, and replaces a culture of blame with a culture of learning. Achieving this will require a major shift in how the NHS operates, with a renewed focus on ensuring that staff are valued and supported.

The findings and recommendations set out in this report are a starting point for a much wider conversation – about how we can change the NHS for the better and empower those who work in it to do what they do best: provide outstanding care for patients.

2. Executive summary

The responses contained in this report reflect the views of doctors across the UK with the exception of some sections which deal specifically with England-only issues. Responses specific to Scotland, Wales and Northern Ireland are not covered in this report but are being collated and used in each nation as part of ongoing engagement with the governments in those nations. A separate report relating to responses in Scotland will be published later this year.

2.1 Culture, quality and safety

Key findings

- A majority (78%) of doctors say that NHS resources are inadequate and that this significantly affects the quality and safety of patient services.
- Most doctors say that patient services have worsened, including waiting times for patients (76%) and staffing levels (74%).
- Around three-quarters of doctors say that national targets and directives are prioritised over the quality of care.
- Nearly half of doctors (45%) are often fearful of making a medical error in their daily workplace and over half (55%) say they are more fearful than they were five years ago.
- Nine out of ten doctors (89%) say one of the main reasons for making errors is pressure or lack of capacity in the workplace.
- Over half of doctors (55%) worry they will be unfairly blamed for errors that are due to system failings and pressures; as a result, half of doctors practise defensively (49%).
- The majority of doctors (93%) say that system pressures have a negative impact on their ability to deliver safe patient care.
- GPs were more likely to identify being pressured to attend to multiple tasks, lack of time with patients and fatigue from working long hours as factors affecting their ability to provide safe care, with hospital doctors more likely to highlight lack of doctors, support staff and beds.
- Three-quarters of doctors are cautious about recording reflections for fear it could be used against them; with junior doctors expressing particular concern.
- Half of doctors (49%) said they do not have the time to learn and develop professionally in their role.
- Two-fifths of doctors said that bullying, harassment and undermining is often or sometimes a problem in their main place of work.
- Only 55% of BAME doctors said there was respect for diversity and a culture of inclusion in their workplace compared to 75% of white doctors.
- In England, just 9% of doctors say CQC inspections take into account system pressures, with 71% saying that these inspections add to fear and worry amongst staff.

Analysis and next steps

- Current NHS funding does not match the job it is expected to do. Increasing funding to bring the UK in line with other major European countries, which face similar challenges in terms of changing demographics and patient expectations, is needed.
- In the short term, a real terms funding uplift of at least 4% per year is required – which goes beyond the limited new funding announced by the UK Government in June 2018.
- Governments must ensure the NHS has sufficient funding and capacity across the system to reduce patient waiting times, whilst providing recurrent and sustainable investment to deliver more services in the community, as well as adequate funding for public health and mental health services.
- The findings show that a culture of fear and blame in the NHS persists, despite being highlighted as a problem five years ago in two major reports by Robert Francis QC and Don Berwick.
- We need a fundamental shift in culture in the NHS, involving the creation of a genuinely supportive learning environment for staff. This should be considered essential to patient safety.
- As part of this, those who regulate the profession and health services need to drastically change their approach, starting with a clear acknowledgement that errors may result from the environment in which a doctor works rather than being the fault of an individual.
- Steps also need to be taken to ensure all grades of doctor and doctors from all kinds of background feel confident in raising safety concerns.
- Written reflections in all education and training documents should be legally protected.
- A strong culture of medical leadership and engagement needs to be built, better enabling doctors and other staff to actively contribute to maintaining and improving the quality of care.
- Time needs to be included in job plans and work schedules to enable continuing professional development, research, innovation and teaching, and current excessive workloads need to be reduced to free up time for these activities.
- Bullying, harassment and undermining must not be tolerated. More effective interventions are needed at an earlier stage to address such behaviours.
- In England, action must be taken to reform the current inspection regime to facilitate a culture of openness, support and learning for doctors and other staff.

2.2 Workforce and workload

Key findings

- A majority of doctors (91%) say they feel staffing levels in the NHS are inadequate to deliver quality patient care.
- Most doctors (74%) also say they feel this situation has worsened over the last year
- A majority of doctors (92%) report that they are working over their contracted hours.
- Overtime is particularly prevalent among GPs, who are more likely to say that they provide significantly more hours of work per week than they are contracted for (75% vs 43% hospital doctors). GP partners are particularly likely to do so (84%).
- When asked what improvements UK doctors would like to see in the work place, safe staff levels (57%), IT systems (53%), and fewer consultations (47%) were identified as key areas.
- When asked about why the NHS struggles to retain staff, GPs were more likely to highlight excessive workload pressures (91% vs 72% of hospital doctors), whereas hospital doctors were more likely to state a negative workplace culture (53% vs 40% of GPs).
- Some doctors support expanding the non-medical clinical workforce to ease pressures, with 47% saying they approve of recent trends in this area (compared to 25% saying they disapprove).
- This is unsurprising, given at least half of doctors said they spend over one hour on work daily that could be done by another non-medical clinical professional (52% spend an hour or more).
- However, doctors have concerns around the current expansion of the non-medical clinical workforce including a lack of accountability for actions among the new workforce (with this falling back on doctors) and that they will be seen as a cheaper alternative to doctors and will undermine medical recruitment.

Analysis and next steps

- The findings show how understaffed the NHS is for the work that is expected of it, and that this is now endangering patient safety.
- There is a need to introduce safe staffing levels, safe working limits in general practice and practical solutions to help mitigate the negative impact of rota gaps.
- Better IT systems could improve doctors working lives drastically. The development of minimum standards for IT across the NHS that promote patient safety and reduce workload could help with this.
- Governments must invest in the expansion of a collaborative multi-disciplinary workforce and fund this on an ongoing basis.
- Alongside this there must be appropriate regulation of new non-medical clinical roles to ensure there are clear lines of accountability and clarity regarding their scope of practice, as well as robust evaluation of their impact.
- Doctors' pay has declined in real terms by around 20% over the past decade. If morale, recruitment and retention are not to become even bigger issues for the NHS, this cut to pay has to be addressed. Not only should pay keep track with inflation but effort must be made to start to restore pay to expected levels.

2.3 Structures and collaboration

Key findings

- A high proportion of doctors (73%) say there are organisational barriers between primary and secondary care, which result in increased bureaucracy and administrative costs. Many doctors (60%) say that these barriers result in compromised quality and safety of patient care.
- In England, just 8% of doctors are happy with the current arrangements between primary and secondary care, with 84% across the UK agreeing that organisational barriers between primary and secondary care are resulting in increased bureaucracy and administrative costs.
- In England, the majority of doctors (78%) say they have not been involved in or engaged for their views in their STP (sustainability and transformation partnership) in the last 12 months. 80% of doctors believe STP plans are primarily driven by cost pressures, whilst 51% believe their local STP plans will cut services.
- In England, 73% of doctors are not aware of plans to establish an ACO (accountable care organisation, now known as integrated care providers) or ICS (integrated care system) in their area.

Analysis and next steps

- In the future primary and secondary care clinicians should face fewer barriers to effective joint working across traditional settings. All health systems across the UK should be considering how they can facilitate this change to happen, including making better use of technology.
- Doctors in England strongly support looking at ways of improving collaboration such as better data sharing (95%), shared pathways (92%), system-wide incentives to work together more closely (80%) and protected funding for schemes designed to promote joint working (70%).
- In England, much more needs to be done to engage doctors in the development of new commissioning and delivery structures.

3. Culture, quality and safety

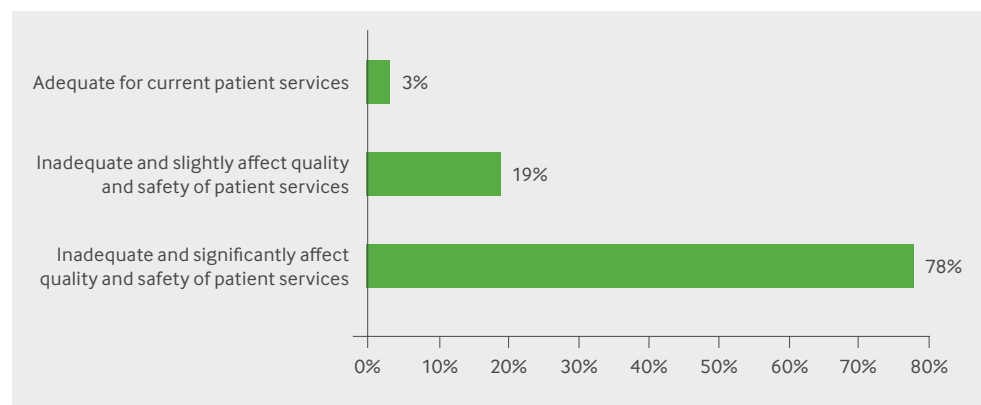
3.1 NHS resources

We asked doctors for their views on changing resource levels in the health services they work in, how this has changed over time, and the impact on quality of care and patient safety.

Resource levels, quality and patient safety

The overwhelming majority of doctors (97%) say that current NHS resources are simply inadequate to meet the needs of patients, and that as a result the quality and safety of patient care is significantly affected.

Figure 1: Which of the following statements best reflects your views about NHS resources in your nation?

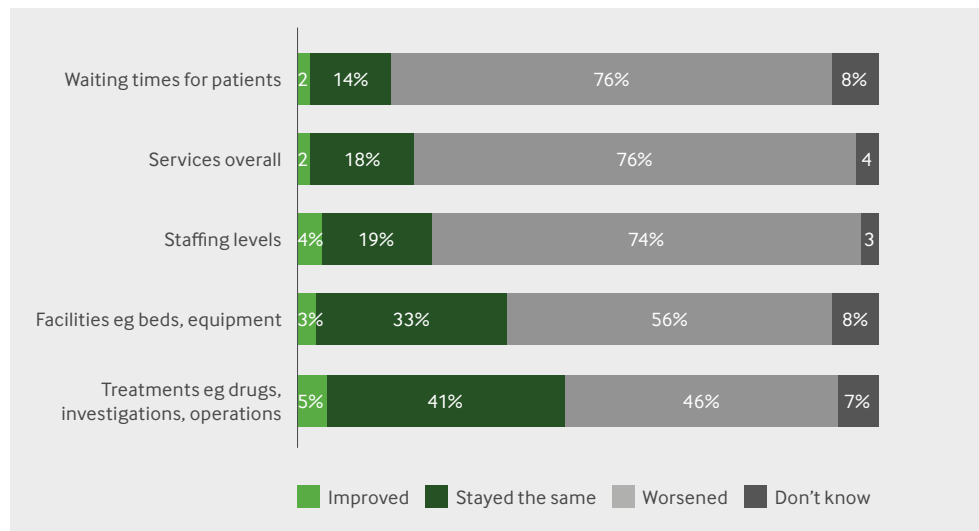


GP partners and GP salaried/locum doctors are particularly likely to say that services are inadequate and have a significant impact on the quality and safety of patient services (87%), although a high proportion of consultants (77%), junior doctors (68%), medical students (64%), SAS doctors (78%) and those who have retired (80%) also said this.

Changes in resource levels over time

Most doctors reported that services have worsened in the past year and that there has been a significant deterioration.

Figure 2: How have the following patient services changed in your main place of work in the past 12 months?



Waiting times for patients (76%), services overall (76%) and staffing levels (74%) are the top three areas that doctors believe have worsened.

