Rest, recover, restore:
Getting UK health services back on track

Summary

To safeguard patient safety and the wellbeing of healthcare staff, a realistic approach to tackling the backlog of non-COVID care is needed. **NHS[1] and public health services have been running 'hot' for a prolonged period of time and an overstretched and exhausted workforce must now be given time to rest and recuperate as they meet the challenges ahead. If staff are being pushed too hard to restore routine care in an unrealistic timeframe and without suitable resources , the likelihood is that we will see a workforce squeeze due to a combination of increasingly high staff absence rates and staff reducing their hours or leaving the workforce altogether.** This would make it harder for health services to get back on track and provide timely and safe care to patients who need it.

To ensure services resume safely both for patients and for those providing care, the BMA is calling for:

1. **All governments and system leaders across the UK to have an honest conversation with the public about the need for a realistic approach to restoring non-COVID care, and support for systems to tackle the backlog**
2. **Health, safety, and mental wellbeing of the workforce to remain a top priority**
3. **Additional resourcing to help tackle the backlog**
4. **Measures to expand system capacity**
5. **Measures to retain doctors and expand the medical workforce**

Across the UK, the impact of months of lockdown measures combined with the rollout of the vaccination program is beginning to take effect. As progress continues, the number of people requiring urgent care for COVID-19 will continue to come down – and with this, the NHS in all four UK nations will come under renewed pressure to restore non-COVID services in order to bring waiting times back down and begin to work through the backlog of unmet care. At the same time, health services will need to be able to scale up COVID-19 services swiftly should this be needed.

The scale of the challenge ahead is not to be underestimated. The backlog from the past year alone is extensive, with millions of normally expected elective procedures and outpatient appointments across the UK simply not having happened. Since April 2020 there have been three million fewer elective procedures in England than expected (based on 2019 levels), and 143,000 fewer in Scotland.[2] The number of patients waiting over one year for treatment across the country has risen significantly: in England it now stands at 185-times its 2020 value,[3] a 13-year high that highlights the large proportion of unmet care. In Wales, it is reported that wait lists for non-urgent hospital treatment have hit a record high of nearly 540,000 patients with the number of patients waiting more than 36 weeks having increased 728% from Jan 2020 to Feb 2021.[4] In Northern Ireland, more than 300,000 patients were waiting for a first consultant-led outpatient appointment as of December 2020.[5] A return to pre-pandemic levels of service provision is also unlikely for some time given the ongoing disruption to NHS services as a result of COVID-19 and the requirement for more stringent infection prevention and control measures. There is also extra and rising demand from patients with long-COVID and those who have seen their mental health deteriorate during the pandemic, which will be a continuing requirement for the foreseeable future.

1   HSC (Health and Social Care) in Northern Ireland
2   https://beta.isdsscotland.org/find-publications-and-data/healthcare-resources/waiting-times/cancelled-planned-operations/
3   https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2020-21/
4   https://www.bbc.co.uk/news/uk-wales-56111743
5   https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-outpatient-waiting-times-q3-20-21.pdf

Meeting this challenge will fall to an already exhausted workforce. Prior to the pandemic, NHS staff were already working in the context of year-round escalating pressures – the result of more than a decade of underfunding and under-resourcing. Workforce increases over the past decade have simply not kept pace with rising demand for services, and despite the recent increase in FTE doctors[6] there are still significant medical, clinical and non-clinical vacancies across the secondary care workforce in the UK.[7] In general practice the workforce has barely grown since 2015, while the number of FTE GP partners has contracted.[8] The workforce is also faced with an increase in frail and complex patients. The impact of these shortages has long been apparent in the worryingly low morale and increasingly high burnout rates of NHS staff, alongside growing rates of poor mental wellbeing. Anxiety, depression, stress or other psychiatric illness have been the most reported reason for sickness absence for some time now.[9]

The pressures of delivering care during a pandemic have not only compounded the existing wellbeing crisis but added further trauma and fatigue to daily working life as well as moral distress which occurs when people are forced to make, or witness, decisions or actions that contradict their core moral values.[10]

Doctors and other healthcare workers have been going above and beyond for months now, working in intense and stressful environments with little respite. This is taking its toll:
— **51%** of respondents to the BMA's latest COVID tracker survey[11] report a worse state of overall health and wellbeing than during the first wave of COVID-19
— **59%** report higher than normal levels of exhaustion or fatigue
— Burnout and workload levels are at an all-time high, and many staff will leave the pandemic with PTSD – **32%** of respondents to the survey say that they or clinical colleagues in their department have been on sick leave due to anxiety, stress, depression or PTSD directly caused from working during the pandemic. This stark picture is echoed in the NHS (England) Staff Survey 2020, in which **44%** of respondents report feeling unwell as a result of work-related stress in the past year.[12]
— When asked if they have changed their career plans for the next year, **26% of doctors** said they were more likely to take an early retirement, another **26%** said they were more likely to take a career break, and **18%** said the same about leaving the NHS for another career.

