

Workload, recruitment, retention and morale

A BMA member briefing for the 3 May 2016 Special Representative Meeting

The Special Representative Meeting on Tuesday 3 May 2016 was requisitioned by Council to discuss the current crisis across the UK in the NHS and morale amongst doctors, as well as potential solutions. This briefing considers the issues at a UK level, mentioning developments in England, Scotland, Wales and Northern Ireland. It is mindful of the timing of the meeting with respect to the elections in Scotland, Wales and Northern Ireland in its references to policy developments in these nations.



Introduction

The NHS is one of the best and most cost-effective health services in the world. It is also universally admired as a just institution: none of us has to face the financial burdens of illness alone. Key to its success is its workforce.

The NHS employs over 1.7 million people in the UK, making it one of the world's top 10 biggest employers.¹ Within this are around 181,000 medical staff including approximately 66,000 career grade doctors, 71,000 doctors in training and 43,500 GPs. The number of medical staff working in the NHS in the UK has increased significantly in the last decade – by 14%, from approximately 159,000 in 2005 to around 181,000 in 2014.² However, growth has started to slow. Recent figures³ for England show only a 1.8% increase in staff working in the NHS from December 2014 to December 2015. This is important because there has been no sign of a similar slowing of demand for health services.

The fact that the UK has an ageing population with complex, on-going health and care needs has been well documented,⁴ as has the extent of the financial challenge facing the NHS. NHS England has warned that the NHS in England is heading for a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21.⁵ The devolved nations are also facing tightening budgets combined with rising costs and higher demand for services. In addition, it is getting harder to recruit and retain doctors across the UK. In 2015 more than 600 GP trainee posts were left vacant across England.⁶ In hospitals, geriatric medicine and emergency care in particular continue to have to rely on overseas doctors to fill shortages that have not been addressed.

It is then perhaps unsurprising that doctors are reporting increased workload, low levels of morale, plans to retire early and the intention to leave the UK to practice abroad. This paper explores these themes in more detail and sets out the BMA's (British Medical Association) policy in these areas. It should be read in conjunction with the 'Population health and underpinning drivers of demand for healthcare' briefing, which looks at the changes in the demand for healthcare services and the population's health which have resulted in the current funding crisis. The 'Healthcare delivery structures and funding' briefing then examines changes to healthcare delivery structures and funding.



What has been happening to the medical workforce?

This section examines key trends across the UK's medical workforce. It looks at doctors' current workload, staffing levels, morale, intentions to leave the NHS and what the government has been doing to address these challenges – both across the profession as a whole and with regards to specific branches of practice.

Doctors have more work to do

The demographics of the UK population are changing. The population is forecast to rise to 67 million by 2020 and to reach over 70 million by 2028. The proportion of the UK population aged 75 and over will grow from 7.9% in 2012 to 13% in 2037. The number of people aged 80 or over is set to more than double to 6.1 million by 2037.⁷ As such, doctors are increasingly caring for an ageing population with chronic and multiple long-term conditions.

There are an estimated 18 million patients in the UK suffering from a chronic condition. Around 53% of all patients in England report having long standing health conditions. Around 40% of people in Scotland have at least one long-term condition. By the age of 65, nearly two-thirds of people will have developed a long term condition in Scotland.⁸ Doctors are also dealing with higher prevalence of multiple morbidities across the UK. The number of people with multiple long-term conditions in England is set to grow by a million, to 2.9 million, by 2018. Across the UK, by 2021, it is predicted that more than one million people will be living with dementia and by 2030, 3 million people will be living with or beyond cancer.⁹ In Scotland, 27% of people aged 75-84 already have two or more long-term conditions, a population group that is set to continue to grow.¹⁰ The 'Population health and underpinning drivers of demand for healthcare' briefing in this series looks at this in further detail.

This has a substantial effect on the frequency with which patients use the NHS and the time it takes to see them. There have been significant increases in NHS activity across the UK in recent years. Hospitals across the UK have been getting busier, with increased numbers of emergency and elective admissions, and outpatient attendances. In England, between October and December 2015 there were 1.4 million emergency admissions to hospital; almost 1.5 million elective admissions; and more than 5.5 million people went to A&E.¹¹ Hospital activity is increasing at a faster rate than the population is growing, which can in part be explained by the increasing number of older people in the UK.¹² In general practice, the number of consultations in England rose from 300 million in 2008 to an estimated 340 million in 2013.¹³ In addition, historical figures show that the average length of a GP consultation rose from 8.4 minutes in 1993 to 11.7 minutes in 2007.¹⁴

Doctors' workloads also reflect the increasing demands being put on the NHS. A 2011 BMA survey of GPs across the UK revealed that full time GPs were working around 47 hours per week including administrative duties,¹⁵ higher than the average 44.4 hours per week reported in 2006/7.¹⁶ A 2012 survey showed that hospital doctors across the UK were also working more hours than before. This increase was in direct clinical contact, forcing doctors to in effect undertake their supporting professional activities in what was previously personal time. For junior doctors there was a mismatch between contracted hours and those actually worked: in their last full placement, doctors in training reported 50.1 hours per week on average against their contracted 45.1 hours.¹⁷