Services are more likely to be perceived as having worsened in the last 12 months by doctors who work significantly beyond their contractual hours (>10% over, 82% vs 76% UK average) and those who work in places where cover cannot usually be found for absences or vacancies (83% vs 76% UK average). Compared to GPs, hospital doctors across the UK are more likely to think that facilities (eg beds, equipment) have worsened (58% vs 54% GPs). GPs across the UK are more likely to think that treatments eg drugs, investigations, operations (61% vs 37% hospital doctors), waiting times (86% vs 71% hospital doctors) and services overall (84% vs 72% hospital doctors) have worsened over the past year.

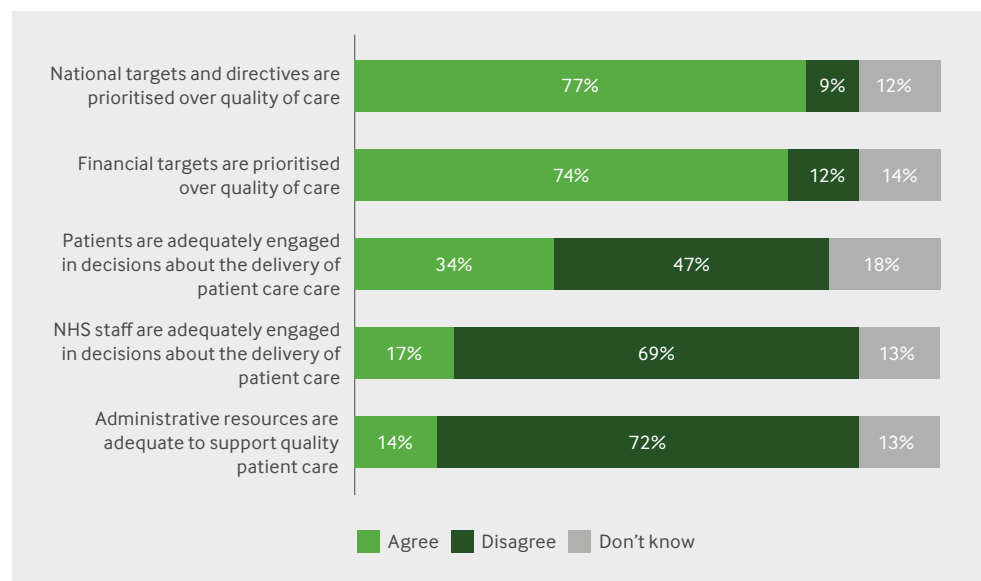
Financial targets and quality of care

In 2013, the Berwick report on patient safety recommended: “Operational targets and financial management have taken precedence over delivering high quality care”. Instead of leaders and organisations being focused primarily on the delivery of national targets, the report called for a culture of engagement with patients and carers and a culture that focused wholeheartedly on the growth and development of staff, including their ability to improve and support the health services in which they work.

Despite this, a clear majority of doctors think that the pursuit of national targets/directives (77%) and financial targets (74%) are prioritised over the quality of patient care.

GPs are more likely than hospital doctors to believe that national targets and directives (81%) and financial targets (77%) are prioritised over the quality of patient care.

Figure 3: Do you agree or disagree with the following statements?



BMA analysis

- These findings add to the now overwhelming evidence that underinvestment in the NHS is having a significant negative impact on patient safety and quality of care.
- The UK continues to spend less on health than many other leading European countries as a proportion of its GDP. In recent years health spending has not kept pace with the growing needs of patients, with annual increases since 2010 falling well short of the long run average real-terms growth in NHS funding (3.7%)³. Partly as a result of this, we also lag behind other countries in terms of numbers of beds and equipment such as MRI scanners, as well as in numbers of doctors (see section 4.1 above)⁴.
- As well as clearly being bad for patients, putting doctors in situations where they do not have adequate resources, beds, equipment and workforce support has contributed to plummeting morale across the NHS, leading to poor staff retention and engagement.

Our vision for change

- Any vision for the future of the NHS must be grounded in a realistic, evidence-based assessment of how it will be adequately funded, and what it can be expected to deliver with this funding. This requires political leadership to engage the public in an honest and transparent conversation about what they can expect from the NHS.
- Current NHS funding does not match the job it is expected to do. Increasing funding to bring the UK in line with other major European countries, which face similar challenges in terms of changing demographics and patient expectations. We support calls from organisations such as the IFS (institute for fiscal studies)⁵ for a real terms funding uplift of at least 4% per year – which goes beyond the limited new funding announced by the UK Government in June 2018.
- Governments must ensure the NHS has sufficient funding and capacity across the system to reduce patient waiting times, whilst providing recurrent and sustainable investment to deliver more services in the community, as well as adequate funding for public health and mental health services.
- Doctors' pay has declined in real terms by around 20% over the past decade. If morale, recruitment and retention are not to become even bigger issues for the NHS, this cut to pay has to be addressed. Not only should pay keep track with inflation but effort must be made to start to restore pay to expected levels.
- We must replace a narrow focus on hitting financial targets (or other arbitrary organisational targets) with a culture of engagement, better enabling doctors and other staff to actively contribute to maintaining and improving the quality of care. The BMA has developed a set of principles for good medical engagement that should become common practice throughout NHS organisations⁶.

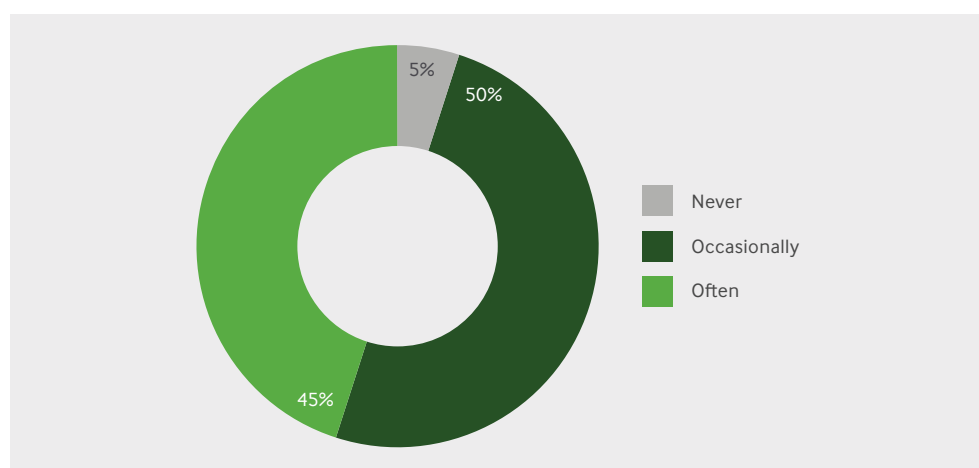
3.2 Patient safety in a system under pressure

We asked doctors for their views on how the culture of their workplace affects their working lives and patient care, including their concerns around making medical errors, what they feel are the causes of such errors, and how system pressures relate to this.

Fear of making medical errors

In 2013, the Berwick report on patient safety stated that 'fear is toxic to both safety and improvement'. It is concerning, therefore that a clear majority of doctors (95%) told us that they are occasionally or often fearful of making a medical error in their daily work with 45% saying they are often fearful and 50% saying they are occasionally fearful. Only 5% of doctors say they are never fearful.

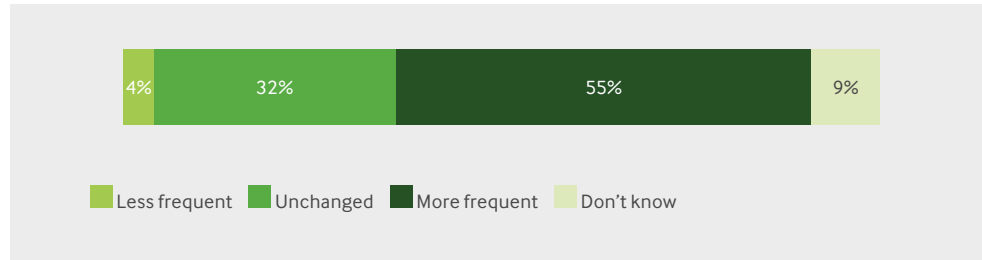
Figure 4: Are you fearful of making a medical error in your daily workplace?



There is a connection between adequacy of resources and fear of making medical errors. Doctors who said that resources were sufficient were more likely to report that they are never fearful of making a medical error (21% vs 5% UK average). In addition to this, more GPs report that they are often fearful of making a medical error (53%) than hospital doctors (41%).

The situation is getting worse. Asked whether they are more or less fearful of making a medical error now compared to five years ago, over half said they are more afraid now (55%) and a third (32%) said they are just as afraid as five years ago. Only 4% are less fearful.

Figure 5: How has this [see figure 4 above] changed compared to five years ago?

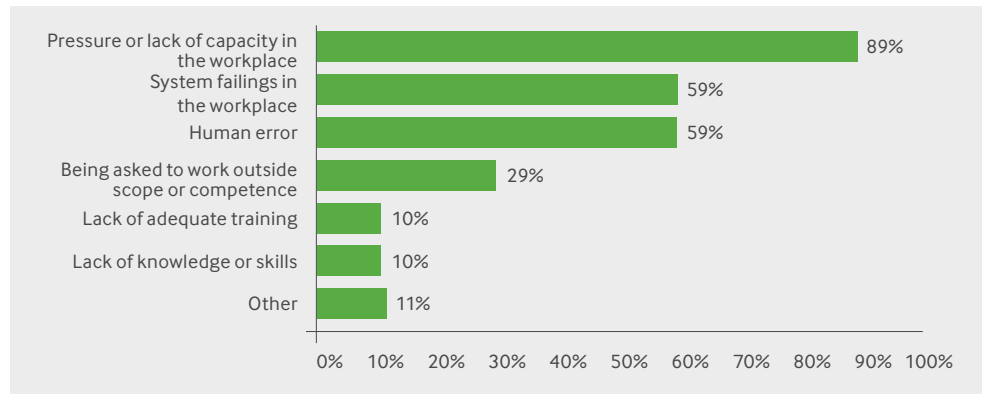


Why do errors happen?

System pressures make errors more likely. Asked about why errors are likely to happen, the main reason doctors give is workplace pressure and lack of capacity (89%). This is followed by system failings in the workplace (59%) and human error (59%).

More GPs than hospital doctors said that pressure or lack of capacity is a main reason for making errors (93% vs 87%). GPs were also more likely to say that errors could arise from being expected to work outside their scope or competence (39% vs 24%). In contrast, more hospital doctors than GPs said that errors are likely to be due to system failings in their workplace (69% vs 44% GPs).

Figure 6: What would you say are the main reasons you feel you are likely to make errors?



Fear of being blamed for errors

A majority of doctors (55%) say they fear being unfairly blamed for errors. Nearly half (45%) reported they practise defensively because they believe that they work in a blame culture. Around half of doctors (51%) also agree with the statement 'I believe there is insufficient protection and support for those reporting errors'.

Slightly more GPs than hospital doctors said that they practise defensively (55% vs 46%). However, a large number of GPs also said that they work in a learning environment in which reporting errors contributes to preventing errors, near misses and incidents in the future (49% of GPs vs 35% of hospital doctors). In addition to this, a higher proportion of GPs said they feel content to report errors in their workplace (45% vs 38% of hospital doctors). In contrast, hospital doctors are more likely to believe that there is insufficient protection and support for those reporting errors in their workplace, and hospital doctors are also more fearful of being unfairly blamed (see Table 1).

Those doing overtime are particularly worried. Doctors who work significantly over their contracted hours are more likely to say they are fearful of being unfairly blamed, that there is insufficient protection and support for those reporting errors, and that they practise defensively.