1. All governments and system leaders across the UK must have an honest conversation with the public about the need for a realistic approach to restoring non-COVID care
Actions for: governments, system leaders

Restoring non-COVID care will take time and resources. The BMA has estimated that even if the NHS were to run at 110% of its pre-COVID capacity, it could take up to five years to reduce the backlog of elective care in England back down to (already high) 2019 levels. In light of this:

— Clarity is needed on what expectations will be placed on the NHS and public health for restoring services, tackling backlogs and managing waiting times. Ministers and NHS leaders should set out clear plans for how the NHS in each UK nation, public health and community services will be supported to do this, engaging clinicians across primary, secondary and community care to ensure frontline views are reflected.

— A cautious approach is needed to reopening services. In many areas, ICUs are still running

6   https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics
7   https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey
8   https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services
9   https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates
10 https://www.bmj.com/content/372/bmj.n28
11 https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-bma-actions-and-policy/covid-19-analysing-the-impact-of-coronavirus-on-doctors
12 https://www.nhsstaffsurveyresults.com/

well above pre-pandemic capacity with patient to nurse ratios that are not safe and must not be continued longer term, making it difficult to safely expand many non-COVID services such as elective procedures. Infection control measures and reduced capacity due to COVID-related staff absence, also make the expansion of these services difficult, and the additional time that most tasks will take compared to pre-pandemic must be acknowledged in any instructions given to services. GP practices are still facing increased workloads due to clinical pathways being closed and patients therefore returning to visit their GPs, and that GPs are having to spend more time caring for patients with resolvable conditions than would previously have been the case. Support to safely increase non-COVID care must therefore cover both secondary and primary care and encourage clinicians across the NHS to work together, as recommended in our recent paper on '*Supporting collaboration in the wake of COVID-19*'.[13] It will also be important to ensure that new initiatives are not introduced in general practice to avoid further disrupting the re-start of non-COVID services.

— Support must be provided to local systems to develop COVID recovery plans that:
    — Understand the scale and nature of the backlog in their areas
    — Identify patients most at risk of deteriorating
    — Embed new ways of working trialled effectively during the pandemic e.g. Develop and implement new models of care e.g. using new community diagnostic support, remote monitoring, and community hospitals models
    — Bring clinicians together across primary, secondary and community care to discuss problems/blockages and agree approaches
    — Identify the health improvement measures that would have the most effect in reducing health inequalities
    — Enable clinicians to determine effective use of resources e.g. operating theatres
    — Understand and resource additional workforce capacity requirements
    — Is backed with sufficient funding

— Any timescales for tackling the backlog and bringing down waiting times must be realistic. Waiting lists for care were growing even before the pandemic and are likely to increase rapidly as more COVID-19 restrictions are lifted and people who have put off seeking care enter the system. **There is a backlog of care that will take years, not months, to work through (see Box 1 below).**

— NHS leaders should avoid using crude targets for returning to pre-pandemic levels of activity, as was the case in England after the first wave when Trusts were threatened with financial penalties if they did not meet challenging targets for elective care and outpatient activity. These act as an incentive to employers to push staff to meet short-term targets, with negative consequences in terms of increased staff absence and retention in the medium-to-long-term. Governments across the UK must be realistic about the current range of targets in place, and how achievable they are in the current circumstances. Equally, financial incentives for meeting or exceeding targets are counterproductive. They also direct much needed funding away from organisations that may need it most.

— Above all, politicians must be honest with the public and with NHS staff about the scale of the challenge we are now facing. A reduced threat from severe, acute COVID-19 will not mean a return to normality for the NHS in any of the four UK nations — the process of recovery will take years and there will be ongoing disruption to patient care. More patients will be seeking care in the coming months and this is a good thing — particularly given concerns that some patients may be delaying seeking care for urgent conditions — but long waits, particularly for routine care, will become the norm for some time.

— Finally, it is vital that whilst the NHS focuses on reopening more non-COVID care plans must also be in place to ensure services in each locality can revert back to high levels of critical care capacity, including much safer nurse to patient rations, in the event of future spikes in the number of patients needing acute care due to COVID-19. This should be a requirement of the NHS major incident plan, as well as local incident planning.

13 https://www.bma.org.uk/media/3334/bma-supporting-effective-collaboration-between-primary-secondary-care-covid-19-oct-2020.pdf

Box 1: Estimating the size and impact of the backlog in elective care in England

During the pandemic routine care has been hugely disrupted, with elective procedures in particular being scaled back to enable health systems to focus on caring for large numbers of COVID-19 patients.

This effect can be seen in chart 1 below, which compares the number of elective procedures in England in the year prior to the pandemic (Feb 2019-Jan 2020) with the last year (Feb 2020-Jan 2021). There was a dramatic drop in elective treatments in the initial months of the pandemic, with a steady recovery over the summer and a further drop towards the end of 2020 as the virus resurged. In total there were three million fewer elective treatments during the last 12 months compared to the previous year.