Furthermore, doctors across the UK consistently report that their workload is increasing in intensity and complexity. In 2012, 59% of consultants and 86% of GPs reported that their workload had increased in intensity over the past year. Likewise, 40% of consultants and 77% of GPs reported that their work had become more complex over the same time period. The findings were replicated among SAS doctors and junior doctors.¹⁸

There are other factors that impact on doctors' workload:

- Levels of bureaucracy have increased. In 2013, 97% of GPs reported bureaucracy and box ticking had increased since 2012 while nine out of 10 GPs felt this took them away from spending time with patients.¹⁹ A separate study found that clinical staff spent up to 10 hours a week collecting or checking data and that more than a third of the work was neither useful nor relevant to patient care.²⁰
- The public expects more. Patients expect to be involved in decisions about their treatment and care in a much more comprehensive way and have greater expectations of what the NHS should do for them.
- There have been significant cuts to other support services across the UK, such as local authority social care and community mental health services (the 'Healthcare delivery structures and funding' briefing in this series looks at this in further detail).

The BMA's tracker survey,²¹ which follows medical staff across the UK, shows that 68% of GPs and 44% of consultants now find their workload unmanageable.

There are fewer medical students and trainees and more job vacancies

Fewer students are applying to study medicine across the UK. Statistics from the Universities and Colleges Admissions Service show that the total number of UK students applying for places at medical school fell for the second year running in 2015, 3% fewer than in 2014 and 13.5% fewer than in 2013. While new applicants actually increased by 2%, there was an 18% fall in students reapplying for medicine, which accounts for the overall figures.²²

Alongside this there are a significant number of trainee vacancies across the UK. Leaked figures from February 2016 show that applications for medical specialist training in England have fallen by 3% compared with the previous year, albeit we currently await data from the second and third recruitment round.²³ A recent survey²⁴ of foundation trainees in the UK found that only 52% were progressing directly into specialty training. This compares to 64% in 2013 and 71% in 2011. Other research has revealed shortages in fill rates for higher specialty training in certain specialties including emergency medicine, acute medicine and psychiatry, with significant geographical differences as well.²⁵ The situation for general practice is particularly serious – applications for GP training have fallen for the third consecutive year, by 5%.²⁶ Previous research has shown that it is particularly difficult to fill GP trainee positions in the north of England and Scotland. For example, in 2014 and 2015 only around 60% -70% of posts were filled in the east midlands and the north of England compared to 100% in parts of the south.²⁷

There are also a growing number of vacant clinical posts across the NHS. Data has shown an increasing problem in certain locations and specialties (emergency medicine, general practice and psychiatry in particular). However the quality and consistency of data on vacancies remains limited. Figures from the Health and Social Care Information Centre²⁸ show over 6,000 medical and dental vacancies advertised in one quarter on NHS Jobs,^a which suggests an increasingly significant problem in vacancy levels in England. A small scale survey in England from the Smith Institute²⁹ showed that 63% of NHS Trust HR directors were "unsure" that they had enough staff to meet demand, with 85% finding recruitment "very or fairly difficult", particularly for skilled and experienced staff, which includes consultants and mid-grade doctors.

The devolved nations are also experiencing high vacancy rates across clinical posts. Data from local health boards and trusts in Wales from March 2015 showed a high consultant vacancy rate of 6.8%, with considerably higher rates in some health boards and trusts.³⁰ In Northern Ireland, the DHSSPS (Department for Health, Social Services and Public Safety)

a Measuring job adverts will understate the true level as jobs may either not be advertised through that route, one advert may reflect several posts, or jobs may have been previously advertised but then remain unfilled.

recorded an overall medical Full Time Equivalent vacancy rate of 5.3%, of which over 60% were long-term vacancies.³¹

Universities and local authorities are also experiencing difficulties with recruitment. A 2014 Medical Schools Council report³² showed a vacancy rate for medical academics of 6% overall, or 11% at lecturer grade. Twenty-three medical schools cited specific difficulties in recruitment, including a shortage of high quality applicants particularly for some specialties such as cancer and cardiology. A freedom of information request of Local Authorities in England in June 2015 showed 32 vacancies for public health specialists.³³ This is slightly higher than previous figures which showed 112 of the 131 Director of Public Health posts to be filled substantively, with interim arrangements in place for the remainder. A 2014 BMA survey of public health doctors across the UK³⁴ also uncovered very strong concerns about overall future workforce numbers – only 12% thought that, in 10 years' time, there would be sufficient substantive consultant posts available to serve the needs of the population, and concerns were voiced that the workforce is being spread too thinly.

