

BMA Consultation Response: Facing the facts, shaping the future – a draft health and social care workforce strategy for England to 2027





Foreword

It is both an honour and a privilege to work as a doctor in the NHS. The NHS is regarded as one of the best health systems in the world which is a testament to the thousands of dedicated doctors, nurses and other health and care professionals who deliver the highest quality patient care on the front lines each day.

The BMA has long called for a comprehensive, forward-looking workforce strategy to address issues relating to workforce monitoring and planning, resourcing sufficient education and training capacity and expanding skill-mix to support the doctor-led medical model of care. We are very pleased that the moment has finally arrived where everyone with a stake in the NHS can contribute to and help deliver a national workforce strategy that can increase medical, clinical and non-clinical workforce supply and ensure it is sustainable long into the future.

Doctors, and all staff, are working in a system that is under immense pressure. Understaffed and under-resourced NHS services are currently having to manage unprecedented levels of patient demand. Chronic staff shortages and difficulties recruiting and retaining staff are major challenges across all health and care sectors. Increasing rota gaps and vacancies are a key driver of dissatisfaction for doctors, impacting on their health and wellbeing, their training, patient care and the sustainability of the NHS over the long-term. These pressures also present a real risk to the quality of care and patient safety.

The consequences of working in such a severely pressurised environment, without adequate resources, capacity or support, can have tragic consequences as the case of Dr Bawa-Garba demonstrates. This extremely sad scenario has also brought the prevailing culture of blame within the NHS to the fore. This needs to change – we must strive to create a culture of learning that seeks improvement, not punishment – for the benefit of staff, but, ultimately, for the benefit of patients.

Over the coming months, the BMA will be developing its vision for a health service that is caring, supportive and collaborative – a system that puts valuing staff at the heart of its commitment to high quality patient care. As part of this effort we will be seeking input from stakeholders from across the NHS and the medical profession.

It is my hope that by working in partnership we can develop practical solutions to the workforce challenges facing the NHS.

A handwritten signature in black ink that reads "Anthea M Mowat". The signature is written in a cursive, flowing style.

Dr Anthea Mowat
BMA representative body chair

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Executive summary

The BMA (British Medical Association) is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We welcome this opportunity to respond to the draft national health and care workforce strategy consultation.

Introduction

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. In some cases, these pressures can lead to tragic consequences. The BMA's recent report, "[Working in a system that is under pressure](#)" explores these issues, consequences, and possible solutions in greater depth.

While medicine remains a popular career choice, many doctors find working in today's NHS too taxing on their work-life balance, health and wellbeing and are subsequently leaving to seek alternative employment opportunities either at home or abroad, considering early retirement or leaving the profession altogether ([BMA 2017, Career Choice Survey](#)). Forty-one percent of doctors taking part in the BMA's most recent [quarterly survey](#) described their morale as being low or very low. The medical workforce therefore finds itself caught in a vicious cycle which risks the ability of the NHS to deliver a safe and reliable service.

Improving recruitment and retention in the medical workforce will require long-term approaches and making jobs genuinely attractive to a modern workforce. However, the immediate needs of the service must also be addressed in the short-term. The quality of continuous education and training, for both medical trainees and throughout a doctor's career, plus fair terms and conditions of service, flexible working arrangements and an employer focus on the health and wellbeing of staff will have a long lasting and positive impact in terms of patient care and value for public investment.

Creating positive cultures within organisations and teams that support collaborative working among professionals and across sectors will be key to any future workforce strategy. There must also be a sustained commitment to tackle bullying and harassment and to move toward a no-blame culture that fosters continuous learning and improvement.

The workforce is the most important aspect of any organisation. Adequate numbers of trained, motivated and healthy staff, with the right skills delivering care in the right places is what is needed for the NHS to continue delivering the highest quality care among any health system in the world.

Key points from the BMA's response:

1. **Better workforce planning supported by adequate data to ensure safe staffing levels**

It is vital that consistent infrastructure is put in place swiftly for robust and frequent workforce planning. This will ensure the future healthcare workforce is sufficiently staffed and has the flexibility to be able to deliver care in different locations. To support this, there must be accurate data to support future workforce projections and planning of training and educational needs.

2. **A focus on the recruitment and retention of NHS staff**

Recruitment and retention of NHS staff is dependent on various factors, including the promise of a rewarding career, which enables people to consistently develop and progress, fair remuneration for their efforts, clearly defined and funded professional indemnity arrangements, an employer focus on the wellbeing of staff and a positive NHS culture that values and supports doctors.