Chart 1: Elective activity in England has been 3 million lower this year than last
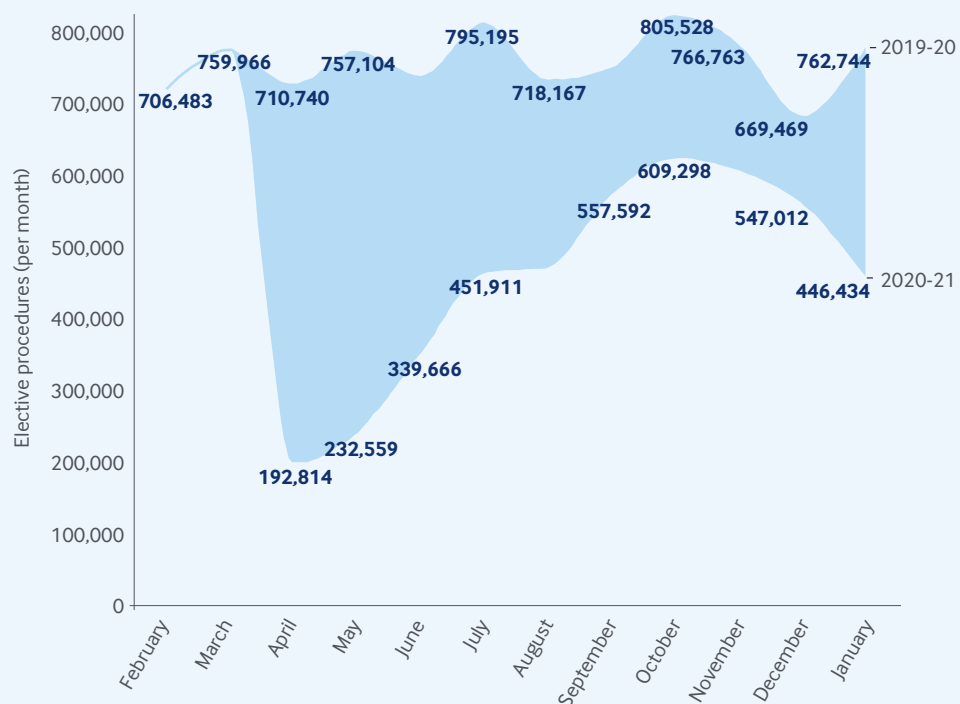
In addition to this backlog, there are currently 4.6 million people on the elective care waiting list, up from 4.4m in February 2020. As the NHS recovers from the pandemic and patients who have been holding off seeking care now start to come forward, this waiting list is likely to grow rapidly. The BMA has explored a number of scenarios for tackling the backlog, outlined in Chart 2 below. Based on an estimated waiting list of 7.6 million comprising of the current waiting list and the 3 million fewer elective treatments that have occurred over the last year (which may underestimate the scale of the challenge given the backlog continues to grow), we have estimated that:

— Even if the NHS returns to pre-pandemic levels of elective activity (based on the 2019 average) waiting lists will continue to grow
— **If elective activity increased to 110% of 2019 levels, the waiting list would begin to come down but would take up to five years to come back down to pre-pandemic levels, and up to a decade to return to more manageable levels**
— If elective activity increased to 120% and 130% of 2019 levels (both of which are likely to be unachievable given current workforce constraints), it would still take several years to reduce the waiting list down to more manageable levels.
— If the NHS is not able to return to pre-pandemic levels of activity (due to ongoing disruption, staffing pressures, safety requirements etc), the waiting list could grow rapidly over the coming years (the chart below shows one scenario based on the NHS returning to levels of activity before the second wave in October 2020).

Chart 2: Scenarios for working through the elective waiting list and estimated 3m backlog
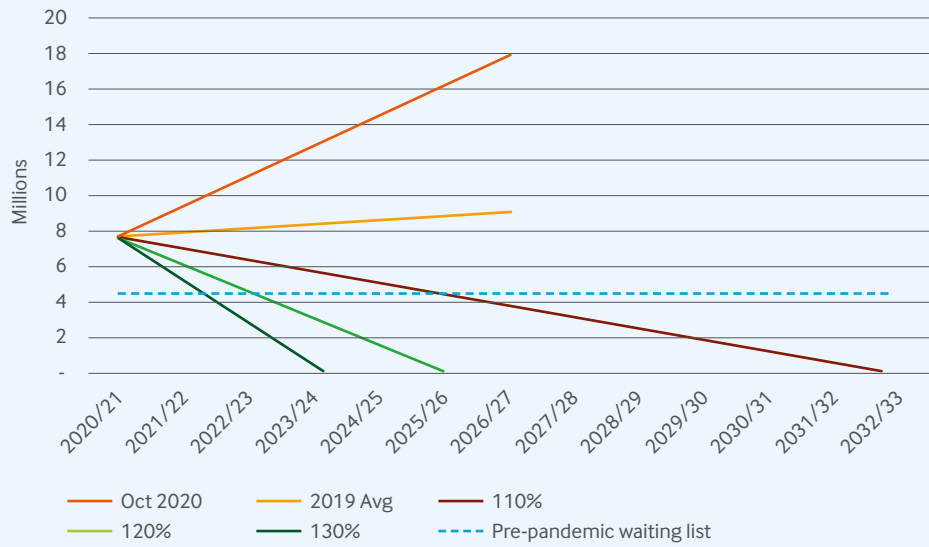

Box 2: Estimated size of the elective care backlog in Scotland

A similar trend in elective activity can be observed in Scotland compared to England (see Box 1 above). Elective procedures in Scotland dropped rapidly in the first months of the pandemic, recovered slightly during the summer, and began to fall again towards the end of 2020 and beginning of 2021.