In general practice, vacancy rates have continued to rise. In England, almost one in 10 GP partner positions were vacant in April 2015. Research found that 9% of full-time equivalent GP positions were unfilled, compared with a 6% vacancy rate the previous year.³⁵ The situation is similar across the rest of the UK.

Doctors are leaving the UK to practise abroad

The ninth report of the BMA cohort study,^b published in 2015, shows that across the UK overall, eight years after graduation, around a third of cohort doctors plan to practise medicine overseas either temporarily or permanently at some point in their career. Of these, 10% intend to work abroad permanently.³⁶ The BMA's tracker survey shows that the proportion of doctors who have considered leaving the NHS to work abroad in the previous 12 months has increased from 25% in January 2014 to 32% in December 2015.³⁷ Moreover a recent survey of medical students³⁸ found that over 80% of them were more likely, as a result of the decision to impose a contract on junior doctors, to pursue a medical career outside of the UK when they graduate.

Figures from the GMC (General Medical Council) show that an average of 2,852 certificates enabling British doctors to work abroad were issued annually between 2008 and 2014 – a total of 19,522. The GMC also issued 2,008 certificates of good standing (the document that enables doctors to register with an overseas regulatory body or employer), taking the total who have applied to work overseas in the last eight years to almost 22,000.³⁹ It has been reported that more than 600 consultants and trainee A&E doctors have gone to work abroad in the past five years,⁴⁰ but there are no accurate figures for how many doctors overall have left the UK to practise overseas.

In the 10 days after the new English junior doctor contracts were confirmed in November 2015 there were 3,468 requests for a certificate to practise medicine outside of the UK. The GMC normally receives between 20 and 25 requests a day.⁴¹

b The BMA cohort study of 2006 medical graduates is a 10 year longitudinal study of the career paths of 430 doctors.

Morale among doctors is low

The factors detailed above, and others, have contributed to general feelings of low morale and motivation among doctors, sometimes leading to a desire to leave the profession. This is a real challenge, as evidence shows that staff who are happy in their work and feel well treated themselves will feel better motivated to treat patients well.⁴² In the latest edition of the BMA's tracker survey nearly 50% of respondents reported their morale as low or very low. Morale has gradually worsened since January 2014.

GPs are more likely than others to report low and very low feelings of morale. A BMA survey⁴³ found that across the UK:

- 93% of GPs feel that their workload has negatively impacted on quality of care given to patients.
- 68% of GPs experience a significant but manageable amount of work-related stress, but a further 16% report experiencing a significant and unmanageable amount of work-related stress.
- Less than half of GPs would now recommend general practice as a career path.
- A third of GPs intend to retire within the next five years.

When asked to rank the factors that most negatively impact on their personal commitment to a career in general practice, the most frequent answers were workload, inappropriate and un-resourced transfer of work into general practice and insufficient time with each patient. Earlier research⁴⁴ found that almost three out of 10 GPs had thought about leaving the medical profession altogether.

Hospital doctors are also experiencing low morale. Less than half of SAS doctors would now recommend their career path.⁴⁵ A 2015 report in Scotland⁴⁶ warned of a loss of leadership, poor staff morale, a 'defective culture', disconnected clinical staff and management, and inappropriate targets and poor accountability mechanisms. This echoes earlier research⁴⁷ which revealed that the consultant workforce was feeling de-professionalised, disengaged and demoralised. A smaller-scale UK survey of consultants and specialist doctors⁴⁸ showed that a third of respondents face unreasonable levels of stress across the working week and 83% said work-related stress had taken a toll on their family life. 81% of those responding had thought about retiring early as a direct result of work pressures.

Public health doctors report similar feelings. The BMA's public health survey⁴⁹ found that just over half of non-trainee respondents reported having considered leaving public health in the last three years, and just under half of trainees reported having considered leaving training. Among the main reasons for this were a poor work-life balance, the work environment not being sufficiently supportive, and disagreement with the overall direction in which the organisation is going. The majority of medical public health professionals responding felt that local authorities did not sufficiently value medical public health.

The BMA's tracker survey shows that – overall – the proportion of doctors who have considered retiring early in the past 12 months has increased from 42% in January 2014 to 46% in December 2016.

As a result there is an increasing emphasis on workforce planning by governments

Effective workforce policy – how the NHS plans, trains and supports its staff – is central to the delivery of affordable high quality care. This care depends on having the right mix of people, with the right skills and qualities, in the right place at the right time. The system aims to provide a reliable and affordable supply of sufficient numbers of staff across the range of professions that make up the modern NHS workforce. Long lead times for training of staff, especially doctors, combined with changing social and technological practices makes health workforce planning particularly tricky. The results of getting it 'wrong' are significant, impacting on quality of care, finances and progress towards new models of care delivery.

As healthcare is a devolved issue, workforce planning for the NHS is done separately in each nation. This means there is no overall UK vision or plan. However, the UK and devolved governments have started to focus more on workforce planning.