3. **A commitment to creating positive working cultures within the NHS**

Creating positive cultures within organisations and teams that support collaborative working among professionals and across sectors is key to recruiting and retaining staff. Organisations must make a commitment to tackling bullying and harassment and to move towards a no-blame culture that fosters continuous learning and improvement within the NHS.

4. **A more controlled workload with flexible working options**

Workload remains a significant factor in terms of making NHS roles attractive. All doctors have reported that their work has become increasingly complex over recent years.¹ BMA research shows that specialty choices are heavily influenced by perceived control over workload and opportunities to work flexibly. While trusts and practices are short of staff and funding, there will continue to be pressure for staff to work longer than rostered hours and not take up flexible working options.

5. **An Improved training experience for doctors**

Medical education, training and development must evolve alongside the population's health requirements and ever changing technological practices. Medical trainees should be valued and supported by their employers, and the wider health and care system, to ensure that the doctors of the future are motivated to develop their careers within the NHS. It is therefore important that all necessary training and education opportunities for doctors and staff within the NHS are consistently funded and organised and not lost to service provision demands. This will ensure that the future needs of staff and the service are met.

6. **A future immigration system that is responsive to the needs of the health and social care sectors**

The health and social care workforce in England is diverse and relies on both UK-trained doctors and the skills and dedication of doctors from overseas. If we are to continue to provide safe and reliable healthcare services, and to remain globally competitive in the life sciences, the NHS must be able to recruit and retain doctors and other staff from the UK, the EEA and elsewhere in the world.

7. **Better remuneration for doctors and staff in the NHS**

Since 2010, doctors have not only faced increased workload but reduced remuneration in real terms too. This has had a significant effect on morale. This is detrimental to the goal of the NHS being the employer of choice. Tackling the issue of [more work for less pay in real terms](#) has to be central to achieving this for staff across the NHS.

¹ BMA, Workload and wellbeing quarterly survey <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/quarterly-survey>

1. Do you support the six principles proposed to support better workforce planning; and, in particular, aligning financial, policy, best practice and service planning in the future?

1. Securing the supply of staff

Successful recruitment and retention of NHS staff is dependent on various factors. The promise of a rewarding career; enabling people to consistently develop, progress and put their clinical and non-clinical skills to best use; fair remuneration and an employer focus on the wellbeing of the people that make up the workforce are among the crucial elements to ensuring sufficient staff supply. The workforce is also the most important aspect of any organisation. In the case of the NHS, without the necessary number of trained, motivated and healthy people, patient diagnosis, treatment and care ultimately suffers.

The NHS workforce is also necessarily diverse. It is reliant on both UK-trained doctors and the skills and dedication of doctors from overseas. If we are to continue to provide safe and reliable healthcare services, and to remain globally competitive in the life sciences, the NHS must be able to recruit and retain doctors and other staff from the UK, the EEA and elsewhere in the world.

2. Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff

Following the 2016 announcement to fund an additional 1500 medical school places from September 2018, it is imperative that guaranteed funding commitments follow to ensure high quality training for these new doctors when they graduate. This is not just important for medical training, but also vital for the training of other additional clinical and non-clinical NHS staff. If high standards are to be maintained, and staff are to be retained within the NHS, our workforce must be recognised as an asset that offers an outstanding return on the public's investment and its long-term health.

Employers must share in the responsibility for training, educating and retaining staff. This includes having access to sufficient *recurrent* resources to ensure ongoing learning, development and wellbeing throughout people's careers, e.g. the £12m Workforce Development Fund for SAS (Staff Grade, Associate Specialist and Specialty Doctor) grades, the healthcare education and training tariff, development funding provided through the GPFV (GP Forward View) etc.

Although we do not oppose appropriate collaborative and integrated systems within the NHS, we continue to raise our opposition² to the proposed development of ACOs (accountable care organisations). If STPs (sustainability and transformation partnerships), ICSs (integrated care systems) and ACOs continue to develop, staff will be increasingly expected to integrate and work collaboratively with colleagues in different organisations and sectors, including both local authorities and social care. The workforce strategy needs to recognise this and ensure that training prepares NHS staff for the degree of co-operation required in the future. This includes, for example, onward referrals within secondary care and greater communication and collaboration between secondary and primary care providers / clinicians.