Since April 2020 there have been 143,000 fewer elective treatments compared to expected levels.

Chart 3: Elective activity in Scotland
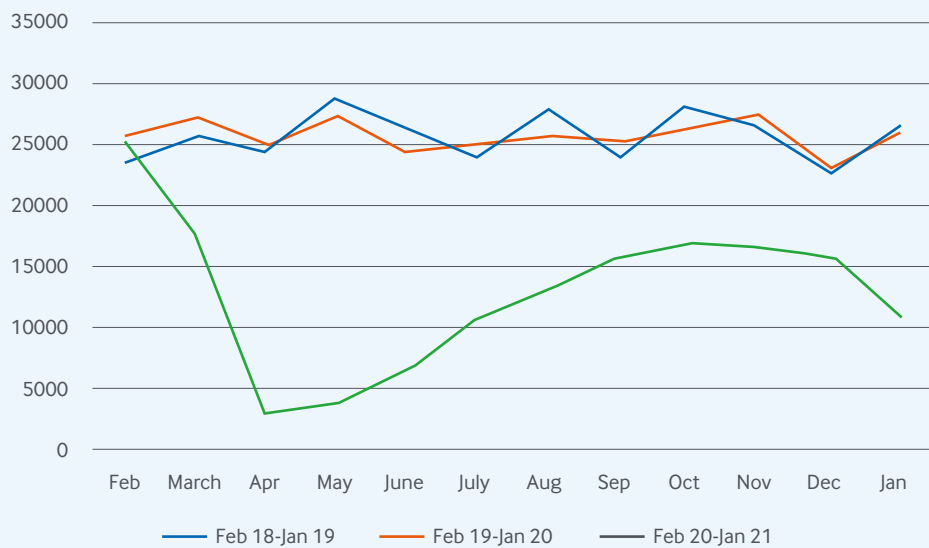
2. Health, safety, and mental wellbeing of the workforce must remain a top priority
Actions for: employers, commissioners, clinical leaders

— **All healthcare workers must be permitted to take leave** as/when they need it and employers must allow staff to carry over any unused leave. Staff must be afforded more flexibility to take leave, while recognising the need for safe staffing levels. Extended leave for those who need it e.g. for international medical graduates who may have been cut off from their families during the pandemic should be granted wherever possible.

— **A safe work environment must be provided** (with appropriate personal and environmental hygiene protective measures) to reduce avoidable absence. This also means having sufficient and appropriate staffing to support staff wellbeing, as well as ensure patient safety.

— **Staff must be given sufficient rest breaks and time off between shifts**, with access to safe changing and rest areas, as well as to nutritious food and water to allow them to recharge, have restorative sleep and stay healthy.

— **Staff must be given up to date physical and psychological health risk assessments** and provided with reasonable adjustments where necessary to ensure they can work safely.

— **Access to occupational health assessments (and ideally a consultant occupational physician-led team) must be timely and accessible to all staff** working in both primary and secondary care, particularly where fitness to return to work advice is required. This is likely to be needed for staff who have been shielding or who have difficulty recovering from a COVID-19 infection. Plans to improve occupational health access for all healthcare workers must be developed as a priority.

  — **Rapid referral, including self-referral (within a week) to an independent specialist occupational physician-led service** should occur where there are signs of stress/distress. The service must be competent to assess work circumstances and diagnose the cause, including whether it is predominantly work or personal issues-based, and able to advise on supportive interventions.
  — **Signposting must be made available to access psychological support services,** either through the occupational health team or on a self-referral, confidential basis, for staff who have already developed distress or burnout. This is to enable staff to stay in work and to minimise lengthy absences.
  — **An organisational structure must exist which implements the advice provided by the Occupational Health team,** to enable staff to timeously regain their health.

— **Permanent large-scale vaccination services** within hospitals must be established to maintain and support ongoing vaccination of staff.

— **Support must be provided for NHS staff with long-COVID** — For those impacted by long-COVID, a phased return to work must be supported if appropriate, following an assessment by an occupational health team (recognising access to OH teams is not available to all staff, particularly those working in primary care). The existing arrangements for full pay for staff who are off sick with COVID and no trigger for sickness absence, should be maintained for as long as necessary, with financial support for employers to enable this provision.

— **Move away from the use or appearance of the politically-charged word "resilience" across NHS organisations** — it is offensive to staff and is not conducive to a good working culture.

