This briefing is intended to inform ARM representatives ahead of Wednesday afternoon’s open session (2-3pm) on the ‘Caring, supportive, collaborative’ project. It includes information about the issues we’ll be exploring in the open session and questions on which representatives will be asked to vote. The open session does not have policy making powers, so the votes will be non-binding and will test the range of views; however, the outcome of these votes will inform the next stages of the project.
Introduction

Across the UK, the health service is facing some of the biggest challenges in its 70-year history. Nearly a decade of underfunding has left services under intense pressure all year round. Doctors are increasingly expected to provide patient care in an unsafe, unsupportive environment, where a persistent culture of blame stifles innovation and discourages learning. This is leading to a vicious cycle of poor morale and recruitment and retention, contributing to endemic workforce shortages.

Greater multidisciplinary working is required to care for the increasing number of patients living with multiple long-term conditions, yet fragmentation, artificial boundaries and bureaucratic barriers are prevalent. It is widely recognised that integration needs to be improved. In England, the challenge of doing so is compounded by the internal market, with payment and commissioning systems that create wasteful competition and perverse incentives, and are not conducive to collaboration.

In Scotland, health and social care services have been integrated since 2016; however, there are still many challenges for the Integration Authorities in planning, delivering and funding across the complex boundaries of NHS boards and local authorities. In Wales, the most recent reorganisation of NHS Wales in 2009 created seven local health boards – responsible for delivering all healthcare services within their geographical areas – replacing the purchaser-provider split which existed previously. However, huge challenges remain. Northern Ireland has had fully integrated health and social care since the early 1970s, but this has not yielded the service gains that would have been anticipated and community based care remains underfunded. There is still a purchaser-provider split in theory, despite there not being a competitive market in real terms. In 2016, it was announced by the Minister that this would be abolished but progress has been slow due to lack of an Assembly.

Despite the different policy approaches taken in all four countries, research shows little difference by way of performance and the challenges described above are shared across national boundaries. While it is essential that we continue to call for healthcare to receive the funding it so urgently needs, a new approach is required if health services across the UK are to survive and flourish, and deliver outstanding care for future generations. As the only organisation to represent all doctors working across all sectors of the UK the BMA is uniquely placed to help meet this challenge. We have launched the ‘Caring, supportive, collaborative’ project to find solutions through an honest conversation with our profession about the sort of health service doctors want to work in.

A service which has a culture that supports and encourages learning and improvement – not one which is rooted in blame. A service based on working collaboratively across the interface between different settings. A service where taxpayers’ money is spent on delivering patient care – not squandered on transaction costs, fragmentation and bureaucracy. And a service which values its workforce and supports doctors to be able to work safely at the top of their licence.

There is more information on how you can get involved in the project at the end of this briefing.
ARM 2018

The open session on Wednesday afternoon will give representatives the opportunity to debate and vote on key questions associated with the project. Further information on these topics is provided below to inform the debate. The open session does not have policy making powers, so the votes will be non-binding, and will test a range of views; however, the outcome of the votes will inform the next stages of the project. There will also be a stand in the exhibition hall all week, with opportunities to share and record your views and find out more about the project.

Questions to be debated
To what extent do you agree with the following statements:

– In my current workplace, there is a commitment to learn and make safety improvements rather than to blame people when things go wrong.
– Since the Francis and Berwick reports in 2013, the culture of the NHS has improved.
– Recognising that additional increases in doctor numbers are unlikely in the near future, increases in the non-medical workforce are necessary to support doctors with their workload.
– It is most important that formal regulation is secured for medical associate professions — ultimately meaning that the eventual regulator defines their scope of practice and their supervisory arrangements within doctor-led multidisciplinary teams.
– The government should fund an increase in resources for the NHS through a tax increase dedicated specifically for this purpose.
– More funding for the NHS should not mean ‘more of the same’: change is needed to ensure that in the future more integrated and collaborative care is the norm, especially between primary and secondary care.

Culture

Culture is an important dimension of this project. Creating a caring, supportive and collaborative NHS will mean changing staff behaviour and shifting the underlying assumptions on which that behaviour is based.

How can we move from a culture of fear and blame to one of openness and learning?
In 2013, Robert Francis QC concluded that ‘a fundamental culture change was needed’ in the NHS after considering the failings in the system that led to the poor care and harm to patients at Mid-Staffordshire NHS Foundation Trust. These findings resonated with doctors and other healthcare professionals across the UK. Similarly, when distilling the lessons from the public inquiry into Mid-Staffordshire, the National Advisory Group on the Safety of Patients, stated that “In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime”. It explained that fear was toxic to safety and improvement and it called for blame to be abandoned as a tool and for pride and joy in work, not fear, to infuse the NHS.