In England, the HEE (Health Education England) mandate looks at how the healthcare workforce can be supported through education and training to deliver the best care to patients. The mandate was due to be updated in early 2016 but this has been delayed. Objectives for 2015-16 included:

- To ensure a minimum of 3,250 trainees per year recruited to GP training programmes.
- To commission the appropriate number of public health specialists to meet demand.
- To develop a more flexible workforce that is able to respond to the changing patterns of service and embraces research and innovation.

The recent Carter review also examined workforce changes in England that could help alleviate pressures (see Box 1).

Box 1: Lord Carter's review sets out a number of proposed workforce changes

Lord Carter's review of hospital efficiency in England focused on workforce as the first port of call for efficiency. The review recommended that NHS Improvement develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day, so that the right teams are in the right place at the right time. This would include improving analysis and application of consultant job plans; collaboration within and between specialist teams to improve productivity and seven day working; developing medical staff banks to manage vacancies in shortage specialties across a geographical region; and a more coordinated and proactive approach to managing the supply of staff to improve efficiency in the NHS, including overseas recruitment campaigns.

In Wales, the Health Professional Education Investment Review was commissioned by the Minister for Health and Social Care Services to undertake a review of the way the Welsh Government invests in the planning, development and commissioning of health professional education and workforce development. It recommended the creation of a single body for workforce planning, development and commissioning of education and training; a clear, refreshed strategic vision for NHS Wales for 2015-2030, which should inform the strategy for the workforce within the same period; the funding of on-going training and development; and greater emphasis on the use of multi-disciplinary teams in the planning and delivery of healthcare.

The NHS Wales Workforce Review was set up in 2015 to consider a range of workforce and pay issues. It was asked to consider the workforce of the future and the staff and skill mix the NHS needs to ensure people receive high-quality care as close to their homes as possible. It made various recommendations for the Welsh Government including the need for a review of existing workforce planning arrangements and that there should be sufficient flexibility within study programmes that allow staff to pursue relevant qualifications and enhance the skills and capabilities among the existing NHS workforce.

In Northern Ireland there have been a number of reviews in recent years that have considered health and social care, including the 2011 Transforming Your Care review⁵⁰ and the 2014 Donaldson review⁵¹ (see also the 'Healthcare delivery structures and funding' briefing in this series). Despite these reviews slow progress has been made on the implementation of their recommendations. This is particularly apparent in medical workforce planning where a lack of implementation has resulted in shortages across a number of specialities. New models of care will require the necessary shift in workforce to happen in parallel. Clinicians can help support reforms but urgent action is needed for workforce planning to make this happen and to ensure there is the appropriate funding.

In Scotland, the 2016 National Clinical Strategy⁵² and the 2020 Vision⁵³ published in 2011, have highlighted the need for a sustainable workforce which will be critical to delivering healthcare in a changing landscape. These strategies have provided some assurances that workforce pressures are being recognised, although proper resourcing and involvement of healthcare professionals will also be necessary to deliver the proposed solutions.

Alongside this measures are being explored for specific groups of doctors

Alongside an emphasis on overall workforce planning, a number of more specific developments have taken place.

Across the UK changes in training are being considered to reduce future workforce pressures. Shape of Training is an independent review into whether changes are required in postgraduate medical training across the UK to ensure it continues to meet the needs of patients and health services in the future. The initial 2013 report made 19 recommendations for change including more flexible training and improving careers advice for medical students. Future areas of focus include how doctors' training can be more generic to better meet the current and future needs of patients and measures to better prepare doctors to work across primary, secondary and community care with more flexibility in training between the sectors.

Efforts have been made to address the crisis in general practice. In England, the GP workforce 10 point plan is a collaborative plan produced by NHS England, HEE (Health Education England), the BMA and the Royal College of General Practitioners. It focuses on three main areas of improvement – recruitment, retention and support for returning doctors. Key developments include:

- The 'Nothing General About General Practice' marketing campaign, designed to recruit more newly trained doctors into general practice as part of the commitment to getting an additional 5,000 GPs by 2020.
- The Targeted Enhanced Recruitment Scheme, which offers £20,000 bursaries to attract GP trainees to work in areas where training places are unfilled.
- A revised national induction and refreshers scheme, designed to help qualified GPs to join or return to the NHS. The scheme offers a bursary of £2,300 per month and participants are given a supervised placement in general practice. By 30 November 2015, 139 doctors had registered for the new scheme.

The 10 point plan has now been migrated into a wider primary care strategy, which has just been announced by NHS England. This rescue package includes commitments to longer term investments in primary care, as well as initiatives to tackle workforce shortages and GP workload pressures.⁵⁴

In Wales, the planned primary care workforce for Wales document identified four main areas for action up to 2018, including putting in place the foundations for a more robust approach to workforce planning and stabilising key sections of the current workforce. In relation to the GP workforce the government will work to retain experienced GPs and support those who wish to return; make it easier for those who wish to step back from full-time work to keep working on a different basis; and explore how training for, and working in, general practice can be encouraged in areas of greatest need.