— **Staff must be supported to raise concerns** if they feel their health, safety or wellbeing — or that of their patients — is at risk.

— Read more BMA [recommendations](#) for supporting the mental health and wellbeing of the workforce post-COVID and the BMA's [Mental Wellbeing charter](#) and [Fatigue and Facilities charter](#).

3. More resourcing to enable the NHS to work through the backlog
Actions for: governments, commissioners

Health services in all four UK nations must be given specific extra resources to tackle the additional challenge posed by a growing backlog of non-COVID care that continues to build.

Prior to the pandemic NHS services were already struggling to cope with significant resourcing challenges. The NHS has experienced a decade of under-spending and both public health and social care have been hit by substantial cuts. This has undoubtedly made it more difficult for these services to respond robustly to COVID-19.

Additional resources are needed across the NHS to support doctors to work through this backlog and to support the restoration of non-COVID care. The cost of working through the 3m elective backlog in England alone, based on the average cost of such procedures in the NHS, is around £4bn.[14]

Capital expenditure
The NHS has suffered with long term underinvestment in capital funding. For example, the proportion of the NHS' budget in England spent on capital fell from 5% in 2010/11 to 4.2% in 2017/18 — mainly as a result of capital budgets being diverted into revenue to pay for day-to-day running costs.[15]

The COVID-19 pandemic has demonstrated the need for investment in NHS estates and equipment to ensure they are fit for purpose and able to cope with increased demand and infection control measures. For example, A&E departments' capacity will need to be expanded to help ensure appropriate social distancing and infection control, there will be a need for more side rooms, better ventilation and facilities for staff that enable social distancing. Investment will also be needed to maintain an expanded critical care capacity (with UK critical care bed numbers lower than many other European countries going into the pandemic)[16] to increase resilience to any future COVID-19 waves and other pressures.

Key areas where capital investment is needed are:

Overdue maintenance
The latest data from 2018/19 for England shows that at least £6.5 billion is needed to tackle the backlog of maintenance costs. Over half of this (£3.4 billion) is needed to address issues that present a high or significant risk to patients and staff.[17] The NHS in Scotland is reportedly facing a £1bn backlog of repairs,[18] and Wales the NHS had an estimated £261m backlog as of 2019.[19]

14　BMA analysis based on NHS Digital Hospital Episode Statistics (HES) data and the National Schedule of NHS Costs
15　NHS Digital (2019) Estates Returns Information Collection Summary page and dataset for ERIC 2018/19
16　Critical care services in the English NHS, The King's Fund, 25 Nov 2020: https://www.kingsfund.org.uk/publications/critical-care-services-nhs
17　NHS Digital (2019) Estates Returns Information Collection Summary page and dataset for ERIC 2018/19
18　£1bn backlog Health boards facing huge bills for hospital repairs, The Press and Journal, 3 Feb 2020: https://www.pressandjournal.co.uk/fp/news/politics/scottish-politics/1990793/1bn-backlog-health-boardsfacing-huge-bills-for-hospital-repairs/
19　NHS hospitals and buildings' £261m backlog of urgent repairs, BBC News, 19 September 2019: https://www.bbc.co.uk/news/uk-wales-49661434

Expanding overall NHS capacity

The UK Government has committed to expanding NHS capacity in England by building 40 new hospitals in the coming years. It should now set out in detail how this commitment will be funded, and what it will mean for the NHS in terms of additional space, workforce, and ongoing spending, as well as timescales. Devolved administrations should also set out how they are planning to support the expansion of their health system in the short and medium term.

GP premises

Additional capital funding is required both to bring up the standard of and to transform the current primary care estate across the UK to ensure clinical teams can respond to the challenge of managing the backlog in purpose-built premises and to support future workforce growth.

Increasing GP numbers is a priority across the UK and those individuals will need physical space from which to operate — which will require upgrades/extensions to existing premises, and new premises to be built. Without this, recruitment of the additional workforce will not be possible, and without the additional workforce health services will struggle to address the challenges of the backlog.

NHS Information technology

Historically, IT funding has taken a back seat to other priorities within the NHS. Fundamentally, core IT systems are still inadequate compared with equivalent systems across the private and consumer sector and further neglect will only exacerbate this. In light of government spending during the pandemic there will continue to be competing priorities, but we cannot afford to withhold digital transformation funding for the NHS. In a recent BMA survey, 27% of doctors estimated they lose more than four hours a week because of inefficient hardware systems. Better IT would free up valuable clinical time and go some way towards mitigating the negative effects of poor staff retention and facilitating the management of the backlog.

The pandemic has accelerated the work around remote working which was already underway. As remote working and remote working preparedness become a long-term reality, adequate financial support must be given to all primary and secondary care clinicians to enable them to work remotely. Laptops must be provided and software purchased to facilitate the use of clinically appropriate remote contact.

Specific funding should urgently be provided to secondary care trusts to procure APIs (Application Programming Interfaces) for their clinical information software. This will enable interoperability within the trust and between the trust and its neighbours. As indicate above, greater interoperability between secondary and primary care would naturally facilitate better communication and better, more coordinated care for patients.