Table 1

Which of the following, if any, do you agree with about reporting errors, near misses and incidents that could have harmed patients in your workplace?	All UK working doctors	UK working GPs	UK working Hospital doctors
I am fearful of being unfairly blamed for errors which are due to pressures or system failings in my workplace	55%	51%	57%
I believe there is insufficient protection and support for those reporting errors	51%	49%	52%
I practice defensively because I believe I am working in a blame culture	49%	55%	46%
I feel content to report errors in my workplace	40%	45%	38%
I feel I work in a learning environment in which reporting errors will contribute to preventing errors, near misses and incidents in the future	40%	49%	35%
I am worried that reporting errors would negatively impact my career/training progression	27%	21%	31%
I am less inclined to report errors, near misses and incidents due to fear of blame	24%	22%	25%

Ability to deliver safe patient care in a system under pressure

The majority of doctors believe that system pressures have a negative impact on their ability to deliver safe patient care. Almost a third (31%) feel that system pressures in their working environment often prevent the delivery of safe patient care and almost two thirds (62%) feel that they occasionally do.

There were significant differences between GPs and hospital doctors when asked about the factors affecting their ability to deliver safe patient care. More GPs mentioned: being pressured to attend to multiple tasks simultaneously, lack of time with patients, fatigue from working long hours, being pressured to work outside their scope or competence, and limited access to diagnostic facilities. In comparison, more hospital doctors mentioned: lack of doctors/unfilled vacancies/rota gaps, lack of nurses and other healthcare professionals, lack of beds, lack of administrative support, and operational rules and organisation in their workplace. Junior doctors were particularly likely to identify lack of doctors/unfilled vacancies/rota gaps as one of their top five concerns (79% vs 62% average).

Table 2

Which of these factors affect your ability to deliver safe patient care in your main place of work?	All UK working doctors, who feel prevented by system pressures	UK working GPs	UK working Hospital doctors
Being pressured to attend to multiple tasks simultaneously	68%	83%	59%
Lack of time to attend to patients	63%	86%	50%
Lack of doctors/unfilled vacancies/rota gaps	62%	53%	68%
Lack of nurses and other health professionals	55%	36%	66%
Fatigue caused by working long hours	39%	54%	31%
Lack of beds	35%	9%	51%
Lack of administrative support	33%	21%	39%
Operational rules and organisation in the workplace	28%	17%	35%
Limited access to diagnostic and other facilities	22%	29%	17%
Being pressured to work outside scope of practice or competence	16%	28%	9%
Lack of equipment	9%	3%	13%
Other	6%	8%	5%

BMA analysis

- The BMA's survey findings show clearly that a culture of fear and blame persists in the NHS. This is a risk for patient safety, prevents people from being open about errors, learning from mistakes and contributing to continual improvement. The recent case of Dr. Bawa-Garba⁷ reinforced perceptions amongst doctors that they will be held accountable for wider systemic failings.
- Patient safety in our health services is of paramount importance – so it is of considerable concern that many doctors (55%) are reporting that they fear being unfairly blamed for errors due to system failures.
- Five years ago, landmark reports by Robert Francis QC⁸ and patient safety expert Don Berwick⁹ called for fundamental cultural change in the NHS. The Berwick report stated clearly that “NHS staff are not to blame – in the vast majority of cases it's systems, environment and constraints they face that lead to patient safety problems”. Not only has no progress been made, but things are getting worse, with 55% of doctors reporting they are more fearful of making an error now than they were five years ago.
- System pressures are a serious patient safety issue, with the vast majority of doctors (93%) saying that system pressures occasionally or often prevent the delivery of safe patient care.

Our vision for change

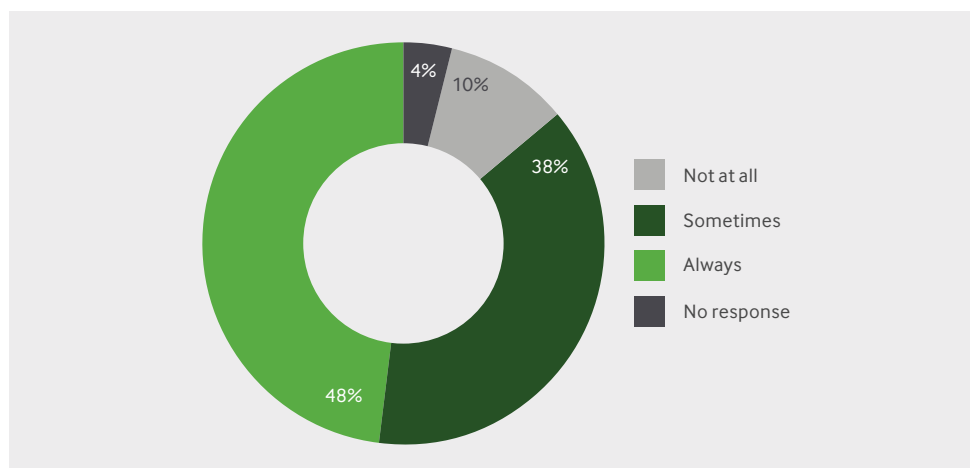
- The NHS needs a fundamental shift in culture. A supportive learning environment for staff should be considered essential to patient safety.
- As part of this, those who regulate the profession and health services need to drastically change their approach, starting with a clear acknowledgement that errors may result from the environment in which a doctor works rather than being the fault of an individual.
- System pressures and the underlying factors causing them – lack of resources, staffing and poor infrastructure – must be addressed.
- Professional autonomy and independence must be valued, to ensure that doctors and other staff can manage their workload effectively.

3.3 Raising concerns about patient care

We asked doctors whether they would feel comfortable raising concerns about patient care in their main place of work.

Not even half (48%) of doctors said that they would always feel confident in raising concerns, with 38% saying they would only sometimes feel confident and 10% saying that they would not feel confident at all.

Figure 7: If you had concerns about patient care within your main place of work, would you feel confident in raising them?



We found that confidence in raising concerns increases with age – for example, only 31% of 25-34 year old doctors said they would always feel confident in raising concerns, compared to 56% of 64+ year olds. GPs feel more comfortable to raise concerns – with 61% reporting feeling confident compared to only 40% of hospital doctors. This finding mirrors the differences between GPs and hospital doctors seen earlier with regards to their belief that there is a learning culture in their workplace.

Doctors do not have the time to raise patient safety concerns. For those doctors who said they would not always be confident in raising concerns about patient care, the main reason given was workload pressures making it difficult to find the time (59%). This was followed by being afraid that they or their colleagues will be unfairly blamed or suffer adverse consequences (50%).

Confidence in raising concerns differs by ethnicity: BAME (black and minority ethnic) doctors are almost twice as likely as white doctors to say that they would not feel confident in raising concerns about patient care (14% compared to 8%). BAME doctors were also more likely than white doctors to say they might not be confident because they feared being blamed or suffering adverse consequences (57% vs 48% of white doctors) or they worried how the reports would be used (48% vs 38% of white doctors).

There are differences in the reasons given by male and female doctors too. More female doctors than male doctors said that workload pressures make it difficult to find time to report concerns (63% vs 55%). However, male doctors are more likely to be afraid that they or their colleagues will be unfairly blamed or suffer adverse consequences (53% vs 48% female).

Some differences are also present between branches of practice. Workload pressures are a key reason why junior doctors (68%), GP partners (66%) and GP salaried/locums (64%) do not always feel confident in raising concerns about patient care, whereas more consultants reported not feeling confident in raising concerns about patient care because they are discouraged by a lack of feedback on previous concerns raised (59%).

Figure 8: What are the reasons why you may not feel confident to raise concerns about patient care within your main place of work?



BMA analysis

- It is worrying that fewer than half of doctors are confident enough to always raise concerns because they fear being unfairly blamed or suffering adverse consequences – further evidence that many doctors still feel a blame culture exists in the NHS.
- The findings also show that a number of other barriers, such as the work pressures, lack of time and lack of feedback on whether lessons have been learnt and change implemented, are making it more difficult for doctors to raise concerns, report errors and learn from mistakes.
- It is concerning that BAME doctors are clearly more fearful about being unfairly blamed or suffering adverse consequences if they raise concerns.
- This fear is likely to stem from the fact that BAME doctors are more likely to face disciplinary proceedings, be referred to the GMC by their employer and face investigations and sanctions¹⁰.

Our vision for change

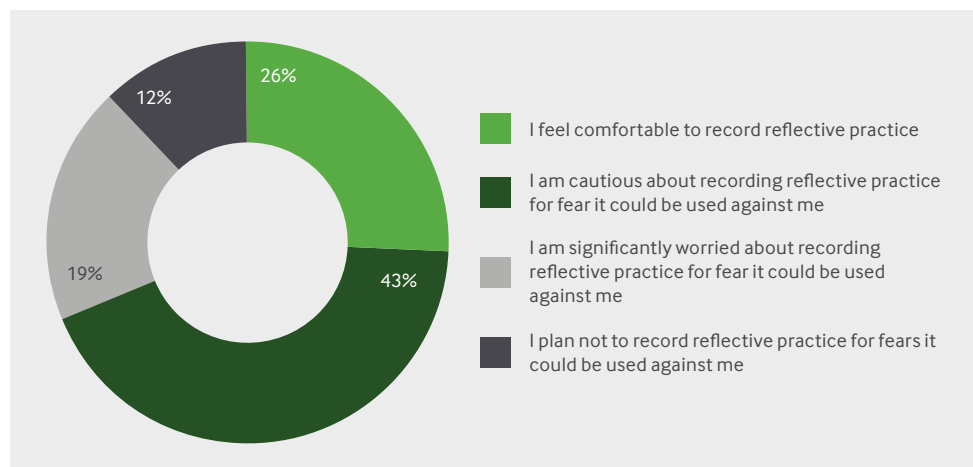
- Raising concerns and learning from them is essential to improve quality and safety. The NHS must work towards an environment in which all staff feel able and supported to raise concerns about patient safety.
- The blame culture that is reported by doctors must be addressed to improve quality and safety in the NHS.
- Addressing ongoing race-based inequalities and bias in the NHS and the profession is a critical part of creating a safer, more open and learning culture.
- Following the Dr. Bawa-Garba case the GMC has committed to working with the BMA, wider medical profession, the four UK governments and national partners to improve the consistency of how all grades of doctor can register safety concerns.¹¹

3.4 Reflective practice

We asked doctors for their views on reflective practice – a vital process through which those who work in the NHS can learn from mistakes and near misses and improve patient safety for the future.

Fear is discouraging learning and reflection. Just over two-fifths of doctors (43%) said that they were feeling cautious about recording reflections for fear that they could be used against them. Just one quarter (26%) said they feel comfortable about reflective practice.

Figure 9: How do you feel about written recording of reflective practice (including for appraisals)?



Junior doctors were most likely to say that they were feeling cautious (51%) about reflective practice. A fifth of doctors (19%) said they were significantly worried about recording reflections and 12% said they planned not to record reflections. Again, responses from junior doctors suggested they were particularly concerned, with 26% saying they were significantly worried about recording reflections.

BMA analysis

- It is vitally important that doctors feel able to undertake reflective practice so that they can learn from the experiences and challenges that all medical professionals face during the course of their careers.
- Our findings indicate that there is widespread concern amongst doctors about recording reflections and the risk that in a blame culture, reflecting on mistakes or challenges could have negative consequences. This is particularly marked amongst junior doctors.
- Our survey was sent out in May 2018, which was five months after the High Court ruling in the Dr. Bawa-Garba case and during controversy about whether written reflections were used against the junior doctor in the criminal prosecution¹².
- Since the Dr. Bawa-Garba case the BMA has secured commitments from the GMC that it will never ask for reflective statements as part of its investigations.
- In response to the recent Williams review into gross negligence manslaughter (GNM) in healthcare, the BMA called for all reflections in education and training documents to be legally protected¹³. The BMA has also produced updated guidance on reflective practice, emphasising the importance of doctors being able to reflect openly and honestly in a safe environment to further their learning and development and improve healthcare¹⁴.