² [BMA Chair of Council statement on ACOs \(March 2018\)](#)

3. Providing broad pathways for careers in the NHS and the opportunity for staff to contribute more, and earn more, by developing their skills and experience.

CPD (continuing professional development) is vital to both the recruitment and retention of staff. Enabling people to expand their knowledge and skills when they choose to do so plays a significant part in keeping people motivated. Sadly, this is not presently the reality, but CPD opportunities for doctors and clinicians are crucial in helping patients to get better and to stay well.

The BMA does not support on-the-job learning routes for other professions to transition into medicine. This is because of the high education standards required to graduate with a medical degree and enter specialty training. However, providing that appropriate standards, competencies and regulation are in place, learning routes of this kind can be a suitable way for other clinicians to advance within their own clinical field.

4. Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare.

The BMA welcomes this principle. Medicine is still behind other professions in attracting students from more diverse and lower socio-economic backgrounds, although national and local initiatives have now been established to widen access to medicine.

Nevertheless, there is more work to be done to join up these initiatives. Further consideration needs to be given to the range of factors that prevent people from poorer/more diverse backgrounds studying medicine – including financial and cultural factors, as well as academic constraints ([The Right Mix](#), BMA, 2015).

5. Ensuring the NHS and other employers in the system are inclusive modern model employers with flexible working patterns, career structures and rewards.

While trusts and practices are short of staff and funding, there will continue to be pressure for staff to work longer than rostered hours and not take up flexible working patterns. Concerns around culture, bullying and harassment and ingrained 'ways of working/operating' are some of the biggest challenges to resolving this issue.

The new national workforce strategy must include clear instructions for the wider healthcare system that enable new care models to establish modern working arrangements for NHS staff within all local providers. Integration of regional and local workforce monitoring, training and education capacity and workforce planning will be the key to success here. If staff do not consider careers in the NHS to be sufficiently rewarding, or employers to be sufficiently supportive of staff wellbeing, it should come as no surprise if many either leave the workforce earlier than necessary or simply choose not to work for NHS employers at all.

Women now make up almost 50% of the medical workforce. Flexibility needs to be incorporated into medical roles at all levels to enable women to combine work with caring responsibilities. If the NHS is to be an attractive career prospect, employers must take seriously the importance of work-life balance. Our response elaborates on this topic in the sections on 'Leave' and 'Less-than-full-time training'. The GMC's *Adapting for the Future* report³, which considers 'varying interpretations of flexibility needed within the [postgraduate medical training] system', is also a valuable resource when considering the final workforce strategy.

³ GMC, *Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training* (2017)

6 Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested.

The BMA is supportive of efforts to take a holistic and considered approach to workforce planning and the risk assessment of policy proposals and initiatives. For example, the initial lack of co-ordination around the introduction of PAs (physician associates) has caused significant concern for the existing medical workforce, including those in training, and efforts must be taken to avoid this in future.

Improve workforce planning

For staff to be able to work across organisations and sectors more easily, and to reduce the frequency and impact of understaffing where it occurs, it is vital that consistent infrastructure for robust and frequent workforce planning happens swiftly. This will ensure the future healthcare workforce is sufficiently staffed and has the flexibility to be able to deliver care in different locations.

There also needs to be a thorough assessment of how the current system of education, training and development of doctors and other clinicians could be improved to encourage and enable cross-sector collaboration and integrated care. Where appropriately assimilated, local training hubs⁴ could be a suitable vehicle for multi-agency integration and collaboration on both workforce planning and the delivery of training and education.

Technology

IT infrastructure needs to be interoperable to enable staff to work across organisations easily. Requiring staff to have multiple log-in details or to use systems that do not work with each other is likely to be a continuing barrier to staff effectively working across different settings. This will take investment in current infrastructure and a requirement that all future software is interoperable with other systems.

Review of data requirements

We support the review into data requirements for workforce planning and agree that there is a need to better capture those who are working outside the NHS and those who work across care settings. However, there are a range of other data requirements that are needed to support effective workforce planning:

Improved vacancy data

It is impossible to accurately assess the impact that medical vacancies are having on the NHS without a consistent approach to the collection, analysis and presentation of the relevant data. Currently, there is no agreed national approach to vacancy data definitions or collection, meaning that the information used in this strategy document includes trust / employer level variation in what constitutes a vacancy. This makes it difficult to analyse the data effectively and creates the option for trusts to use their own definition to obscure the extent of the problem.