Workforce

The BMA has long called for significant investments in developing the workforce for the future. In the immediate term, additional resource must be provided to ensure employers and GP practices are able to secure temporary locum support, particularly where there is a workforce squeeze due to sickness absence or staff who are isolating.

4. Measures to increase system capacity

Actions for: commissioners, governments, system leaders

Alongside supporting staff wellbeing to maximise health systems' current and future capacity, there are a small number of other actions that can be taken.

— **Governments must fund a rapid expansion of diagnostic services** accessible to clinicians across primary, secondary and community care, to ensure patients can receive timely tests and investigations. In England, some funding for community diagnostic hubs was announced in the 2020 Spending Review, but this will only cover part of the country. The Scottish Government has announced it will provide additional investment of up to £5.67 million for cancer diagnostics and scopes.

— **Sharing of clinical data must be improved.** Improving diagnostic services is not only a matter of laboratory and imaging services it is also a matter of enhancing reliable access. Regardless of where the request for diagnostics originates, results should be accessible from primary and secondary care to allow clinicians to continue to care for their patients, both in terms of diagnosis and long-monitoring. More generally, enhanced sharing of data between clinical teams has the potential to improve cooperation at the interfaces between services and therefore increase system capacity. While some progress on this area has been made during the pandemic, the IT infrastructure to do this in the NHS is still largely absent. Action is needed to develop systems where clinicians in different settings could ideally see and contribute to relevant shared patient records, observations, results and background notes from any location, in real-time.

— **Reinforce collaboration at the interface through proper job planning and additional support for clinicians.** Throughout the pandemic clinical teams in secondary care have increased the use of the advice and guidance (A&G) function of the NHS e-Referral Service to ensure they could support GPs to continue providing care in a context of capacity constraints and disruption of outpatient services. To ensure that collaboration and communications between clinical teams at the interface of services is most effective, secondary care employers should ensure that:
  — A&G sessions are categorised as direct clinical work for consultants and SAS doctors.
  — Solutions are offered to junior doctors may be losing out on education and training opportunities.
  — Clinicians have dedicated time embedded in their job plans for A&G sessions.

— **Governments must ensure social care packages are in place to enable patients to be discharged safely from hospital without undue delays** to free up space in hospitals. In England, funding put in place to support discharge of COVID-19 patients who need a care package runs out on 31 March 2021, with no current plans to extend this. NHSE has said this funding avoided the need for at least an additional 5,000 beds and 10,000 staff during the winter. In the immediate term funding schemes to support discharge should urgently be extended. In the longer term, the BMA has called for much wider social care reform backed with additional resources – without this the NHS will face a much greater uphill struggle to provide safe and timely care for patients and tackle the backlog in the coming years.

— **While the private sector has its own backlog of care to tackle, there may be a case for using private sector capacity to support the NHS in tackling the backlog.** If private sector capacity is used, there must be:
  — Transparency around what contracts have been agreed and what capacity is being purchased
  — Acknowledgement of the fact that many of the doctors doing work in private hospitals are also full-time NHS doctors and that they need to work reasonable hours as well as recuperate from the pandemic.
  — Clear expectations and KPIs must be set out, so that private companies can be held to account for any poor performance or failure to deliver as agreed
  — A guarantee of value for money for the NHS, with no repeat of the issues seen in the initial stages of the pandemic where funding was used to block-book private capacity which was then not used

— A clear exit plan to ensure that the NHS can return to not relying on private sector capacity as swiftly as possible, and the private sector can return to normality too.

— **Increase workforce capacity to ensure staff can maintain a healthy work-life balance and are not pressured to take up additional work. Where staff do any work beyond their contracted hours, they must be fairly remunerated.** Additional work must be optional, and doctors should never be pressured or bullied into working beyond their contracted hours. Where staff have changed their working hours or other contractual terms, they must be enabled to return to their previous terms. Those working on a zero hours contract throughout the pandemic should now be offered substantive contracts with appropriate terms and conditions.

— **Dedicated staff should be employed to prevent doctors being diverted towards administrative duties.** Currently, many doctors spend too much time doing administrative duties or tasks that do not require a medical degree and could easily be done by others. Doctors must be helped to focus on tasks where their expertise is most needed. New roles, such as 'Doctors' Assistants' at Band 3 on Agenda for Change, can increase the efficiency and workload of doctors and should be expanded to allow doctors to focus on tackling the backlog.[20]

— **HR passporting needs to be enhanced and further streamlined**, and movement of staff between primary and secondary care must be better enabled. Digital staff passports such as the one introduced in England will help to reduce the administrative burden placed on staff and employers.