Meanwhile the Academy of Medical Royal Colleges chair, Professor Dame Sue Bailey, will lead an independent review into junior doctor training and employment in England, to better understand and deal with the longstanding issue of low morale. The review will explore and make recommendations on non-contractual issues affecting morale, including relationships between junior doctors and their employers, relationships between junior doctors and their senior medical colleagues, competing demands between NHS service requirements and training and education and flexibility around annual leave. The review will report its findings by the end of 2016.

2

What is the BMA's policy on these medical workforce issues?

This section brings together the BMA's policy on the themes discussed earlier in the paper. It looks at issues such as changing ways of working, workforce planning and levels of staffing.

Workforce planning must be done at a national level and based on good quality data

Better workforce planning is required across the UK. Parts of the NHS currently lack a coherent and properly funded plan to deliver a workforce that will meet the demands of the population. This should be a matter of priority for ministers in those nations that have not already started to tackle this problem. Workforce planning needs to take account of the changing current and projected future demands and therefore needs to also look at training requirements as well as measures to support greater retention of doctors. Governments should retain control of workforce planning and development centrally, to prevent unacceptable regional variations in training quality, the output of training and workforce availability.

The lack of robust data relating to the medical workforce across the UK is of real concern. Adequate data is necessary, not only for the effective delivery of current care, but also for sustainable planning, and in understanding the requirements for medical training provision. There needs to be improved availability, quality and accuracy of NHS data collection across the UK, particularly around workforce numbers and vacancies, which are not routinely collected.

Current staffing levels and the numbers of trainees are insufficient to meet rising demand

Across the UK the reported rise in staffing levels is insignificant in response to rapidly increasing patient demand, especially from an ageing population with complex health needs that requires expanding support in the community and in hospitals (see also the 'Population health and underpinning drivers of demand for healthcare' briefing in this series). There is little evidence of the huge expansion in the workforce that is needed to deliver the NHS's current priorities. The decline in the number of trainees is also concerning, especially as it comes before the full impact on morale from the dispute over the junior doctors' contract can be felt.

Too few doctors are progressing to specialty training

The increasing number of foundation year 2 doctors not progressing directly into specialty training in the UK is a concern and poses a real problem for workforce planning. Foundation programme doctors should be better supported to access specialty training posts and to return to specialty training after they have pursued alternative career pathways, should they wish to.

The numbers of doctors emigrating is concerning and measures must be taken to address this

We are concerned about the number of doctors emigrating and support schemes to develop incentives to promote retention of doctors in the NHS, including those developed as part of the GP workforce 10 point plan. There should be a national financial resettlement programme to incentivise and support doctors to return to work in the UK.

We also believe that employers must have the capacity to recruit and retain overseas doctors where other solutions to staffing have been unsuccessful and where a clear workforce need exists. The immigration system must remain flexible enough to recruit doctors from outside the UK/EEA should the resident workforce be unable to produce suitable applicants to fill specialist or generalist vacant roles or if an individual has particular skills and knowledge not readily available in the UK.

Public health is becoming fragmented and must be protected as a discipline

Public health staff were transferred into local authorities and Public Health England by the Health and Social Care Act 2012. Currently there is no requirement on local authorities to ensure they employ any medically qualified public health consultants. This is problematic for many reasons not least because it both undermines the quality of public health work and impacts upon the future of public health medicine as a specialty. Local authorities must commit to minimum staffing of one full time consultant in healthcare public health (the domain of public health concerned with planning healthcare services) with adequate information analyst support.

Local authorities must also ensure that their multidisciplinary public health teams are properly staffed with the right skill mix for the local population, including adequate consultant staffing levels. It is essential that local teams combine a diverse range of skills, experience and specialist knowledge in order to provide a service in all three domains of public health (health protection, health improvement and healthcare services). In addition to this, we would like to see at least one public health doctor on the board of each clinical commissioning group in England.

A comprehensive strategy must be implemented to boost general practice

As has been discussed earlier, across the UK there are currently not enough GPs to meet demand. This decreases patients' ability to get an appointment when they need it, cuts the time doctors can spend with their patients, and increases GPs' workloads – thus contributing to a vicious cycle in which the ability to recruit new GPs and retain existing ones is reduced. As such, a comprehensive strategy to boost the GP workforce needs to be implemented. This should include:

- Measures to improve the image of general practice in medical schools.
- Increased resources to grow the number of GP placements for foundation doctors and full funding for returner and retainer schemes.
- Introduction of an equitable and fair tariff for GP practice undergraduate placements so that all practices across the country can participate.

Not all GPs wish to work as independent contractors. Sessional GPs have reported seeing their partner colleagues being overworked as one of the most important factors in their reason for being a sessional GP. It is therefore important that different employment models for GPs are available. The use of different contracting models can place greater, more clearly defined, limits on GPs' workload and thus leave them with more time to deliver the care that patients need.