We would like to see one organisation take on responsibility for national vacancy data collection, working with the BMA and other stakeholders to establish national definitions and approaches to this essential element of workforce planning. In our view, the most appropriate organisation to take on this responsibility is NHS Digital.

Data on the international workforce

According to NHS Digital, approximately 22% of all doctors currently working in the NHS in England are from countries other than the UK, with additional staff working in public health and academic medicine. However, because of the lack of data and the way it is captured in certain parts of the country, it is difficult to calculate a precise UK-wide figure. For example,

4 HEE, [Training Hubs](#)

the GMC (General Medical Council) collects information on the number of EEA (European Economic Area) doctors who received their PMQ (Primary Medical Qualification) in another EU (European Union) country. However, these figures include non-EEA doctors who received their PMQ in another EU country and excludes EU doctors who received their PMQ in the UK.

Medical supply data

It has been proposed that the current method of medical supply data will be replaced with a standard GP dataset that will be extracted clearly from General Practice in England. The data extracted will be anonymised. This data can then be used to understand local health demographics, by looking at activity data such as smoking rates, obesity rates and alcohol use alongside demographic data which could help national workforce planners better understand the needs of local areas. This in turn could build a national picture of medical speciality needs in each area. We think this is a sensible step forward as the more knowledge local planners have about patient need the better prepared they can be for the future.

Workload data

Workload data for general practice is severely lacking when compared with secondary care. NHS England has started gathering data, using two data extractions that look at GP workload and appointment data, to try to understand the pressures that GPs are facing. Currently, the quality of this data is not robust enough to be published, but it is hoped that it will become a valuable tool to help understand workload pressures in general practice in the future.

System responsibilities

Data quality and workforce planning go hand in hand. To improve and streamline this process it would be best for one organisation to collect, analyse and present workforce data, ensuring it is broken down at both a regional and national level. Much the same as the differences across employers in the way workforce data is captured and recorded, there are specific differences across the country in the way data is collected, presented and analysed nationally. This makes it difficult to get an accurate picture of the workforce. If one organisation had responsibility for data quality, collection from employers, analysis and presentation, whilst consistently collaborating with those who can share intelligence, e.g. medical training numbers, locum use, vacancy numbers based on consistent definitions etc, this would improve overall data quality and workforce planning.

We welcome the introduction of a Workforce Impact Assessment and see this as an essential element of any workforce planning process. Through our involvement in HEE's MAPs (Medical Associate Professions) Career Framework and Professional Identity Working Group, we raised concerns about the way in which PAs have been introduced. We subsequently requested an independent assessment of the impact of PAs on medical training and education. We are grateful that this request was granted by HEE and keenly await the report expected in April 2018.

The lack of co-ordination has led to significant regional variation, widespread misinformation and lack of clarity about supervisory responsibilities for PAs. The impact on the existing workforce has by some distance been the strongest concern for BMA committees and membership in relation to new clinical roles. This could have been mitigated with better planning, communication and public acknowledgement of the need for a comprehensive impact assessment.

There is a necessary distinction between new roles that are introduced into the NHS, such as PAs, and 'advanced' roles that develop out of existing roles. We understand the need for flexibility to allow roles of this kind to develop, but this must only happen with a clear focus on the timely development of national standards and regulation as appropriate. The Workforce Impact Assessment must, therefore, allow for appropriate assessment of both type of roles, building in efficient processes for the sharing of good practice and communication with the existing workforce.

We also welcome the focus on workforce sustainability. Where roles are developed in a focussed way, with clear objectives, there can be significant benefit across the system, for patients, existing staff and doctors. When developing national initiatives designed to significantly alter the workforce, such as the Clinical Pharmacists in General Practice Programme, it is important to properly assess the possible consequences if central funding is to be withdrawn at some stage. These consequences are not simply limited to staff salaries, employer pension contributions, maternity/paternity/sickness pay and other costs met as part of an employer's responsibilities, but also include the cost of indemnity cover for individual clinicians.

Where schemes have time-limited funding, there needs to be clear suggestions around how to retain the benefits of the role in the long-term. For example, an increasing number of GP practices are recruiting additional staff via the national Clinical Pharmacists in General Practice Programme. We believe that recurrent investment in clinical pharmacist and other clinical and non-clinical roles is vital. This will ensure practices and providers can sustain and retain staff in these roles. It is essential that the introduction of new staff roles is carried out as part of a long-term plan to benefit the overall workforce and patients – not simply to meet short-term targets.