However, five years on from these reports, the Dr Bawa-Garba case has brought into sharp focus the fear that many doctors feel: that if things go wrong they will be blamed and that the current pressures on the NHS mean that the risk of this happening is increasing.

The project will consider how to progress towards creating a culture of openness and learning in the NHS: a culture in which staff feel able to reflect and to speak up about concerns when they see patient safety is compromised, and in which there is a willingness and capability to learn and improve. We want to hear your views on what needs to change to create an open and learning culture in your workplace and the wider NHS, and how that can be achieved.
How can we move away from a culture of bullying, harassment and undermining?
Bullying, harassment and undermining are at high levels in many NHS workplaces. According to the latest NHS Staff Survey in England, around one in five hospital doctors say they have experienced bullying, harassment or abuse from a colleague or manager in the previous 12 months. Similar levels have been reported in Northern Ireland and slightly lower levels in Wales and Scotland. It is also concerning that only one in three doctors who experience bullying or harassment say that the incidents were reported by themselves or a colleague to their employer. Junior doctors are least likely to say so, with the majority reporting fear of adverse consequences if they do complain about bullying or undermining or a lack of confidence that anything will change.

The BMA’s project on bullying and harassment, which began in 2017, is highlighting the impact that bullying, harassment and undermining have on staff and how it risks patient safety and damages the quality of care. Doctors have shared experiences with us in which they talk about feeling anxious, fearful, demoralised and depressed. Such behaviour erodes confidence, harms teamwork and communication, affects cognitive ability and performance, and makes staff less likely to seek clarification or help from colleagues when needed, all of which undermine the ability to provide safe and good quality patient care.

As part of this project, we want to hear your views on creating a more positive culture in which there are strong and supportive working relationships between staff, at all levels and disciplines, rather than competitiveness, incivility and conflict.

How can we ensure a culture of equality and inclusion?
The NHS and the medical workforce are increasingly diverse. Women now make up almost half the profession and over a third of doctors come from a Black, Asian or other minority ethnic background. However, evidence suggests that some doctors are less likely to get the opportunities and recognition they deserve and are more likely to find themselves in difficulty.

There remains an ethnicity attainment gap in medical education and training and BME doctors are more likely to be referred to the GMC by their employers and face fitness-to-practise proceedings. The gender pay gap in the profession reflects the disparity between men and women at senior levels and those receiving the highest awards. This is in part due to the unequal impact of caring responsibilities and the struggles of balancing work and family life in a service that expects staff to work long, unsocial hours often with little notice. Many disabled and LGBT staff are in an environment in which they feel unsupported and unable to be themselves at work and encounter significantly higher levels of bullying, harassment and abuse than other staff.

In considering what is needed to create a caring, supportive, and collaborative NHS, we must recognise diversity and ensure that we are developing a vision for the future, in which there is equality of opportunity and a culture of inclusion and respect for all staff regardless of background or protected characteristic. We look forward to hearing your experiences and views on how this can be achieved.
Workforce and skills mix

The UK population is growing and the number of people with multiple long-term conditions is set to increase. As a result, doctors are doing more complex and intense work in environments that are understaffed and under-resourced. There are currently chronic staff shortages across all professions, an alarming number of medical vacancies across the NHS and increasing rota gaps. Doctors of all grades are consistently asked to take on additional responsibilities, work increasingly longer and more intense hours, act across specialties and look after inappropriate numbers of patients. Working in such a severely pressurised environment, without adequate resources, 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.

Sufficient increases in doctor numbers are unlikely in the near future. However, measures have been put in place to bolster workforce numbers eg initiatives to increase GP numbers, including overseas recruitment; a focus on the emergency workforce; and local/regional schemes. Beginning next year, 1,500 new medical school places will open in England; an expansion is also planned in Wales and a review of medical school places is underway in Northern Ireland. Nevertheless, given that it takes more than 10 years to train a senior doctor, the impact of any increases will not be realised immediately.

The project will explore what the future workforce will look like and what actions are required to ensure it is able to meet rising patient demands. For example, what workforce changes would improve doctors’ working lives? How do we make the best use of technology? What is the role of the non-clinical workforce?

New clinical roles to support doctors

Multi-disciplinary team working must not simply be seen as the solution to a professional supply problem. Part of ensuring a positive image for the NHS as an employer will come from effective workforce planning and service design, particularly regarding the development of new clinical roles and establishing effective multi-disciplinary teams that complement, support and enhance the work of existing doctors and staff.

Regardless of workforce pressures, new clinical roles cannot and should not replace the work of doctors. It is essential that doctors in training and prospective doctors do not feel that their commitment to the full medical training programme is undermined by the establishment of training short cuts. 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 are all being considered at national levels through a collaborative approach. The BMA is currently involved in all national developmental discussions for these roles. An important part of the project will be gathering your views on the appropriate role of the non-medical workforce in supporting doctors.