— **All efforts should be made to maintain and deliver teaching, training and access to educational opportunities.** Where this is not possible, steps must be taken to mitigate any impacts and collaboratively plan how this will be facilitated at a later date, or in an equivalent alternative format, scheduled within rostered hours. Where professional examinations and courses are able to continue during the pandemic, trainees must be facilitated to sit and properly prepare for these so as not to delay training progression including consideration of the need for study leave. Leave must also be facilitated for specialty recruitment processes. There must be an individualised approach, that ensures a balance is struck between enabling gaining of competencies and progress through training and ensuring those who are burnt out have the opportunity to recuperate. Equally, trainers must be given time and resource for supervision.

— **NHS leaders should ensure that opportunities are taken to prevent ill-health, reduce complications and optimise patient health prior to any interventions.** For example, post-operative complications can reduce by 30%-80% with pre-operative preparation, reducing pressure on the system.[21]

20 https://bmjleader.bmj.com/content/early/2020/11/16/leader-2019-000192
21 https://www.cpoc.org.uk/about-cpoc-cpoc-policy/proving-case-perioperative-care

5. Measures to retain doctors and expand the medical workforce
Actions for: employers, commissioners, governments

— **Take immediate and meaningful action to retain doctors currently working.**

First and foremost, staff must be given time to rest and recuperate. Looking after the health and mental wellbeing of doctors and staff is paramount and will help retain them in the workforce in the short- medium- and -long term. Taking this step will not impact on tackling the backlog – but failing to enable staff to rest and recover will reduce the ability of the NHS to get non-Covid services up and running again. There are many strategies that can be deployed to improve retention in addition to prioritising health and mental wellbeing of staff (see Appendix). In addition, the following approaches should be immediately implemented:

— **A significant pay uplift for all doctors across the UK**, which goes well beyond retail price index (RPI) inflation and helps address the real terms pay cuts doctors have experienced over the last decade. There must be recognition that all doctors, including doctors who had previously agreed multi-year pay deals, have gone to extreme lengths to tackle the pandemic and that they should be rewarded as such.

— **Removal of punitive pensions taxation rules** that are being cited as being a major contributory factor in doctors choosing to either retire early or take steps to reduce their pensionable pay (i.e. reduce their working commitments within the NHS).
   — A recent BMA survey indicated that two-thirds of UK doctors over 55, and one in eight aged between 35 and 54 are considering retiring within three years.[22]
   — A BMA Scotland survey shows that more than 45% of the 261 consultants who responded are considering retiring in the next five years. Of those, more than half report that is earlier than their normal pension age.[23]
   — 53% of surgeons in Wales have been advised (e.g. by an accountant or financial adviser) to work fewer hours in the NHS.[24]

The current pension taxation system is unfair and punitive to doctors working in the NHS. The annual allowance (AA) is fundamentally inappropriate for a defined benefit scheme such as the NHS. The pension taxation system must be urgently reformed to avoid the NHS further feeling the consequences. Even before the COVID-19 pandemic hit, the healthcare system was already under pressure. It is vital that doctors no longer feel forced into reducing their work and, in many cases, stopping working within the NHS entirely in order to avoid huge and disproportionate tax bills on their pensions.

— **Enable flexible and remote working** (where clinically appropriate). This must be facilitated for all staff, including provision of all equipment to enable this. This can promote wellbeing for exhausted staff and retention by enabling a greater work-life balance, reducing risk of illness and increasing productivity.

— **Enable staff to return to normal working patterns** to help the NHS remobilise and after a period of recovery, to start to tackle the backlog. If redeployment is necessary, this should be initiated only with agreement by the doctor, with ample notice given. Giving staff space to reintegrate back into their core specialty is essential for wellbeing and patient safety. This is particularly important to re-establish confidence / competence of medical trainers e.g. if they have not performed certain procedures or primary operations for the past year.

22 https://questionnaires.bma.org.uk/news/payingtowork/index.html
23 https://www.bma.org.uk/bma-media-centre/bma-scotland-nhs-recovery-from-the-pandemic-will-beimpossible-without-focus-on-retention-of-senior-doctors
24 https://www.bma.org.uk/media/3875/bma-ddrb-submission-march-2021.pdf

— **Make it easier for staff to join the workforce or return to clinical practice including retired doctors, refugee doctors and international medical graduates**

- — **Produce a real-time picture of where there is demand** for additional staff. This will require proper collation and publication of up-to-date and accurate vacancy data.

- — **Connect people to roles** that make the best use of their skills.

- — **Recognise that recruiting returning doctors for educational and research roles** will free-up the time of others for clinical work or for rest and will help ensure that students and trainees continue to progress on time.

- — **Assure retired doctors they will not be penalised with large tax bills** if they return to work.

- — **Enable all returning staff to work both flexibly and, if they choose, remotely with a focus on what they** *can* **do rather than what they** *cannot* **do.**

- — **Halt unnecessary mandatory checks and training,** maintaining only those strictly and demonstrably necessary for ensuring safe patient care. Minimise the burden of appraisal and revalidation which can take a significant amount of time away from providing direct patient care.

- — **Remove the national performers list** as it is bureaucratic and serves no purpose — the GMC is perfectly capable of regulating the profession on its own.