2. What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?

Ensuring a future immigration system that is responsive to the needs of health and social care sectors

To further the interests of patients, doctors and the wider health and social care workforce, we are [calling on the government](#) to implement a flexible immigration system, which facilitates the entry of doctors, nurses and other key health and social care staff to the UK, and enables UK-trained doctors to work in the EU where they choose to do so.

The needs of the workforce and immigration cannot be considered in isolation and the future workforce strategy needs to be supported by a flexible immigration system that fills workforce shortages and meets the needs of the health and social care sector. MRPQ (mutual recognition of professional qualifications in healthcare) and immigration also go hand in hand, as a flexible immigration system will only be effective if the MRPQ system, or whatever replaces it, allows doctors to move freely to the UK.

Staffing levels and workload

A report from the Royal College of Physicians⁵ shows that the UK has one doctor for every 360 people, compared with an EU average of one doctor for every 288 people. This has left hospitals chronically understaffed. Between 2013 and 2015, the number of doctor vacancies increased by 60%. Furthermore, 70% of doctors in training reported working on a rota with a permanent gap, and eight in ten consultants report gaps in the rotas of doctors in training; more than one in four reported that the gaps are so serious and frequent that they cause significant problems for patient safety⁶.

In a 2017 BMA survey of consultants⁷ in England, respondents reported that, outside their contracted time, they work on average an extra 4.5 unpaid hours per week. A quarter of the respondents described their current workload as 'consistently unmanageable' and nearly half (49%) had felt unwell over the last 12 months as a result of work related stress. Unsurprisingly, 61% of respondents went on to describe their morale as low or very low. In addition, half of respondents said that their current workload has a negative or significantly negative impact on the quality of care that their patients receive. The survey clearly demonstrates that doctors' unmanageable workloads impact on their morale, motivation, well-being and on the quality of care they can offer to patients.

Similarly, in a 2015 BMA survey⁸ of SAS doctors 74% of respondents reported that they had worked more hours than in their job plan in the past year. 75% reported giving up SPA (supporting professional activities) time in order to fulfil clinical duties. Perhaps even more worryingly, 27% reported that they intended to leave medicine within the next five years, whilst 45% said they would not recommend an SAS grade career to junior doctor colleagues.

Workload remains a significant factor in terms of making NHS roles attractive too. The GMC's 2017 NTS (National Training Survey)⁹ confirmed that almost 25% of doctors in training feel short of sleep while at work on a daily or weekly basis, and just over 40% rated the intensity of their work by day as 'heavy' or 'very heavy'. Medical trainers are also reporting high workloads – with almost 80% working beyond their rostered hours at least once a week, which was in turn impacting on training. Around a third say they don't have enough time in their job plan (or equivalent) for education¹⁰.

⁵ Royal College of Physicians (2017), *Underfunded. Underdoctored. Overstretched. The NHS in 2016*.

⁶ Ibid

⁷ British Medical Association (2017) *Survey of consultants in England*.

⁸ BMA *SAS Doctor Survey* (2016)

⁹ <https://www.gmc-uk.org/education/surveys.asp>

¹⁰ *Training environments 2017: Key findings from the national training surveys* (November 2017), General Medical Council

Expanding medical school places without expanding resources would also be bad for educational standards¹¹. The 1,500 new medical student places will be expensive, but so too will the extra foundation places, and then the extra specialty training places that the doctors will need. It is imperative that guaranteed funding commitments follow to ensure high quality training for these new doctors when they graduate. This is not just important for medical training, but also vital for the training of other additional clinical and non-clinical NHS staff. If high standards are to be maintained, and staff are to be retained within the NHS, our workforce must be recognised as a valuable asset that offers an outstanding return on the public's investment and its long-term health.

The recruitment and retention problems experienced in general practice result from the workload burden and the consequent impression that general practice is not a good place to work. The BMA's 10-year cohort study¹², which concluded in 2016, showed that only around a quarter of those who started out wanting to work in general practice still wanted to do so 10 years later. This situation presents the possibility of a vicious cycle, with a reputation for an excessive workload burden reducing specialty recruitment numbers and exacerbating the problem. It is encouraging that general practice specialty recruitment reached a record high in 2017, even if it is yet to meet the HEE target initially set in 2015/16. However, our recent career trends survey results suggest that a career in General Practice remains especially unattractive¹³.