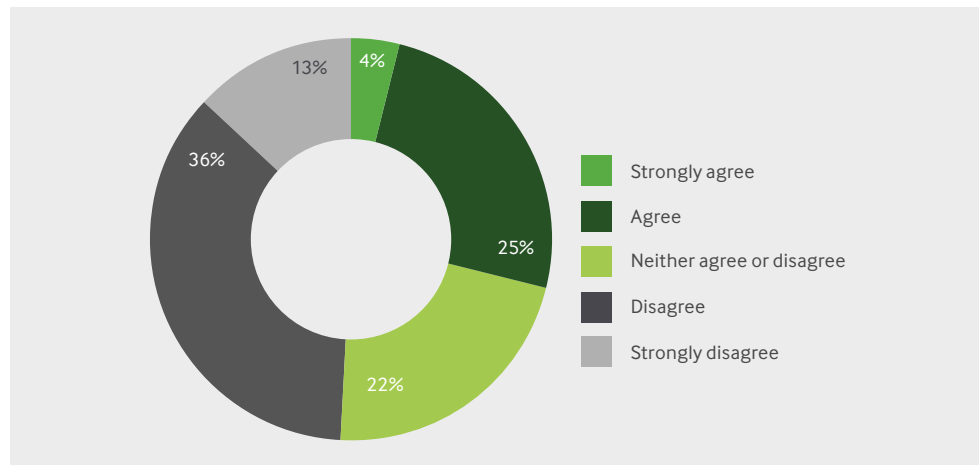
Our vision for change

- Those who work in the NHS must feel able to reflect on their experiences in a safe environment without any fear of negative consequences to further learning and development and improve healthcare. All reflections in education and training documents must be legally protected.
- Leadership is needed throughout the NHS to turn around current negative perceptions amongst many doctors about the risks of recording reflections.

3.5 Support for learning and development

Almost half of doctors (49%) said they do not have adequate time to learn and develop professionally in their role. Only 3 in 10 said they do, while 22% neither agreed nor disagreed.

Figure 10: To what extent do you agree or disagree with the following statement: 'As a doctor, I feel that I have adequate time to learn and develop professionally in my role'



GPs are less likely than hospital doctors to agree they have time to learn and develop professionally (21% vs 33% of hospital doctors). Women are also less likely to agree they have time to learn and develop professionally in their role (26% vs 32% of men).

BMA analysis

- It is of great concern that half of doctors feel they do not have adequate time to learn and develop professionally. This has potential consequences in terms of quality improvement and safety in the NHS and may negatively impact staff retention.
- The BMA has been concerned for some time about the erosion of Supporting Professional Activities (SPA) time and the need for sufficient SPAs to be included in consultant and SAS (staff, associate specialist and specialty) doctor contracts to enable continued learning, professional development and research, and to ensure that the work of these doctors is underpinned by effective quality control and patient safety.
- The GMC's annual national training survey highlights the significant workloads of junior doctors, with almost half of trainees reporting that they are regularly working beyond their rostered hours. A third of doctors with training responsibilities also said it was hard for them to find the time to fulfil their educational roles. It is extremely worrying that only one in five GPs say they have time to learn and develop. Clearly, the significant problems that GPs face in finding time for training and development activities will not be addressed until the pressures on general practice are dealt with.
- There also needs to be recognition of the need for time for learning and development activity in the GP contract and proper resourcing for it. For secondary care doctors, including time for learning and reflection in job planning and work scheduling is also crucial.

Our vision for change

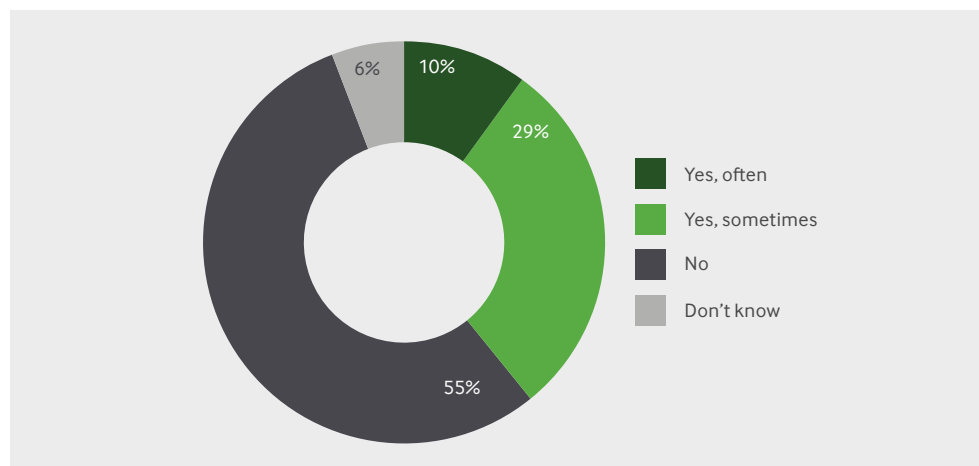
- Learning and development must be given priority if we are to continue to improve care and ensure safety in the NHS. Health systems must offer doctors rewarding careers that develop their skills and help retain them within the NHS for the future
- Time needs to be included in job plans, work schedules and in general practice contracts to enable continuing professional development – and current excessive workloads need to be reduced to free up time for learning.

3.6 Bullying, undermining and harassment in the workplace

Extent of bullying, undermining and harassment in the NHS

A significant proportion of doctors feel bullying, harassment or undermining is an issue in their main place of work. Two-fifths of doctors agreed that it was sometimes (29%) or often (10%) a problem. Just over half (55%) said it was not and 6% said they don't know.

Figure 11: Is there a problem with bullying, undermining or harassment in your main place of work?



Bullying, harassment or undermining is a particular issue in hospitals. Half of hospital doctors said it was a problem in their main place of work. Hospital doctors were four times more likely than GPs to say it was often (13% vs 3%) a problem and more than twice as likely to say it sometimes was (38% vs 14%).

There were also differences between BAME doctors and white doctors, with BAME doctors being more than twice as likely to say that there is often a problem with bullying, undermining or harassment in their main place of work (18% vs 7%).

Causes of bullying, undermining and harassment

Pressure at work makes unacceptable behaviour more likely. When doctors were asked why they thought there is or may be a problem with bullying, undermining or harassment in their main place of work, the most common reason given by two-thirds of respondents was that people are under pressure. This was followed by it being difficult to challenge such behaviour as it comes from the top and the fact that people who are bullied, undermined or harassed are too afraid to speak up. Difficulties in challenging such behaviour and fear of speaking up about it undermine efforts to create an open and learning culture. (See table 3 overleaf).

Table 3

Why do you think there is or may be a problem with bullying, undermining or harassment in your main place of work?	All UK working doctors, who say there is a problem with bullying/undermining/harassment in the workplace, or don't know
People are under pressure	65%
Difficult to challenge as behaviour comes from the top	58%
People who are bullied, undermined or harassed are too afraid to speak up	48%
Colleagues do not speak up when they see others being bullied, undermined or harassed	46%
Lack of management commitment to deal with it	43%
Inadequate people management training for managers and supervisors	39%
Lack of clarity about what is acceptable behaviour at work	31%
Lack of adequate or unclear procedures to report and deal with it	21%
Other	7%

Fewer medical students in England (thinking about their place of study) than doctors said that there is often a problem with bullying, undermining or harassment (2%), but are significantly more likely to think it happens sometimes (34%), or to say they don't know (16%).

Below are the reasons for medical students thinking there is a problem with bullying, undermining or harassment in their place of study. These centre around pressure and a difficulty in challenging the behaviour. Fellow students not speaking up when they see others being bullied and people being afraid to speak up, along with unclear procedures, were also more prominent compared to the responses for all working doctors.

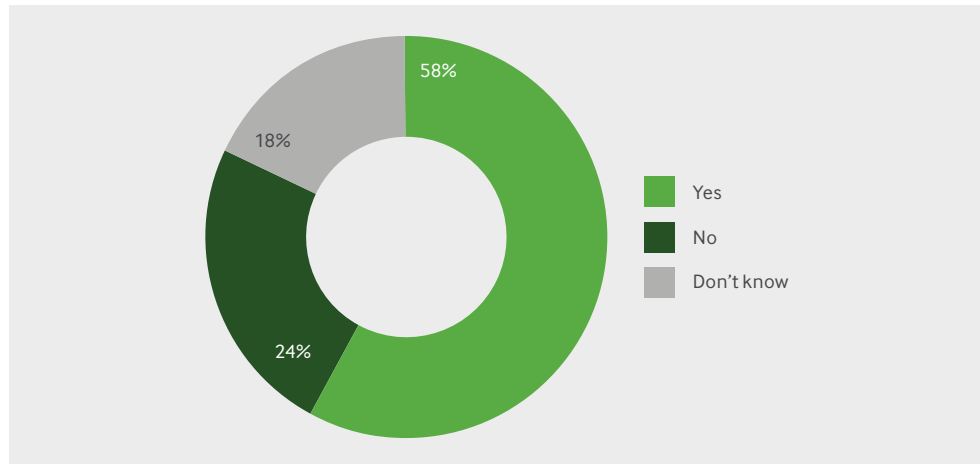
Table 4

Q: Why do you think there is or may be a problem with bullying, undermining or harassment in your place of study?	All students, who say there is a problem with bullying/undermining/harassment in their place of study, or don't know
People are under pressure	64%
Difficult to challenge as behaviour comes from the top	62%
Fellow students do not speak up when they see others being bullied	59%
People who are bullied, undermined or harassed are too afraid to speak up	54%
Lack of adequate or unclear procedures to report and deal with it	34%
Lack of clarity about what is acceptable behaviour at work	34%
Lack of management commitment to deal with it	26%
Inadequate people management training for managers and supervisors	20%

Reporting incidents of bullying/undermining/harassment

Thinking about themselves personally, nearly a quarter of UK working doctors (24%) would not feel confident in reporting incidents of bullying, undermining or harassment in their main place of work. 58% would feel confident and 18% are unsure.

Figure 12: Do you feel confident in reporting incidents of bullying, undermining or harassment in your main place of work?



Fewer younger doctors said they were confident about reporting incidents of bullying, undermining or harassment than older doctors – 45% of those under 25 and 54% of those aged 25-44 compared to 64% of those aged 55-64 and 61% of those aged 64+. There are significant differences by ethnicity in terms of confidence in reporting incidents too – 49% of BAME doctors said they would feel confident reporting incidents of bullying, undermining or harassment to their employer compared to 61% of white doctors.

When medical students were asked whether they feel confident reporting incidents of bullying, undermining or harassment in their place of study, they are less likely to feel confident (43%) and more likely to feel unsure (29%) than doctors.

BMA analysis

- Bullying, harassment and undermining add to a climate of fear and make it hard to raise or address patient safety concerns, especially when it comes from the top and is difficult to challenge, as the survey findings suggest is often the case.
- It is worrying that BAME doctors were more likely to agree bullying, undermining and harassment was a problem in their main place of work and they were more likely to be fearful about reporting incidents.
- Such behaviour must not be tolerated.
- Particular attention needs to be paid to creating a climate in which staff, especially junior staff and those in minority groups who may be most vulnerable to bullying and harassment, have confidence that they will be supported if they do speak up about it.
- The underlying environmental factors that are likely to fuel such behaviour in the NHS must also be addressed, including the pressures on staff and bullying down the line.