- — **Bolster HR capacity** in all sectors of the NHS to optimise and hasten the return to work process.

- — **Ensure a smooth process for returning to work to minimise absence:** Doctors require better support to facilitate a timely return to work after any significant absence and the BMA's mental wellbeing charter outlines steps that employers can take to do so.

- — **Develop proper NHS and public health 'reserves' in each UK nation** to support services in tackling the backlog as well as respond to any future spikes in demands and pandemics. Develop a permanent and simplified national return to work programme, akin to NHSE/I's temporary national [Bringing Back Staff programme](#) in England during the COVID-19 pandemic, to connect returning staff to employers with additional capacity/specialty needs.

APPENDIX: Strategies for retaining doctors in the workforce

Retaining doctors in the short-, medium-, and long-term will require a number of approaches. The following (not exhaustive) will help retain staff and could help make returning to clinical practice more attractive:

— **Offer sabbatical leave.** Sabbatical leave should be offered as an incentive for established consultants across all stages of their careers. Employees value sabbaticals as a chance to take time out from a stressful work environment, an opportunity to acquire new skills, to study the operation of other healthcare systems or organisations or to acquire new knowledge. They have been difficult to access within the NHS for many reasons, including cost and potential loss of service provision. Organisations offering sabbatical leave, particularly where such offers are facilitated by active assistance in setting up the sabbatical, may more easily retain staff who would otherwise have considered leaving. Those returning are also likely to come back refreshed, with new ideas, perspectives and skills.

— **Provide opportunities for leadership, training, development and research.** Expanding the range of clinical services that an individual, a department or an organisation can offer benefits both the individual and the provider, particularly if tailored towards services that have not formerly been offered before. The available training and development should be widely known, and there should be an expectation for staff to make use of such offers. Staff should also be supported to undertake leadership training courses, e.g. those offered by the BMA and medical royal colleges, and university diplomas and degrees, as well as certificates from or membership of organisations.

— **Support staff going through the menopause:** Focus is needed on effective organisational interventions to support employees going through the menopause. Such measures might include allowing doctors experiencing these symptoms to work flexibly and placing an equal focus on supporting employees with the mental, as well as the physical, symptoms of menopause.

— **More support for childcare:** The UK's costly and inflexible childcare system has led to many parents leaving the workforce and the many problems with the system have been enhanced by the pandemic. An expansion of NHS nurseries and other support for childcare would enable more parents to return to work. The BMA's Covid-19 and Childcare report, DHSC's Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England, the former Chief Medical Officers Women Doctors: making a difference report all demonstrate the impact the availability of childcare has on staff retention and set out recommendations to employers on how they can address this issue.

— **More generous parental leave rights:** Women leave the medical profession as they disproportionately face the pay and career penalties that still exist for doctors with caring responsibilities. To retain and bring back women, employers could offer better parental leave rights to incentivise both parents to take leave so the impact can be shared. We ask for the extension of enhanced pay for shared parental leave to all doctors in the NHS and to work with the BMA to fulfil the contract commitment to allow GP partners to offer more generous parental leave rights to their staff.

— **Support for staff with disabilities:** Up to now, workplaces have paid insufficient regard to the realities of living and working with a disability or health condition. This has, in some instances, made it difficult for those doctors to work as effectively as they could.[25] This is unwise, as it may lessen the ability of those staff to deliver their best. Employers could improve access to workplace adjustments, strengthen OH support (Occupational Health), enable staff to self-refer to OH teams and raise awareness within the NHS of the essential

25 https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/disability-in-the-medical-profession

need to support workers with hidden/ invisible and fluctuating disabilities and long-term health conditions. Line managers and supervisors should also have training and access to advice so they can handle conversations about disability sensitively, constructively and appropriately.

— **Ensure that training time lost to pandemic redeployment is made up with no detriment** if the trainee and their trainers agree that they have not achieved the required competencies due to the emergency redeployment. The first priority post-pandemic should be allowing staff to rest and recuperate. Following this, there must be a clear and public commitment from national bodies, which individual employers are committed to, that training opportunities will be a priority and will be protected and will not be cancelled in the face of service pressures from the backlog of care. There will be a drive to clear as much of this as possible, as quickly as possible, but this must not be at the expense of training. There will be training opportunities, and these must be targeted to allow continued progression of junior doctors through training programmes. Junior doctors are the consultants and GPs of the future and it is vital to make sure that training is prioritised to ensure they are adequately skilled and prepared to meet future demand.

  — **Flexible stepping on/stepping off training, promoting and improving accessibility to 'out of programme' pauses.** This will enable trainees who are feeling burnout, as a result of the pandemic, to have a break from training without having to resign their training number and potentially be lost from the workforce for an extended period.
  — **Expediting and expanding the roll out of category 3 LTFT.** This will improve retention during this difficult stepdown period, as it should avoid trainees resigning their training numbers if they feel they are unable to continue working full time.
  — **Explore the possibility of annualised rostering** which could enable trainees to structure their work around their personal commitments, promoting flexibility, wellbeing and retention.