SAS doctor grades

The blue triangle (on page 102 of the consultation document) has caused concern within our SAS doctor membership, as it can be interpreted as undermining the importance of SAS doctors to the NHS workforce. This grade is likely to expand over the coming years as younger doctors choose flexible working options, traditionally more prevalent in SAS and trust grade roles, rather than taking on consultant roles where flexibility has been harder to achieve. They also feel the term 'Non-consultant and non-trainee medic' substantially weakens the value and attraction of a career as an SAS doctor.

The SAS doctor charters, agreed by the BMA, NHS Employers, the Academy of Medical Royal Colleges and relevant national health education bodies within each UK nation, recognise the key role that SAS doctors hold in the delivery of high quality, safe medical care for patients. Employers must be required to adopt these and demonstrate a commitment to supporting and enabling SAS doctors to realise their full potential.

To prevent employers creating non-standard contracts, the BMA strongly advocates the creation of a single national SAS contract. This would help to make SAS doctor careers more attractive, while resourcing employers and requiring them to continue education and training pathways that include routes to becoming a consultant if desired. For example, where they choose to do so, SAS doctors should be enabled to re-enter formal training at a set interval in their career. Having this as another potential consultant recruitment pathway is also prudent for sustaining workforce capacity, accurate workforce planning and staff retention generally.

The AoMRC (Academy of Medical Royal Colleges)¹⁴ have also acknowledged that it is not always the case that a consultant is the responsible clinician for a patient – in some cases it may be another senior doctor, e.g. a specialty doctor, with the right level of competence. The 2006 Summary Agreement, which formed the basis of the 2008 SAS terms and conditions of service and is also outlined in the UK Job Planning guidance for SAS Doctors published by NHS Employers in November 2012¹⁵, specified that 'at the top of the grade, SAS doctors will have acquired a high level of specialist knowledge and expertise and have the capacity and

11 BMA, [Five questions the Government must answer](#) (October 2016)

12 [BMA Cohort Doctor Study report](#)

13 [BMA Junior doctors career trends survey](#) (February 2018)

14 AoMRC, [Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients](#) (2014)

15 BMA, [Autonomy for SAS grade doctors](#) (March 2018)

opportunity to work independently within agreed lines of responsibility and will also take a broader role in the organisation through other activities such as teaching and audit'.

Funding and pay

The BMA believes that reversing the current recruitment problems requires the NHS to be properly resourced. For example, increased levels of funding for GP practices would enable them to develop an expanded primary care team. Whilst funding streams for support staff set out in the GPFV are welcome, they need to be delivered in a way that offers long term investment for GP practices to utilise flexibly and meet the needs of their patients. The financial burden of providing indemnity cover for other healthcare professionals often falls on the practice or individual GP partners, and the significant differential between primary and secondary care indemnity fees is pushing much needed doctors away from a career in general practice.

Crucially, funding needs to be accessible to practices on a recurring basis, rather than one-off payments or on a reducing basis, preferably by including it within core practice funding. This would allow practices to invest time and energy into fully integrating a wide range of primary care staff, including via internal training and on the job experience, without the uncertainty of funding streams being reduced or removed at some point in the future. It goes without saying that increased staffing and manageable workload in primary care will result in increased patient access, improved diagnosis and preventative care and the realisation of efficiencies through reduced A&E attendances, hospital admissions and expensive urgent care episodes.

Since 2010, doctors have not only faced increased workloads but also reduced remuneration in real terms. This can only be detrimental to the stated goal of being the employer of choice. Tackling the issue of [more work for less pay in real terms](#) has to be central to achieving this goal.

Looking at comparator pay increases over recent years, the pay cap on doctors' wages has meant that increases for doctors have been significantly lower. According to the ONS,¹⁶ pay increases in the wider economy were just below 2.5% in 2016/17. This means that doctors' capped pay awards of 1% were about 60% less than in the wider economy.

The above findings are supported by the *UCL Wage Growth in Pay Review Body Occupations*,¹⁷ which was published in July of this year. Out of 10 pay review body occupations, doctors have seen the biggest fall (-22.5%) in median real gross hourly earnings, confirming that the pay awards recommended by the DDRB over the past decade have led to significant real terms reductions in doctors' earnings. This has affected morale and living standards. The rising costs of professional indemnity, housing in cities and transport are also important considerations when developing a long-term national workforce strategy.