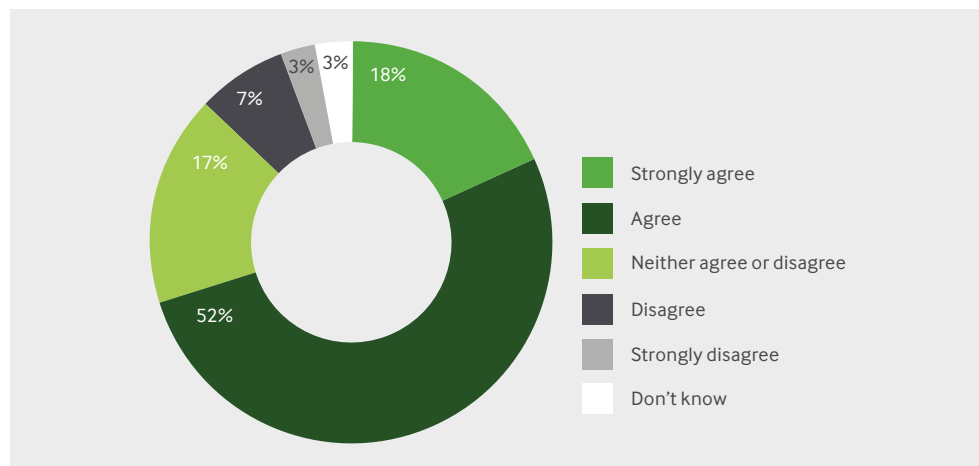
Our vision for change

- Leaders in the NHS must strive to create a working environment in which bullying, undermining and harassment are not tolerated. There need to be more effective interventions to deal with incidents. The BMA is working on a bullying and harassment project which seeks to raise awareness, provide better support to members, seek better resolution and help create a more positive culture in the profession and NHS. It will be developing policy recommendations at the end of 2018¹⁵.
- The underlying environmental factors that are likely to fuel such behaviour in the NHS must also be addressed. It is unsurprising that a system with such a strong focus on finance and targets translates into pressures on staff and bullying down the line.

3.7 Respect for diversity and an inclusive working environment

The majority of doctors (70%) agreed that there was respect for diversity and a culture of inclusion in their main place of work. However, there were significant differences by ethnicity – with only 55% of BAME doctors agreeing with the statement compared to 75% of white doctors. There was also variance by ethnicity in terms of team working, with only 57% of BAME doctors agreeing there is effective team working in their workplace compared to 72% of white doctors.

Figure 13: Which of the following statements, if any, do you agree with? 'There is respect for diversity and an inclusive working environment in my workplace'



More encouragingly, there were no significant differences by gender in response to questions about respect for diversity and an inclusive working environment, with 71% of women agreeing with the statement and 70% of men (although women were slightly less likely to strongly agree – 16% vs 20% of men).

There is considerable dissatisfaction among doctors with the balance between work and personal life, with only 31% of doctors agreeing that they are able to achieve a satisfactory balance. There were no significant differences by gender in response to this question with 31% of both men and women agreeing.

However, only one in five doctors agrees that there is fairness in recognition of achievements and delivery of services with rewards based on merit.

BMA analysis

- The medical profession is increasingly diverse – for example, published data on registered medical practitioners shows that over a third of doctors are from BAME backgrounds and almost half the profession are women¹⁶.
- However, the survey findings highlight that experiences vary significantly by protected characteristic. The responses of BAME doctors suggest they are more likely to fear being unfairly blamed, to think bullying and harassment is a problem, and to lack a sense of support and belonging at work.
- Some differences in responses between male and female doctors throughout the survey show that women are struggling more to find the time to do additional activities outside of core tasks, such as find the time for learning and development or find the time to raise safety concerns. While men and women reported equal dissatisfaction with the balance between work and personal life, it must be remembered that women doctors are much more likely to have reduced their paid working hours to try and achieve a better balance.

Our vision for change

- Everyone who works in the NHS deserves to feel valued, supported and included. There needs to be recognition and respect for diversity and the benefits it brings – the wider pool of talent, different perspectives and experiences, and ability to better serve a diverse population.
- Unjust barriers to employment, development and progression need to be removed to create a genuinely fair and inclusive profession.
- The BMA itself will continue to act as an agent for change. For example, we held a race equality summit in July 2018 focused on developing solutions¹⁷, we played an active role in securing the current independent review of the gender pay gap in medicine¹⁸ and will continue to input into the research and development of recommendations. We are represented on the steering group of the GMC's current health and disability review¹⁹ and its equality and diversity group overseeing a programme of work to address differential attainment²⁰.

3.8 England only results – CQC inspection

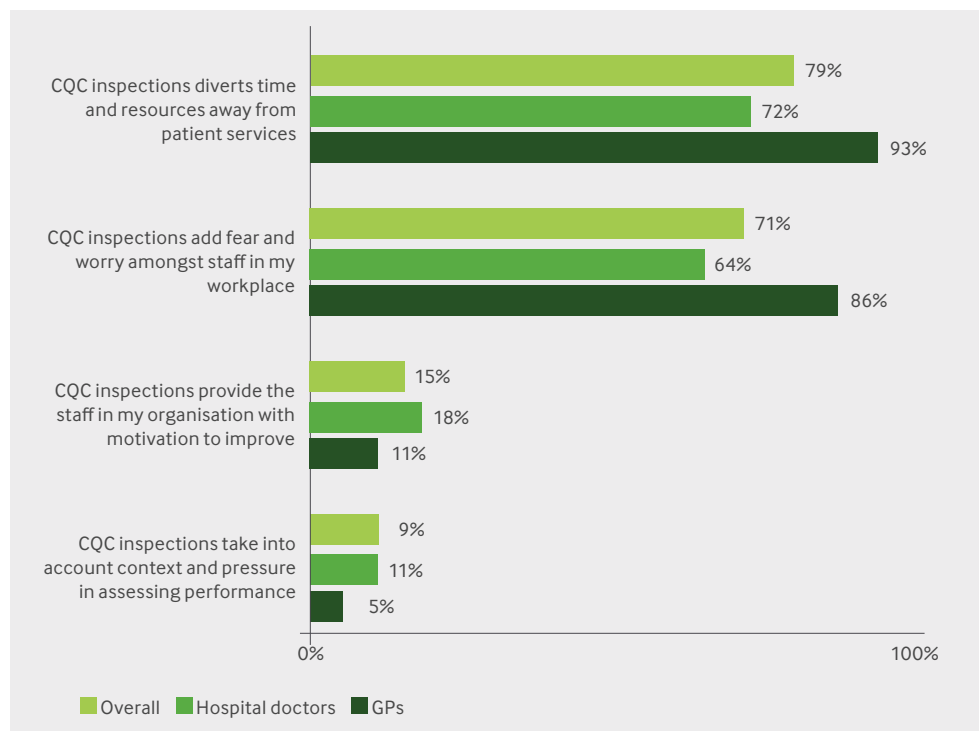
We asked doctors for their views on the CQC (care quality commission), the body which regulates and inspects healthcare organisations (including trusts and GP practices) in England.

Doctors based in England who said their main place of work had been inspected by the CQC within the last two years were asked for their views on how good they felt the inspection was for measuring quality of their services. The feedback is mixed:

- 25% say it was a fair assessment of the quality of care provided by their organisation
- 32% say it assessed some aspects of quality of care provided by their organisation
- 9% say it did not fairly or adequately measure the quality of care of their organisation
- 21% say it was a measurement of the organisation of their organisation, but not of the quality of care provided
- 10% say it was a misleading portrayal of the quality of care provided by their organisation.

Doctors in England were also asked more broadly about the impact of CQC inspections on the organisations they work in.

Figure 14: Which of the following statements about CQC inspections, if any, do you agree with?



As Figure 14 shows, GPs were generally more likely than hospital doctors to agree that CQC inspections divert resources and add fear and worry amongst staff where they work. GPs were also less likely than hospital doctors to say that inspections provide staff with motivation to improve, and that they take into account context and pressures. This may reflect the fact that as independent contractors, GP partners are legally responsible for compliance, with more GPs likely to be directly involved in preparing for CQC inspections than hospital doctors. However, the proportion of hospital doctors who shared these views is still very high.

Overall, only 12% of doctors say the CQC rating system provides a fair assessment of an organisation's performance, whilst 23% say it is a misleading system. Meanwhile, 62% of doctors say that it is a simplistic assessment system that does not describe the quality of care of individual components of services in an organisation.

BMA analysis

- The survey findings strongly suggest that CQC regulation and inspection in the NHS in England is contributing to an already stressful working environment for doctors both in primary and secondary care.
- It is particularly concerning that so few doctors (just 9%) feel inspections take into account system pressures, given that these are now having an increasingly damaging impact on the NHS all year round.
- The findings suggest that the current approach to inspections in the NHS may be having a detrimental impact on the quality of care provided, and patient safety in some respects, with 79% of doctors saying inspections divert time and resources away from patient care, and 71% saying they add to fear and worrying amongst staff in the workplace.
- It is notable that both GPs and hospital doctors expressed similar concerns about inspections, indicating that concerns about the CQC are not confined to primary care (although concern appears to be particularly high amongst GPs).

Our vision for change

- Inspection and regulation are an important part of any health system, but they must be proportionate and fair, and support healthcare organisations to reinforce a culture of openness, support and learning for doctors and other staff.
- Our findings suggest strongly that the current approach to inspection in England should be reformed to help remove the culture of fear highlighted elsewhere in the survey.
- The way in which the CQC rates services must be reconsidered – one overall rating cannot adequately capture the complexities of delivering healthcare.
- These issues need to be urgently addressed by policy makers and the CQC in England.

4. Workforce and workload

The NHS is facing pressures all year round and doctors are increasingly doing more complex and intense work in environments that are woefully under-resourced. The health service is facing severe medical workforce shortages which will not be corrected for years to come. Despite an increase in medical school places beginning this year²¹, it takes more than a decade to train a senior GP or consultant, meaning that any impact on the workforce will not be seen in the immediate future. Working under such conditions without adequate capacity or support puts both doctors and patients at risk. These pressures are key drivers of the dissatisfaction with working life for doctors and other NHS staff, which in turn impacts on morale, wellbeing, the quality of patient care and the long-term sustainability of the NHS.

4.1 Doctors' views on their working environment

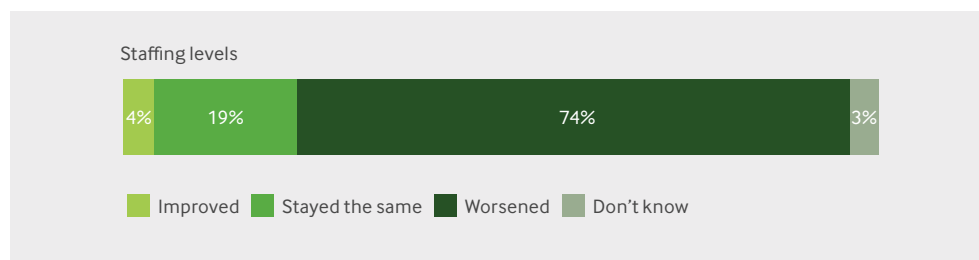
Staffing levels

Staffing levels in doctors' main place of work are deteriorating. An overwhelming majority of doctors (91%) said they feel current staffing levels in the NHS are inadequate to deliver quality patient care. When asked about how staffing levels in their place of work have changed over the last 12 months, most doctors (74%) reported that they feel the situation has worsened.