Not all new clinical roles will be employed in all the UK nations and progress in development and implementation varies. New non-medical clinical roles being introduced include:

Advanced Clinical Practitioners (ACP)

Advanced clinical practice is delivered by experienced, registered health and care practitioners such as nurses, paramedics, occupational therapists, physiotherapists, etc who are formally regulated. According to HEE (Health Education England), it “is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master’s level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area-specific clinical competence.

Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people’s experience and improve outcomes.”
Medical Associate Professions (MAPs)
- Physician Associates (PAs)
- Physician Assistants (Anaesthesia) [PA(A)s]
- Surgical Care Practitioners (SCPs)
- Advanced Critical Care Practitioners (ACCPs)

MAPs support doctors in the diagnosis and management of patients, have direct contact with patients, work under the direct supervision of a doctor, and are trained to perform a number of day-to-day tasks such as taking medical histories, performing examinations, diagnosing and treating illnesses and injuries, requesting and analysing test results, developing management plans and providing counsel on preventative health care.

MAPs are graduates who have undertaken post-graduate training specifically to become a medical associate. They usually need to have a biomedical sciences-related degree, but registered healthcare professionals such as nurses, allied health professionals and midwives, can also apply to a MAP course.

MAP training (postgraduate diploma) lasts two years, with students studying for 46-48 weeks each year (1,600 hours of clinical training in total). It does involve aspects of an undergraduate or postgraduate medical degree but focuses principally on general adult medicine (350 hours) in hospital and general practice, rather than specialty care.

Clinical pharmacists (general practice)
An increasing number of GP practices are recruiting clinical pharmacists to address different aspects of workforce need. While employment models and the roles and responsibilities vary, many practices have found that having a clinical pharmacist means GPs can focus their skills where they are most needed. Clinical pharmacists generally perform the following functions:

- Clinical services
  working with GPs and patients to address medicine adherence, reviewing patients on complex medicine regimens, triaging and managing common ailments, responding to acute medicine requests and managing and prescribing for long-term conditions (often in conjunction with the practice nurse).

- Prescription management
  dealing with medication for patients recently discharged from hospital, supporting the practice to deliver on the QIPP and QOF agenda and enhanced services, delivering repeat prescription reviews, being the point of contact for all medicine-related queries and overseeing the practice’s repeat prescription policy.

- Audit and education
- Medicines management
  Pharmacists can hold minor ailment clinics, freeing up GP appointments and time. They can also be responsible for all prescription-related queries and clinical medicines reviews can be handed over from GPs to the pharmacist. Equally, in the case of a dispensing practice, a pharmacist can take responsibility for effective business management of the dispensary.

Other roles
There are several other roles that have been or are being developed, such as physiotherapists (First Contact Practitioner for musculoskeletal services), mental health therapists, nursing associates and (non-clinical) medical assistants.
Healthcare funding, structures and collaborative working

During this project we will explore how health systems should be structured and funded in a way which best supports doctors across the system to collaborate, innovate and deliver high quality care.

How can doctors be empowered to work together collaboratively?

Despite the fact that healthcare is organised differently across the UK, all four countries face similar challenges in working across the interface between different parts of the system. This includes the primary-secondary care interface, but also interfaces with community care, mental health, social care and public health. The project will therefore explore what solutions are needed to overcome barriers to collaboration and genuinely joined-up care.

It will also look at patient pathways, asking how they may need to change in the future. Related to this, it will also consider the drive for more care to be delivered in the community. Is this a sensible objective, and if so, what should this care look like? How would this relate to primary and secondary care, and what might the impact on these services be?

The project will also ask whether new organisations or structures can help doctors work collaboratively. This will be informed by experience to date from across the UK, including Integrated Authorities in Scotland, GP Federations in Northern Ireland, GP clusters in Wales and emerging Integrated Care Systems in England. Should these be new legal entities, or based on cooperation and partnership between existing organisations? And how might the role of GP partners change in a future system, given their independent contractor status?

How should health systems be organised and run to promote better joint working?

Again, while the organisation of health systems has evolved differently across the UK, in each country similar questions are being asked as to how best promote joint working and more joined-up care for patients. One increasingly prevalent view is that services should be organised on a population or place-based approach. This project will ask whether this is the best approach and how it might work, while looking at related questions, such as to how to balance local autonomy with national standards, and how best to organise public health and social care. It is also crucial to ask how to ensure public accountability and meaningful engagement with doctors and other healthcare professionals.

In England, the challenge of joint-working is compounded by the purchaser-provider split and the use of competition within healthcare, which has long been opposed by the BMA. More recently, proposals for ACOs (Accountable Care Organisations) and ICSs (Integrated Care Systems) suggest greater collaboration but in the context of competition/procurement rules ACOs run the risk of the private sector taking over provision of large geographic areas in England. This project will therefore be exploring how to reform or replace the current commissioning model in England, including repealing the competition and procurement regulations that prevent collaborative working. In Scotland, despite the creation of 31 new Integration Authorities in 2016, there remain challenges for joint working, compounded by lack of resources, and complex governance arrangements with local authorities and NHS boards.