Rota gaps

In a BMA survey of consultants¹⁸ conducted in 2017 in England, almost half of the respondents (46%) reported consultant rota gaps in their department and 71% reported junior doctor rota gaps in their department. The BMA will shortly be issuing a report into secondary care rota gaps, including recommendations for good practice and ways to minimise the negative impact that rota gaps can have on doctors' morale. This will also include results from our recent survey of junior doctors which showed that nearly two thirds (62.4%) of respondents had missed training or study leave to cover a rota gap in the previous

16 Office for National Statistics (2017) *Earnings and Working Hours*, available at <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours>

17 UCL (2017) *Wage Growth in Pay Review Body Occupations*. Report to the Office of Manpower Economics, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/623810/Wage_Growth_in_PRB_Occupations_-_final_report__3_.pdf

18 British Medical Association (2017) *Survey of consultants in England*.

month and that more than a fifth (21.4%) had worked on call without the appropriate level of supervision. These results not only demonstrate the scale of the current problem and raise concerns around safety, but highlight potential future workforce consequences in terms of the level of training that junior doctors are currently receiving.

We support the NHSI (NHS Improvement) [rostering guidance](#)¹⁹ and recommend that it is incorporated into the workforce strategy to ensure that the training needs of the future NHS workforce are met. Similarly, we support the standardisation of exception reporting as a way of highlighting workforce shortages at a national level and to better understand training and workload issues.

Pensions

Pension flexibility is important for retaining staff in the later stages of their career. In ongoing talks about the new consultant contract, the parties have been considering the potential for various pension flexibilities, including allowing consultants who choose to opt-out of the NHS pension scheme, and who would in any case cease to contribute to it, to choose to be paid a proportion of the employers' pension contribution. It is worth noting that such provisions are made available to other staff groups at the discretion of employers in England as part of individual remunerations packages. A similar arrangement may also incentivise older GPs to remain, at the least, in part-time practice or to offer their expertise and experience to commissioners and younger doctors in non-clinical or education-based roles.

Mental Health Workforce

We welcome the plan to employ 19,000 new mental health staff by 2020, but it is an ambitious number of vacancies to fill without substantial investment to support recruitment and retention. It will require the creation of a dedicated mental health workforce development budget, as set-out in HEE's Mental health workforce plan²⁰, which needs to be substantial enough to expand the workforce to this level.

HEE should collaborate with other stakeholders, e.g. the RCPsych (Royal College of Psychiatrists), in running campaigns to promote psychiatry as a career. Common misconceptions about the role of the psychiatrists should also be tackled, e.g. a 2013 RCPsych survey found that psychiatry is considered by some to be "less scientific" than other branches of medicine.

Attempts to promote psychiatry as a career and to improve retention must acknowledge the wider working environment for psychiatrists too. A 2018 BMA survey of CAMHS (child and adolescent mental health services) professionals indicated that many doctors feel that these services are underfunded and, because of this, they feel less able to do their jobs. Overall funding for mental health services must be increased, so that mental health trusts are fully resourced and are therefore more appealing places to work.

We support a major return to practice campaign for psychiatrists and mental health nurses. However, there needs to be specific actions identified to fill the number of additional nursing posts needed to support a mental health workforce expansion.

Understanding career choices

Efforts to improve recruitment could be improved by gaining a better understanding of the choices made by school leavers. For example, if students have initially shown an interest in medicine / clinical roles but then decide against it, there would be value in understanding what had influenced their change of mind. Surveying or carrying out focus groups with students should help inform the future direction of any recruitment strategy.

19 NHS Improvement 2016, Good Practice Guide: Rostering [file:///C:/Users/sallam/Downloads/Rostering_Good_Practice_Guidance_Final_v2%20\(1\).pdf](file:///C:/Users/sallam/Downloads/Rostering_Good_Practice_Guidance_Final_v2%20(1).pdf)

20 HEE (2017) Mental health Workforce Plan <https://hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf>

Workforce planners must also be cognisant of the fact that some staff, including doctors, do not want to see the scope of their practice expand. Some believe that being overstretched in this way affects their ability to provide quality care to their patients. A focus on a reduction in bureaucracy, to make best use of valuable staff time, and adequate workforce supply would be more beneficial than the merging of clinical responsibilities.

Leave

Many doctors continue to face practical obstacles when it comes to trying to take their leave at a suitable time. Sufficient time to rest and recuperate away from their often highly stressful and tiring jobs is essential. Doctors should be assisted to use their leave in ways that facilitate work-life balance, whether that means taking time off during school holidays to be with family or when moving house. The 2016 doctor in training contract does include a stipulation that leave should no longer be fixed into rotas, and that requests must be granted for significant life events, but this contract only applies to some trainees in England. It will also require a major cultural shift to ensure that the benefits of these new clauses are actually experienced by all junior doctors.