Figure 15: Do you agree or disagree with the following statement?



Figure 16: Doctors' views on how staffing levels have changed in their main place of work in the past 12 months?

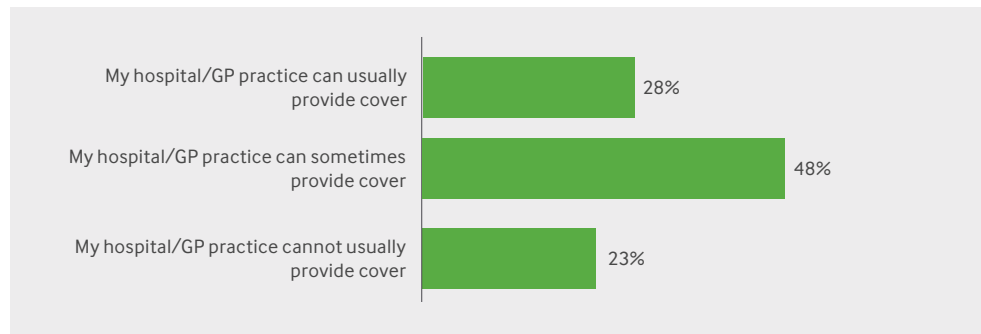


Absences and unfilled vacancies

Filling absences and vacancies is crucial for patient safety but often simply does not happen. The majority of UK working doctors do not think that their hospital or GP practice can usually provide cover in the case of absences or unfilled vacancies. This is often seen as the result of a lack of locum resource or an inability to provide cover due to costs or willing/available doctors in the area.

Fewer than three in ten doctors say that their hospital/GP practice can usually provide cover for absences or unfilled vacancies. Around half (48%) say that their workplace can sometimes provide cover and just under a quarter (23%) say that they cannot usually provide cover.

Figure 17: Which of the following statements best reflects the approach in your main place of work to providing cover for doctor absences or unfilled vacancies (locum or overtime)?



Doctors who said that their hospital or GP practice can't always provide cover were then asked what they thought the main reasons behind this are. Doctors cited:

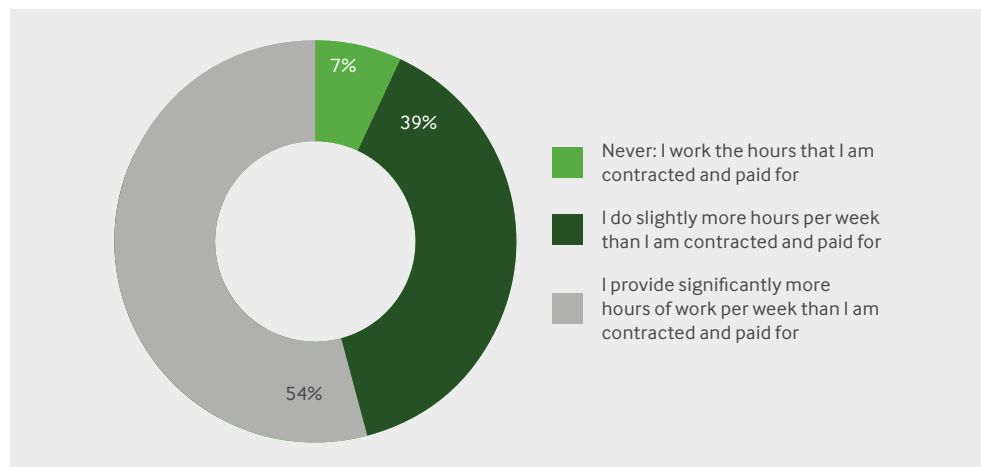
- A lack of locums in their area (54%)
- the organisation not being able to afford the cost of locums or overtime due to financial pressures (52%)
- and doctors being unwilling or unable to work additional overtime in their area (44%) as the top reasons.

GPs were more likely to say that inability to provide cover is due to a lack of locums in their area (67% vs 47% hospital doctors). For junior doctors, unwillingness or an inability for doctors to work additional overtime in their area is more often stated as a key reason (60%).

Working hours and over-time

Relatively few doctors in the UK say that they only work the hours they are contracted for, with the majority working over these. When asked to consider their working hours, more than half (54%) of working doctors in the UK say that they work significantly beyond their contracted hours (more than 10% over), with 39% saying they do slightly more hours per week than they are contracted for and 7% saying they only work the hours they are contracted for.

Figure 18: On average, do you work unpaid beyond your contractual hours? If you are an independent contractor GP please base your answer on a session being half a day or if a salaried GPs on the basis of full time working hours being 37.5 hours per week.



Overtime is particularly prevalent among GPs, who are more likely to say that they provide significantly more hours of work per week than they are contracted for (75% vs 43% hospital doctors). GP partners are particularly likely to do so (84%).

BMA analysis

- The NHS is facing a recruitment and retention crisis – which, if not tackled, will make it virtually impossible for health services to continue to meet the needs of patients. Our survey provides further evidence of this, with 91% of doctors agreeing that staffing levels are currently inadequate.
- These results reflect the fact that the UK has fewer doctors compared to other similar countries, with 2.8 doctors per 1,000 population compared with the OECD average of 3.3 and far behind countries such as Germany, with 4.2²².
- It is particularly worrying that 74% of doctors say staffing levels are getting worse, and that nearly a quarter (23%) say their place of work cannot usually provide cover if there is an absence or vacancy. This is backed up by other BMA work on vacancies and rota gaps.
- Financial pressures can lead to a failure to secure cover if employers are unable/unwilling to pay adequate locum rates, imperilling patient safety and increasing pressure on doctors.
- Many doctors are forced to work outside of their contracted hours (and GP partners to work long hours) in order to ensure patients are getting the care that they need. This goodwill often goes unrecognised and contributes to burnout and low morale.
- These issues need to be tackled urgently – staffing shortages clearly impact on doctors' morale, motivation, well-being and on the quality of care they can offer to patients.

Our vision for change

- Governments, national workforce planners and commissioners should establish and enforce safe medical staffing levels alongside a standardised definition of rota gaps.
- Governments must invest in recurrently funded strategies to enable an expansion of a collaborative multi-disciplinary workforce.
- There should be clear processes for reporting excess hours worked, missed breaks or training opportunities.
- Health systems should explore practical solutions implemented locally to mitigate the negative impacts of rota gaps²³.

4.2 Doctors' views on improving retention

Difficulty retaining medical staff

The inability of the NHS to recruit and retain adequate numbers of staff is perhaps one of the greatest threats to its ability to provide safe and effective services into the future. There are myriad reasons why doctors are choosing alternate career paths or why many choose to leave the profession altogether.

When asked to rank the top five reasons for why the NHS was having difficulties retaining medical staff, the most commonly mentioned was excessive workload pressures (78%).

Table 5

Please rank up to your top five reasons why you think there are difficulties retaining medical staff	All UK & overseas working doctors
Excessive workload pressures	78%
Blame culture, with increased risks of prosecution or GMC referral compared with other nations	50%
Negative workplace culture with lack of valuing and respect for staff	49%
Unsatisfactory pay and working conditions	47%
System not supporting work life balance and non-traditional career paths	47%
Better opportunities to work as a doctor elsewhere	45%
Burden of appraisal and revalidation processes	32%
Lack of autonomy for doctors as professionals to lead decision making	32%
Reductions in pension benefits	25%
Lack of flexible working arrangements (eg shift, less than full time, locum opportunities)	24%
Lack of parity on pay compared with other nations	19%
Lack of development and training opportunities and time	18%

GPs, compared to hospital doctors, are more likely to point towards excessive workload pressures (91% vs 72%). Hospital doctors were more likely to state a negative workplace culture (53% vs 40%).

Improving doctors' day-to-day working lives

While sufficient increases in doctor numbers are unlikely in the near future, given the time it takes to train medical professionals, measures can be put in place, in the short-term, to ease workload burden and improve doctors' day-to-day working life.

Measures the profession identified as having the biggest potential impact on their day-to-day working life in the immediate future are: guaranteed safe levels of medical staffing (57%), followed by more effective IT systems that are interoperable (53%), limits to the number of consultations per session to a safe number (47%) and improved systems and processes for the primary and secondary care interface (43%).

Views on what would make the most difference vary by age. Younger doctors are more likely to say that safe levels of staffing would most improve their day-to-day working life (72% 25-34 vs 57% UK average). Another factor that is more important to younger doctors is more effective IT systems (64% 25-34 vs 53% UK average). Older doctors on the other hand identified limiting the number of consultations per session to a safe number as more important to improving their day-to-day life (53% 45-54, 49% 55-64 vs 47% UK average).

Table 6

What workforce changes would improve your day-to-day working life?	All UK working doctors
Guaranteed safe levels of medical staffing	57%
More effective IT systems that are interoperable	53%
Limit number of consultations per session to a safe number	47%
Improved systems and processes for the primary and secondary care interface	43%
Additional support from non-medical clinicians (eg physician associates, primary care pharmacists)	42%
More favourable pay, terms and conditions of service	40%
Additional support for patient related administration	35%
Patient empowerment to self-care/manage	34%
More flexible working options	26%
Visible and accessible senior management who engage with the medical profession	26%
Improved facilities (eg rest, food, etc.)	21%
Greater use of new technologies	18%
Better access to health and wellbeing services (including occupational health)	14%

There are also some differing views between GPs and hospital doctors on what would improve their day-to-day lives. GPs are more likely to state a limited number of consultations (72% GPs vs 32% hospital doctors – top option chosen by GPs), improved systems and processes for the primary and secondary care interface (54% vs 36%), additional support from non-medical clinicians (53% vs 35%), patient empowerment to self-care/manage (56% vs 21%) and better access to health and wellbeing services (19% vs 11%).

In contrast, hospital doctors are more likely to state guaranteed safe levels of medical staffing (63% hospital doctors vs 48% GPs – top option chosen by hospital doctors), more effective IT systems (62% vs 39%), more favourable pay, terms and conditions of service (43% vs 37%), more flexible working options (33% vs 15%), visible and accessible senior management who engage with the medical profession (36% vs 9%), improved facilities (eg rest, food, etc.) (30% vs 7%) and greater use of new technologies (21% vs 12%).

BMA analysis

- The survey results highlight that doctors want to see straightforward, sensible solutions implemented to help alleviate the workload burden. The BMA has called for many, if not all, of the potential solutions listed in Table 6 to be implemented.
- The BMA has called for published and enforced safe staffing levels and has proposed a strategy for reducing workload in general practice through demand management. We know that poor IT is a leading cause of stress among doctors and the BMA is working to identify minimum IT standards that staff should expect in their place of work.
- Pay is one of a number of factors that would improve doctors' working lives, but there are other priorities that must also be addressed.
- Doctors' pay has declined in real terms by around 20% over the past decade. If morale, recruitment and retention are not to become even bigger issues for the NHS, this cut to pay has to be addressed. Not only should pay keep track with inflation but effort must be made to start to restore pay to expected levels.

Our vision for change

- Action is needed to establish safe working limits for all doctors, including in general practice.
- Governments must address the long term decrease in doctors' and health professionals' pay.
- We need IT that is fit for purpose and interoperable that helps to reduce workload and ensures patient safety, as well as improved systems and processes for the primary and secondary care interface.