A model to address workload issues in primary care, as well as support the aspirations of Transforming Your Care, has been developed by BMA Northern Ireland in the form of GP Federations.⁵⁵ These are not-for-profit community interest companies and have the potential to support primary care to work at the scale needed to increase the range and type of services in the community; reduce demands on emergency and outpatient departments; and free GP's time to deal with patients who have complex co-morbidities and long-term conditions. There should also be an immediate increase in the number of GP training places.

In England, the BMA has set out a number of practical solutions to address the current crisis in general practice in 'Responsive, safe and sustainable: our urgent prescription for general practice'.⁵⁶ NHS England has recently launched its proposals, which set out its vision for primary care and how it can be supported now and in the future,⁵⁷ and we are now examining whether its plans represent the comprehensive strategy needed to make a difference. In Scotland a strategy to address the crisis in general practice already exists.

One further way to raise the appeal of general practice for younger doctors would be to make it easier for GPs to undertake an academic career in primary care. Even though all medical schools now have academic primary care staff, the number of Academic Clinical Fellow posts allocated to general practice remains disproportionately low and academic

career pathways in general practice have been under-resourced. Work should be done to redress the balance.

Steps need to be taken to help doctors better manage their workload and increase morale

We believe that the continuing increase in workload, and pressure to deliver more direct clinical contact, will have a detrimental effect on both doctors' morale and ultimately career choices. We are profoundly concerned by the significant and growing health burden on doctors and students and the increasing potential for stress and burnout. Unchecked workload pressures will also effect service innovation (which will be crucial if the NHS is to achieve the level of efficiency savings expected of it), continuing professional development, research and education, clinical contributions to organisational change and the wider NHS, and ultimately limit scope to improve quality of care. In the worst case scenario, workload pressures will undermine the safety of care to patients. Steps need to be taken to help doctors better manage their workload. There should be comprehensive guidance to recognise stress and burnout and provide support to doctors and students, as well as pastoral support in every medical school.

In general practice, where morale is extremely low, there should be:

- Greater and sustained funding for general practice, with a payment system that delivers new resources for increased workload in community settings.
- Measures to empower patients to manage their own care better through a government-backed national self-care strategy and encouraging commissioners and practices to promote self-care.
- Measures to manage demand and stem the shift of un-resourced workload onto GPs.

Other potential ways to help alleviate doctors' workloads should be developed and trialled across the UK, including the use of other health professional roles, such as physician assistants or other allied health professionals such as clinical pharmacists, advanced nurse practitioners or medical assistants. These professionals can perform valuable roles as part of a wider health team and take pressure off GPs by undertaking some defined clinical tasks, although it must be understood that they are not a GP substitute.

Workforce planning is needed to respond to a changing population and new ways of working

As discussed previously, the population of the UK is changing, to include a far greater number of older people with multiple conditions. As such, the NHS needs doctors who are technically specialised but also have the broader skills to be able to treat complex patients in a holistic way ie generalists. All doctors should be able to provide a level of generalist care and it is perfectly feasible for a well-trained doctor to be simultaneously a good generalist and specialist. There are already training programmes for specialist-generalist care in areas such as care of the elderly and community paediatrics, and a large proportion of physicians with general internal medicine training combine this with a specialist interest, as do doctors in other specialty areas. Any need for more generalist care should first be met by existing groups of doctors – GPs and hospital generalist specialties – with investment in and sensible deployment of these doctors. In the general context of the growing need for generalist care, consideration should also be given to the respective roles of doctors and other health professionals and how the training of each can be used to cement collaborative working.

It is vital that specialist training is not shortened, as has been suggested by the Shape of Training review. There is no evidence to support this move, which could threaten patient safety, and we believe that developing specialities which already deliver generalist care or creating new specialities are worth exploring.

For many years, there have been calls for greater integration of care in the NHS – for more care to be provided outside hospitals and closer to patients’ homes and for new models of care that will allow NHS staff to work in a more coherent and efficient way (the ‘Healthcare delivery and structures’ briefing in this series looks at these new models in further detail). Substantive workforce planning will be required to manage these shifts of care. It is vital that proper planning is done now, to ensure that the future healthcare workforce is sufficiently staffed and has the flexibility to be able to deliver care in different locations as required, without leaving parts of the health service inappropriately or under staffed. There also needs to be a thorough assessment of how the current systems of education, training and development of doctors could be improved to encourage and enable cross-sector collaboration and integrated care.

3

What has the BMA been doing on workforce issues?

The BMA has long been a strong advocate of effective national workforce planning and has consistently raised many of the challenges that doctors across the UK face, as highlighted in this briefing. Box 2 sets out some of our recent work in this area. With a recently established new Workforce and Innovation team in BMA House, workforce issues will remain an important priority for us going forward.