The project will also consider some of the key enablers that are needed to support joined-up care. For example, how should data be used to support services, particularly if they are set up on a population-health basis? How should data be shared between different parts of the system? Which IT and data challenges should be prioritised to maximise benefits for patients and reduce barriers and inefficiencies across the system?

How should budgets be set in a more collaborative system?

The way budgets are set and funding is allocated can have a huge impact on the way different parts of the health system work together. In England, the national tariff (‘payment by results’) currently dominates payments made to the acute sector. It has long been criticised by the BMA and others for preventing collaboration and creating perverse incentives.
This project will explore payment methods that best enable doctors and other healthcare professionals across the system to be part of one team, jointly managing patients with aligned incentives to prevent and treat ill health. This will include looking at new ‘capitated’ payment models and existing models such as ‘block contracts’ and the development of “pathways of care” across boundaries. It will also look at wider questions, such as how should general practice funding best operate within a collaborative healthcare system?

**Hypothecated taxation**

It is widely acknowledged that health and care services across the UK are under severe, year-round pressure and in need of additional funding. Government faces politically difficult options for how to raise additional revenue, through increased taxation or by cutting spending in other areas. One proposed solution is that there should be a ‘hypothecated’ tax for healthcare. This is not a new proposal, but as pressures grow it is being discussed with increasing frequency.

In ‘hard’ hypothecation a dedicated tax would fund all healthcare spending. In ‘soft’ hypothecation the tax would only fund part of the expenditure, or increases in a tax would be nominally linked to a specific area. For example, in 2002 the UK government raised National Insurance rates, advertising their intention to spend the additional revenue on the NHS.

Public opinion is clearly in favour of increased spending on health. The most recent British Social Attitudes survey found 86% of respondents believed that the NHS is facing a ‘major’ or ‘severe’ funding problem, and 83% were in favour of the government spending ‘more’ or ‘much more’ on health. However, public attitudes towards taxation and healthcare spending are less clear. When asked which measure they would accept if the NHS needed more money, 26% said they would be happy to pay more through their existing taxes and 35% supported a separate tax that would go directly to the NHS. Since 2014 these figures have increased from 17% and 25% respectively.

Proponents of hypothecation can be found across the political spectrum. They believe that hypothecation would create a steady funding stream that is known in advance and can grow over time in response to changing needs. They also believe it would increase transparency between tax rises and spending, and is the most likely way to garner public support for tax raises. Hypothecation may, therefore, be a pragmatic solution to the NHS funding crisis.

However, critics argue that in hard hypothecation revenue (and therefore spending) would be directly linked to wider macroeconomic factors. The Treasury’s ability to respond would be restricted, with potential impacts across all areas of government spending, and during a recession health spending would have to be cut or tax rates raised. To mitigate against this problem, governments could build up a fund to smooth fluctuations between boom and bust cycles. However, it is argued that this undermines the principle of a direct link and would increase complexity rather than improve transparency. Similarly, critics have highlighted that in softer forms of hypothecation spend and revenue are not actually linked, and can be seen as ‘tokenism’ or ‘empty rhetoric’.

There are further complications with the design of any such tax. For example, will long-term funding commitments still be at risk from a change in government? Should it include social care? And if the UK government adopted such a tax, how would this impact on the Barnett Formula and spending in Northern Ireland, Scotland and Wales?

The BMA has clear policy in favour of a fully funded health service free at the point of delivery, and at ARM 2014 rejected ‘any proposal of a means tested monthly levy to pay for the NHS’. In 2012 ARM did support calls for a Financial Transactions Tax or ‘Tobin Tax’ of 0.05% on the banking sector to be spent on public services including the NHS. However, while the BMA has published previous research on hypothecation, we do not have policy on this issue specifically. Similarly, we do not have policy on social care funding, beyond the need for a long-term resolution ‘without jeopardising the principles of the NHS’.
How else can you be involved?

Our vision will be shaped by the views and experiences of BMA members working in all settings and branches of practice, while drawing on expertise from across health and social care, including from patients. National and regional committees have begun to discuss the project and we have held an initial workshop for elected members, as well as holding a discussion at the first BMA annual conference in Scotland and wider stakeholder events.

In the coming weeks and months, the BMA will expand its engagement with members, stakeholders and the public to gather evidence and hear different perspectives.

Details of upcoming events for members across the UK will be posted on the project webpage bma.org.uk/nhsfuturevision and promoted locally.
References


5. General Medical Council (2014) National Training Survey 2014 report