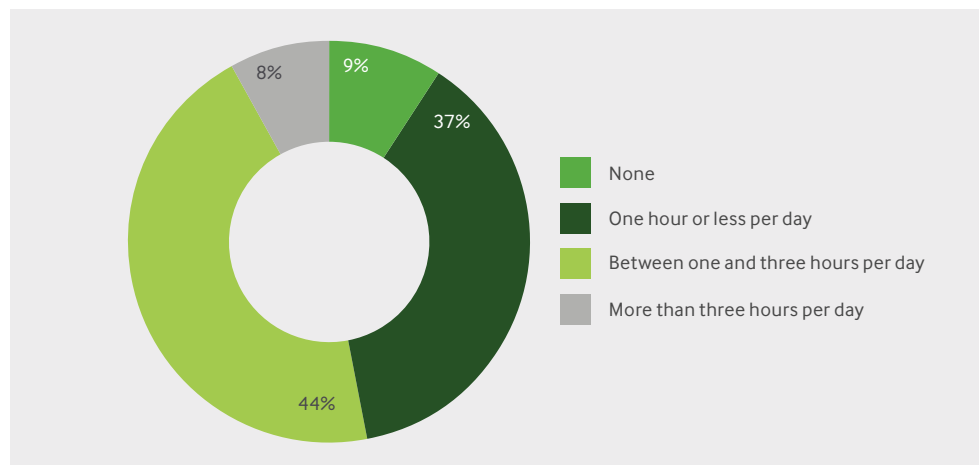
4.3 Support from the non-medical workforce

As noted above, ultimately the NHS must address medical workforce shortages (including improving both recruitment and retention of doctors) if it is to continue to meet the needs of patients. However, we must consider other strategies to support doctors given that current medical workforce shortages will not be corrected in the immediate future. We have therefore also asked doctors for their views on the role of the non-medical workforce – which includes a range of professionals such as surgical care practitioners, advanced care practitioners, physician associates and general practice pharmacists. We sought to explore to what extent doctors feel some of the work they currently do could be taken on by these professionals working in the NHS, what concerns they have about this, and to what extent such concerns could be addressed.

Time spent on non-medical work

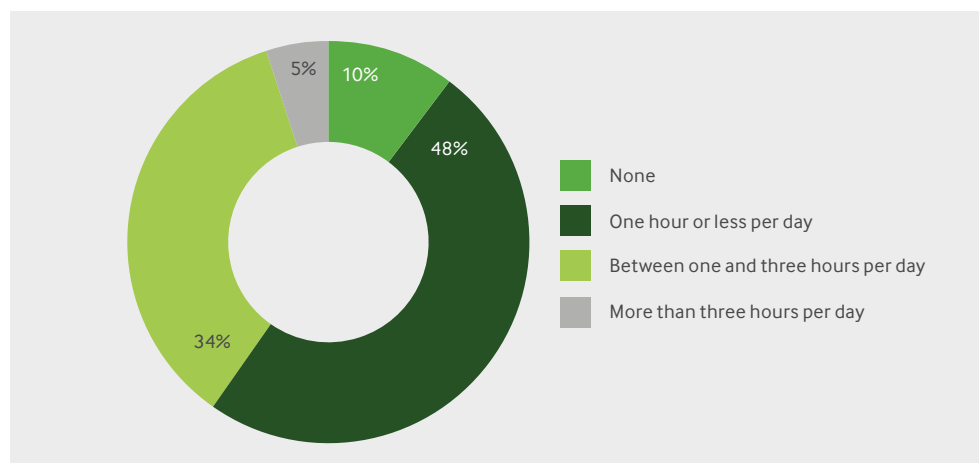
Doctors are currently spending a lot of time on work they could delegate to somebody else. Our survey results indicate that at least half of doctors say they spend over one hour per day on work that could be done by another non-medical clinical professional (52% spend an hour or more on this).

Figure 19: How much time on average do you spend on work that could/should be done by a non-medical clinical professional?



We also asked about work that could be done by non-clinical staff. Four in ten doctors said they spend over one hour per day on work that could be done by non-clinical staff (39% spend an hour or more on this).

Figure 20: How much time on average do you spend on work that could/should be done by a non-clinical staff?



Doctors who work significantly over their contracted hours are more likely to be spending longer on non-clinical professional work, with 51% spending between one and three hours a day compared to 29% of doctors who don't work over their hours spending this long.

Time to train staff or a lack of resource hold doctors back from delegating currently when it could improve their working life in future. Overall, the primary reasons stated for this work not being done by another professional are that there are not enough appropriately trained staff who could do the work (67%), there are no resources to fund more appropriately trained staff to do the work (57%) and it is quicker/easier for the doctor to do the work themselves (55%).

Views on expansion of the non-medical clinical workforce

The majority of doctors want a more multi-disciplinary workforce. When asked to what extent they approved of the current focus on expanding the non-medical clinical workforce (eg surgical care practitioners, advanced care practitioners, physician associates and general practice pharmacists) 48% of doctors overall approve and 25% overall disapprove. GPs are more likely to approve (53% vs 45% hospital doctors).

That being said, doctors have a number of concerns with expanding these roles. Concerns currently focus around a lack of accountability for actions among the new workforce (with this falling back on doctors) and a fear that they will be seen as a cheaper alternative to doctors and that they will undermine medical recruitment. See Table 7, opposite.

Figure 21: To what extent do you approve of the current focus on expanding the non-medical clinical workforce (eg surgical care practitioners, advanced care practitioners, physician associates, general practice pharmacists)?

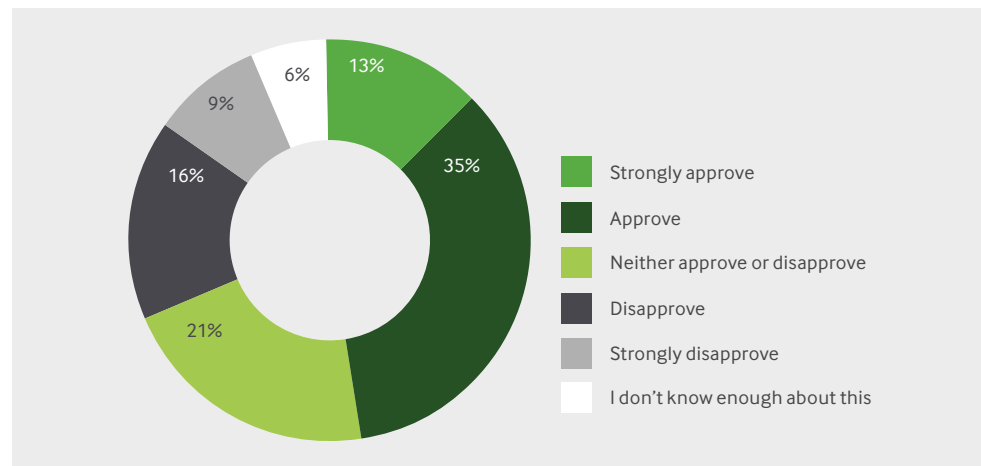


Table 7

Which of the following concerns, if any, do you have about the current expansion of the non-medical clinical workforce (eg surgical care practitioners, advanced clinical care practitioners, physician associates)?	All doctors who know enough about the current focus on non-medical clinical workforce
Lack of accountability for actions, with doctors carrying responsibility	74%
Seen as a cheaper alternative to doctors and will undermine medical recruitment	62%
Lack of regulation of non-medical practitioners	51%
Lowering of standards due to non-medical practitioners providing care that doctors are better placed to provide	50%
Training of non-medical practitioners interfering with junior doctor training	39%
Disproportionately funded and remunerated compared to doctors	37%

Doctors of BAME ethnicity are significantly more likely to raise all of these concerns than doctors of white ethnicity (3%-9% points higher). GP partners, salaried GPs and junior doctors are especially concerned about a lack of accountability for actions, with doctors carrying the responsibility (78%, 78% and 80% respectively).

BMA analysis

- An ever-increasing workload impacts on doctors' wellbeing and morale and the ability of the NHS to retain staff.
- At least a portion of that workload could potentially be managed by other clinical or non-clinical professionals, given that at least half of doctors say they spend over one hour on work that could be done by another non-medical clinical professional.
- However, regardless of workforce pressures, new clinical roles cannot and should not replace work that requires the knowledge and skills of doctors. The greater involvement of non-medical clinical professionals in the NHS must not simply be seen as an easy solution to shortages of doctors.
- Many questions and concerns remain when it comes to the expansion of the non-medical clinical workforce. These include regulation and indemnity, scope of practice, impact on doctors' training and education, lack of clarity among doctors, patients and the public about the new roles; and supervision.

Our vision for change

- With appropriate safeguards in place, non-medical clinical professionals have a potentially important role to play in the NHS to carry out some work currently done by doctors to free up time and ease pressures on the medical profession. More research is needed to understand the impact they can make.
- NHS leaders need to consider carefully how they are going to conduct effective workforce planning and service design, particularly regarding the development of new clinical roles and establishing effective multi-disciplinary teams, in a way that complements, supports and enhances the work of existing doctors and staff.
- There must be appropriate regulation of new non-medical clinical roles with clear lines of accountability and clarity regarding their scope of practice. Governments must work with the BMA on how to best integrate these new roles within the NHS.

5. NHS structures and collaboration

5.1 The primary and secondary care interface

We asked doctors about their experience of how primary and secondary care interact in the NHS where they work.

A high proportion of doctors (73%) say that there are organisational barriers, unfunded workload shift and compromised quality and safety of patient care as a result of problems at the interface between primary and secondary care.

Table 8

Which do you agree with regarding the primary/secondary care interface?	All UK doctors	UK GPs	UK Hospital doctors
Organisational barriers between primary and secondary care are resulting in increased bureaucracy and administrative costs	73%	84%	67%
There is unfunded workload shift from one sector to the other	66%	92%	52%
Quality and safety of patient care is being compromised due to barriers between primary and secondary care	60%	74%	52%
Organisational interests take priority over patient services	57%	60%	52%
There is a good relationship between GPs and hospital doctors	28%	24%	29%
There is duplication of staff and services in primary and secondary care	21%	25%	19%
There are clear channels of communication between primary care and secondary care	16%	13%	19%
Patients experience co-ordinated care between hospitals and general practice	9%	6%	11%

The results show that this is an issue that affects doctors across the UK and not confined to any of the four health systems – although there is some variation. Broken down by nation, 76% of doctors in England said organisational barriers between primary and secondary care are resulting in increased bureaucracy and administrative costs, compared to 71% in Scotland 60% in Wales and 68% in Northern Ireland.

BMA analysis

- It is widely recognised that better joint working would help improve outcomes, efficiency and patient experience across the NHS particularly between primary and secondary care.
- The survey results show that doctors across the UK broadly agree with this, with just 28% of doctors saying there is a good relationship between GPs and hospital doctors, 16% saying there are clear channels of communication between primary care and secondary care, and only 9% that patients experience co-ordinated care between hospitals and general practice.
- These survey results are also supported by findings from the BMA's open session at the 2018 ARM where 81% of respondents agreed (31%) or strongly agreed (50%) that change is needed to ensure that the future is more integrated and collaborative care is the norm, especially between primary and secondary care.
- This is a patient safety issue, with 60% of doctors saying that quality and safety of patient care is being compromised due to barriers between primary and secondary care. GPs are particularly likely to feel this way (74% vs 52% hospital doctors).
- Issues across the primary-secondary care interface are clearly common across the UK; however, further work is needed to fully understand the issues specific to each nation and implement solutions. For example, 66% of doctors agreed that there is unfunded workload shift from one sector to the other, with GPs particularly likely to say this (92% vs 52% hospital doctors) – but addressing this is likely to require a different policy approach in each of the four nations.