Box 2: The BMA has been active on a number of workforce issues

The BMA has been making a difference for members on a number of workforce issues:

- Since 2006 the BMA has been tracking the careers of medical graduates across the UK in a 10 year longitudinal cohort study to enable the assessment of future trends in the UK medical workforce.
- Over the last two years, the BMA has been monitoring the workload and wellbeing of doctors across the UK through a quarterly tracker survey. Using a panel of approximately 3,000 doctors from across the profession, the BMA has collected views on a range of topics, including morale, motivation and changes to the NHS.
- Our recent report 'Responsive, safe and sustainable: our urgent prescription for general practice' sets out practical solutions for how the crisis GPs face can be addressed in England.⁵⁸
- As a member of the Shape of Training Steering Group the BMA has called for implementation of the review's recommendations to be paused. This would allow for further evaluation of previous changes to training and more research on the balance between generalism and specialism that lies at the heart of much of the agenda around reforming medical training.

Conclusion

This briefing has outlined the key factors contributing to problems with the recruitment and retention and the low morale currently felt by doctors across the NHS. It has also set out the BMA's policy in these areas and serves as a background paper for members for the SRM session discussing these issues and potential solutions to the problems identified.

References

- 1 The Telegraph (2012) *NHS is fifth biggest employer in the world*. Accessed on 11/04/16. www.telegraph.co.uk/news/uknews/9155130/NHS-is-fifth-biggest-employer-in-world.html.
- 2 BMA (2015) *2014 UK Medical Workforce Briefing*.
- 3 Health and Social Care Information Centre (2016) *Healthcare Workforce Statistics, September 2015*.
- 4 The Guardian (2014) *NHS finances in crisis due to rising demand and budget cuts*. Accessed on 11/04/16. www.theguardian.com/society/2014/oct/05/nhs-finances-crisis-rising-demand-budget-cuts-30-billion-pound-deficit-2020.
- 5 NHS England (2014) *NHS Five Year Forward View*.
- 6 GP National Recruitment Office. Accessed 11/04/16. www.gprecruitment.hee.nhs.uk/Recruitment.
- 7 The Guardian (2013) *UK population: how will it change over the next few decades?* Accessed on 11/04/16. www.theguardian.com/news/datablog/2013/nov/06/uk-population-increase-births-migration.
- 8 Scottish Government. Accessed on 11/04/16. www.gov.scot/Topics/Health/Services/Long-Term-Conditions.
- 9 See <http://www.lse.ac.uk/newsAndMedia/news/archives/2007/AlzheimersReport.aspx> for the dementia figures. The cancer data are Macmillan Cancer Support estimates of prevalence at the end of 2012 and 2030 by nation in the UK, estimated using prevalence rates from Maddams, J., Utley, M. & Møller, H. *Projections of cancer prevalence in the United Kingdom, 2010–2040*. *Br. J. Cancer* 107, 1195–1202 (2012).
- 10 Scottish Government. www.gov.scot/Topics/Health/Services/Long-Term-Conditions.
- 11 NHS England *A&E Attendances and Emergency Admissions 2015-16 (Monthly and Quarterly)*. Accessed on 11/04/16. www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areasae-waiting-times-and-activityae-attendances-and-emergency-admissions-2015-16-monthly-3/.
- 12 *The King's Fund Hospital activity*. Accessed on 11/04/16. www.kingsfund.org.uk/projects/nhs-in-a-nutshell/hospital-activity.
- 13 NHS England (2014) *Improving general practice – a call to action*.
- 14 The most recent independent UK-wide GP workload survey was published in July 2007 so there are no recent, robust figures on length of consultation.
- 15 BMA (2012) *Memorandum of evidence to the review body on doctors' and dentists' remuneration*.
- 16 HSCIC (2007) *GP workload survey results*. Accessed on 11/04/16. <http://www.hscic.gov.uk/article/2021/Website-Search?productid=713&q=gp+workload+survey&sort=Relevance&size=10&page=1&area=both#top>.
- 17 BMA (2012) *Memorandum of evidence to the review body on doctors' and dentists' remuneration*.
- 18 BMA (2012) *Memorandum of evidence to the review body on doctors' and dentists' remuneration*.
- 19 BMA (2014) *General practice in the UK media brief*.
- 20 NHS Confederation (2013) *Challenging Bureaucracy*.
- 21 A panel of about 3,000 doctors from across the profession are asked for their views on a range of topics on a quarterly basis.