Our vision for change

- In the future primary and secondary care clinicians should face fewer barriers to effective joint working across traditional settings – all health system should be considering how they can facilitate this change to happen.
- Health systems need to consider how they can find better ways of fostering improved communication at the interface, particularly around referrals, in a way that encourages a supportive, collegiate dialogue (and crucially, backed by adequate resourcing).
- Reducing or redesigning structural barriers is one route through which the NHS could encourage better joint working between primary and secondary care, focusing on ensuring that both are working to a shared set of priorities and incentives
- Technology has the potential to radically alter how doctors work together across the primary and secondary care interface. Currently, lack of shared interoperable electronic records causes frustrations for patients and doctors alike.

5.2 England only results: the primary and secondary care interface

Just 8% of doctors in England are happy with the current arrangements between primary and secondary care. We also asked doctors in England specific questions about how doctors could be encouraged to work together more collaboratively across primary and secondary care in the English NHS.

Table 9

Do you agree or disagree with the following statements concerning how doctors work together across primary and secondary care?	All working, overseas and retired doctors in England
Patient data should be shared between primary and secondary care for the purposes of direct patient care (with appropriate information governance safeguards)	95%
Collaboration between primary and secondary care doctors will improve the quality of patient services and experience	94%
GPs and hospital doctors should work together more directly in a collaborated and coordinated manner	93%
There should be shared pathways across primary and secondary care, with resources fairly directed to where care is delivered	92%
Hospital doctors should be able to prescribe medication that can be collected at a patient's community pharmacy	90%
Collaboration between primary and secondary care doctors will reduce bureaucracy and transaction costs	82%
There should be system-wide incentives that encourage doctors to work more collaboratively	80%
Hospital doctors should be able to directly arrange investigations to be done in the community	75%
There should be protected funding for schemes designed to promote closer joint working	70%
Doctors across primary and secondary care should be employed by the same organisation	35%

A majority of doctors in England say that GPs and hospital doctors should work together more collaboratively, patient data should be shared and there should be more shared pathways to access resources.

70% of doctors in England say that there should be protected funding for schemes designed to promote closer joint working, with 6% disagreeing and the remainder unsure. GPs are even more likely to agree that this should be put in place (79% vs 67% hospital doctors in England).

Finally, a majority of doctors based in England say that the lack of capacity in community healthcare service and social care is affecting the ability of patients to be managed in the community and resulting in increased hospital attendance (healthcare service, 84%; social care, 90%). This is unsurprising given funding cuts in these areas in recent years, with adult social care spending in the UK falling by 9.9% between 2009/10 and 2016/2017²⁴.

BMA analysis

- These findings indicate that in England, there is strong appetite amongst doctors for finding better ways to collaborate across primary and secondary care. It is particularly concerning that just 8% are happy with current arrangements, suggesting that this needs urgent attention from policy makers in England.

Our vision for change

- Wherever they work in the NHS, doctors want to work more collaboratively with their colleagues to improve patient care. Currently arrangements in England do not make such collaboration easy, so we need to find new ways to overcome structural, bureaucratic and cultural barriers to closer joint working that can unlock benefits for both patients and doctors.
- The findings show support for a range of potential solutions in England, including better data sharing (95%), shared pathways (92%), system-wide incentives to work together more closely (80%) and protected funding for schemes designed to promote joint working (70%). These ideas will need further development and testing, but provide a starting point for further work in this area.

5.3 Structural change in England

We asked doctors in England only for their views on new ways of commissioning and organising services being developed in the English NHS.

STPs (sustainability and transformation partnerships)

In 2015, the English NHS was divided into 44 health and care systems, known as STPs. STPs were tasked with creating five-year plans detailing how providers in local areas will work together. 48% of doctors say that they know a small amount about the proposals for healthcare redesign in their STP, whilst 42% say they know nothing at all. Only 10% say they know a great deal about the proposals.

The majority of doctors (78%) say they have not been involved in or engaged for their views in their STP in the last 12 months. 80% of doctors believe STP plans are primarily driven by cost pressures, whilst 51% believe their local STP plans will cut services. A lower proportion of doctors believe that their local STP's plans will improve joint working across the health and care system (15%), improve sustainability of services (9%) and transform services for the benefit of patient care (5%).

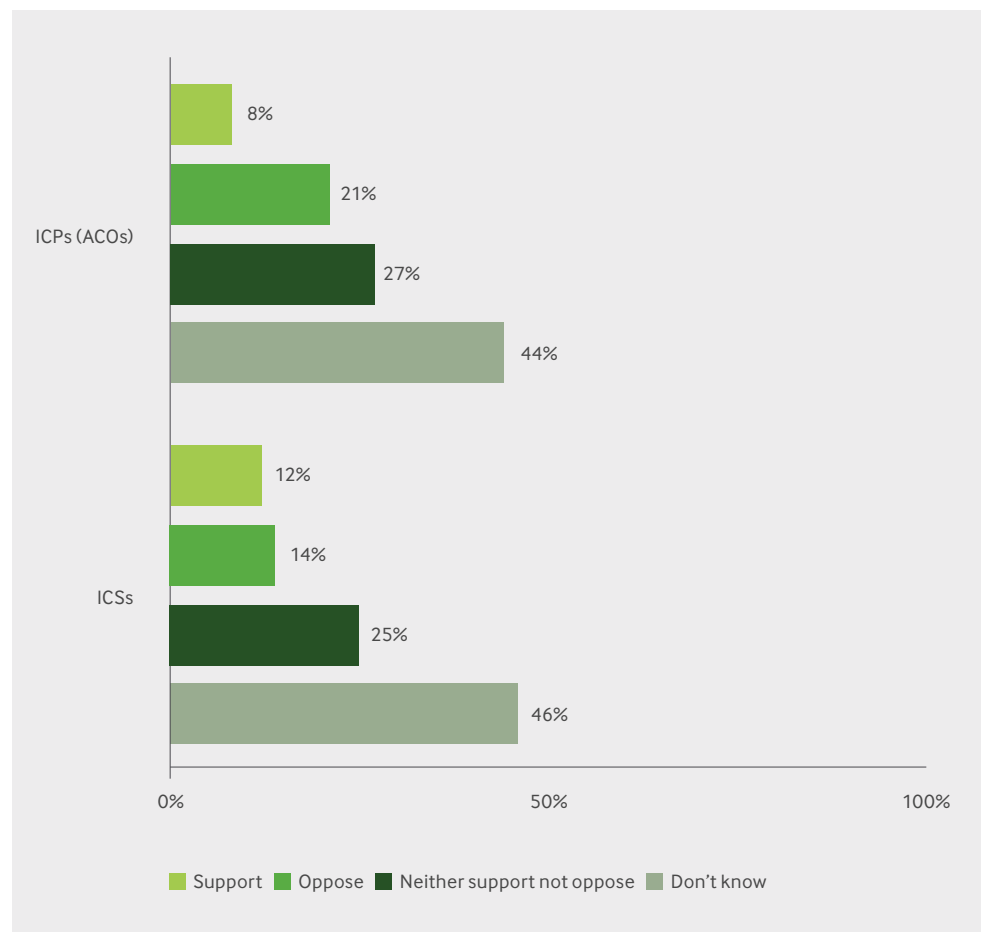
ICPs (integrated care partnerships) and ICSs (integrated care systems)

Two new ways of organising and delivering care are currently making headlines:

- ICPs: formerly known as ACOs^a: commissioners hold a contract with one organisation for most services.
- ICSs: providers have agreements with commissioners to work in a more integrated way.

73% of doctors are not aware of plans to establish an ICP or ICS in their area, while 26% are aware. We also asked doctors about whether they support the development of these new structures.

^a Note: the BMA's survey was conducted before this name change took place, so the term 'accountable care organisation' was used in the survey itself.

Figure 22: Doctors' views on ICPs (ACOs) and ICSs

For both ICPs and ICSs, a significant proportion of doctors said either 'don't know' or 'neither support nor oppose'. This suggests that many doctors feel they don't yet know enough about these changes and have not formed a strong view on them yet. However, it is notable that a relatively significant proportion of doctors (21%) oppose ICPs.

BMA analysis

- The findings indicate that much more needs to be done to engage doctors in the development of new commissioning and delivery structures in the NHS in England.
- The BMA and many others (including the Health Select Committee) have been critical of the lack of meaningful engagement and Parliamentary scrutiny that has taken place to date in the development of STPs, ICPs and ICSs. It is alarming that 80% of doctors believe STP plans are primarily driven by cost pressures, whilst 51% believe their local STP plans will cut services.
- The BMA has already expressed a number of concerns about ICPs informed by the views of our members²⁵ – particularly around the risks of bringing together NHS services into one large contract which would need to put out to competitive tender.

Our vision for change

- There are many problems with the current commissioning and delivery structures in the NHS in England that cause frustrations for doctors – particularly the fragmentation and disincentives to integrated working that stem from the Health and Social Care Act 2012. The government needs to explore solutions to these problems, but it must do so in a transparent way that engages doctors, staff and patients much more effectively.
- Changes to commissioning and delivery structures in England must be properly resourced, and should never be used as a vehicle for cuts. Integration can benefit patients, but cannot be done on the cheap – proper investment is required.
- The BMA's principles for medical engagement⁶ set out ideas for how NHS organisations can effectively engage doctors in structural change.

6. Appendices

6.1 Survey methodology

The survey data presented in this report is based on 7,887 responses to an online survey, which ran from 3 May to 4 June 2018. The BMA designed the survey with input from a professional polling company, ICM Unlimited.

All current BMA members were invited to take part in the survey, include UK working doctors, working doctors based overseas, medical students and retired doctors. ICM Unlimited was responsible for contacting respondents to answer the survey, from a membership list provided by the BMA. Members who had opted out of contact via email or did not have a valid email address associated with their membership account were also able to contact ICM Unlimited to request a survey link (after their membership was confirmed by the BMA).

'Don't know' responses have been included in the calculation of survey response percentages in this report. Whilst key questions were mandatory, some were optional. Where questions were optional (but asked as relevant to the member), 'not answered' have been included in the calculation of percentages in this report. Where results don't sum to 100%, this is due to rounding or multi-code questions (i.e. respondents being able to select more than one answer). All survey figures in this report are based on unweighted data. When we look at the representativeness of each branch of practice within the sample, compared with the BMA membership profile, GP partners are over represented, whilst medical students and junior doctors are underrepresented across all four nations.

6.2 Sample profile

Current status	No. of respondents	% of sample
Consultant	2335	30%
GP partner	1553	20%
GP salaried or locum	760	10%
Junior doctor	1219	15%
Medical academic	94	1%
Medical student	338	4%
Portfolio	57	1%
SAS doctor	413	5%
Other	170	2%
Retired	948	12%
Gender	No. of respondents	% of sample
Male	4037	51%
Female	3752	48%
Non-binary	10	<1%
Unanswered	88	1%
Age	No. of respondents	% of sample
24 and under	298	4%
25 to 34	1098	14%
35 to 44	1316	17%
45 to 54	2124	27%
55 to 64	1949	25%
64 and over	1009	13%
Prefer not to say	93	1%
Nation	Number of respondents	% of sample
England	6071	77%
Northern Ireland	266	3%
Scotland	999	13%
Wales	443	6%
Outside UK	108	1%

Whilst all members were invited to take part in this survey, the total response sample profile does not exactly match that of the BMA membership profile. The total sample slightly over-represents Scotland opinion and under represents England opinion. GP partners are over-represented, whilst students and junior doctors are under-represented. Consultants are over-represented in Wales and Northern Ireland (caution: low base size for Northern Ireland consultants). Doctors up to the age of 35 are under-represented, whilst those over 46 are over-represented in the survey sample.

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