- 22 UCAS. *Deadline applicant statistics: October*. Accessed on 11/04/16. www.ucas.com/sites/default/files/mr_october_151015_medicine.pdf.
- 23 Pulse (2016) *GP training targets in doubt as applications tumble*. Accessed on 11/04/16. www.pulsetoday.co.uk/your-practice/practice-topics/employment/revealed-gp-training-targets-in-doubt-as-applications-tumble-5/20031037.fullarticle.
- 24 The Foundation Programme Office (2015) *Career Destination Report*.
- 25 See <http://www.hcsa.com/news-views/news/2015/09/stress-survey-findings.aspx>.
- 26 Pulse (2016) *GP training targets in doubt as applications tumble*. Accessed on 11/04/16. www.pulsetoday.co.uk/your-practice/practice-topics/employment/revealed-gp-training-targets-in-doubt-as-applications-tumble-5/20031037.fullarticle.
- 27 Pulse (2015) *Half of GP training places unfilled in some areas*. Accessed on 11/04/16. www.pulsetoday.co.uk/your-practice/practice-topics/education/half-of-gp-training-places-unfilled-in-some-areas/20010555.article.
- 28 BMA (2015) *Memorandum of evidence to the review body on doctors' and dentists' remuneration*.
- 29 The Smith Institute (2015) *From pay squeeze to a staffing crisis*.
- 30 BMA (2015) *Memorandum of evidence to the review body on doctors' and dentists' remuneration*.
- 31 DHSSPS NI (2015) *Staff vacancies* www.dhsspsni.gov.uk/index/statistics/workforce/staff-vacancies.htm.
- 32 Medical Schools Council (2015) *Staffing level of medical clinical academics in UK medical schools*.
- 33 BMA (2015) *Public Health Staffing interim report Unpublished*.
- 34 BMA (2014) *Findings from the public health survey*. Accessed 11/04/16. bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/7P3NCUP6YXK2E37NSGTE23YCI419V7.pdf.
- 35 Pulse (2015) *GP vacancy rate at highest ever, with 50% rise in empty posts*. Accessed on 11/04/16. www.pulsetoday.co.uk/your-practice/practice-topics/employment/gp-vacancy-rate-at-highest-ever-with-50-rise-in-empty-posts/20009835.article#.VfruGZdf2VM.
- 36 BMA (2015) *Cohort study of 2006 medical graduates – Ninth report*.
- 37 BMA (2016) *Morale and workload survey*. Accessed on 11/04/16. <http://www.bma.org.uk/working-for-change/policy-and-lobbying/training-and-workforce/tracker-survey>.
- 38 BMA survey of medical students following publication of Junior Doctor Contract to be imposed and Equality Impact Assessment, April 2016.
- 39 The Guardian (2015) *New doctors leave NHS for better life abroad*. Accessed on 11/04/16. www.theguardian.com/society/2015/aug/23/new-doctors-leave-nhs-for-better-life-abroad.
- 40 The Telegraph (2015) *A third of A&E doctors leaving NHS to work abroad*. Accessed on 11/04/16. www.telegraph.co.uk/news/health/news/11883559/A-third-of-AandE-doctors-leaving-NHS-to-work-abroad.html.
- 41 The Guardian (2015) *Doctors who left the NHS for Australia*. Accessed on 11/04/16. www.theguardian.com/society/2015/nov/08/nhs-doctors-in-australia-more-cash-fewer-hours-less-pressure.
- 42 The Health Foundation (2016) *Fit for Purpose? Workforce policy in the English NHS*.
- 43 BMA (2015) *National survey of GPs – The future of General Practice*.
- 44 BMA (2014) *General practice in the UK media brief*.

- 45 BMA (2015) *Memorandum of evidence to the review body on doctors' and dentists' remuneration*.
- 46 AoMRC in Scotland (2015) *Learning from serious failings in care*.
- 47 BMA (2015) *The Changing Experience of Work of Consultants in NHS Scotland*.
- 48 BMA (2015) *Memorandum of evidence to the review body on doctors' and dentists' remuneration*.
- 49 BMA (2014) *Findings from the public health survey*. Accessed 11/04/16.
bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/7P3NCUP6YXK2E37NSGTE23YCI419V7.pdf.
- 50 John Crompton (2011). *Transforming your care. A review of Health and Social Care in Northern Ireland*. Belfast.
- 51 Sir Liam Donaldson (2014). *The right time, the right place. An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland*. Belfast and <https://www.dhsspsni.gov.uk/news/health-minister-confirms-ambitious-plans-restructure-health-and-social-care>.
- 52 Scottish Government (2016). *A National Clinical Strategy for Scotland*. Edinburgh. The strategy is available here: <http://www.gov.scot/Publications/2016/02/8699>.
- 53 Scottish Government (2011). *2020 Vision*. Edinburgh. The vision is available here: <http://www.gov.scot/Topics/Health/Policy/2020-Vision>.
- 54 NHSE (2016) *General Practice Forward View*. London: NHS England
- 55 BMA Northern Ireland (2015). *General practice in Northern Ireland: The case for change*. Belfast: BMA. The document can be accessed here: http://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/negotiating%20for%20the%20profession/general%20practitioners/nigpc_gms_strategy_caseforchange.pdf.
- 56 BMA (2016) *Responsive, safe and sustainable: our urgent prescription for general practice*. London: BMA.
- 57 NHSE (2016) *General Practice Forward View*. London: NHS England
- 58 Published April 2016. Available at www.bma.org.uk.

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