Credentialing

In relation to credentialing, it is vitally important to preserve the current specialty structure, respect the role of the Royal Colleges and Faculties and maintain the level of the CCT (certificate of completion of training). More limited amendments to training pathways, if needed, should be made by the Royal College and Faculties themselves. Consequently, we have [called](#) for a model of credentialing that does not undermine the CCT level or the coherence of specialty training programmes.

Additionally, we support the GMC position that credentials should not 'compete with, overlap or dismantle CCT training programmes'. Agreement among stakeholders and the profession should be required for any future change of approach involving credentials. Any greater use of credentialing must remain subject to GMC regulation, within a GMC framework, and must be developed and lead on by respective Colleges.

If they are to become a reality, a suitable solution would be for future credentials to be acquired outside CCT level training. This would still maintain CCT standards whilst offering other qualified doctors or clinicians opportunities to develop in other clinical and non-clinical areas of interest.

Point of registration

It is critical that the quality of medical education and training and standards of patient care are maintained. Anyone who attains full registration in the future must have met the standards of competence required to complete the first year of the foundation programme.

Given the Mutual Recognition of Professional Qualification requires medical school to last a minimum of five years, of which the first year of the foundation programme can qualify as one, any changes to the point of registration would mean that postgraduate training programmes that attract to experienced professionals will become less appealing. This is because a change to the point of registration would make these courses longer and, therefore, more expensive, acting as a strong disincentive for this vital supply of doctors.

We believe that unless there is an associated move to lengthen medical school programmes, an attempt to incorporate the clinical experience currently provided in the first year of the foundation programme into undergraduate curricula would lead to a reduction in the level of competence required for full registration.

The first year of the foundation programme provides opportunities for medical graduates to participate in and to provide diagnoses and treatment under close supervision. This cannot be matched by current clinical placements in medical school. It allows graduates to learn through experience and to increase their confidence in their abilities. It also creates significant opportunities for trainers to identify and support trainees who may be struggling with their clinical responsibilities.

Doctors undertake some of their most intensive and useful learning during this year. The pressure of responsibility helps them to obtain crucial skills relating to real decision making, working under pressure and leading a clinical team. We think it is unrealistic to expect that changes to the undergraduate curriculum could offer an adequate substitute for this vital experience.

Furthermore, the transition from medical school to medical practice is one of the most challenging stages of a doctor's career. It is likely that, if provisional registration were scrapped and the point of full registration moved to graduation, this transition would become even more difficult and patient safety would be put at risk. We do not, therefore, support any proposal to move the point of full registration to the point of graduation from medical school.

Scope of practice

There is support amongst medical branches of practice for doctors and other clinicians to transfer between primary and secondary care to ensure better management of supply and demand, and also to utilise the skills and potential availability of staff where rota gaps and vacancies exist.

For example, shortages of GPs will inevitably lead to increased demand across secondary care and vice versa. Reduced patient access to primary and community care services therefore increases the likelihood of patients presenting at GP out of hours providers, A&E departments or requiring ambulatory services. This is much costlier at the point of presentation compared to the average annual payment per patient received by GP practices (£151.37²¹ in 2017), with an average of six consultations per year (amounting to around £25.25 per appointment). It can also be expensive in terms of how advanced a patient's condition is and the intensity of the treatment(s) they subsequently need.

If GP practices could offer sessional work to doctors from across the NHS, this could be one solution to the problem of long-term GP vacancies. It would help to alleviate pressures in both primary and secondary care by ensuring patients receive preventative care in community settings. It should also have the effect of reducing workload, retaining doctors of all ages in practice and improving the attractiveness of a career in General Practice to medical undergraduates and foundation doctors.

The decision to ensure PA trainees learn general clinical skills so that they can work across both primary and secondary care is commendable. Nevertheless, it is vital that there is a defined scope of practice for all MAPs (medical associate professions), in all provider settings, due to the significant differences between those settings, as well as clear supervision arrangements for all members of the doctor-led multi-disciplinary team. Not least, this will help to ensure that regulation standards are consistent and do not deteriorate, and that clinical staff can obtain personal professional indemnity. It will also give doctors, other senior clinicians and non-clinical staff the confidence to delegate clinical tasks without doubts about staff competency or fears of being unreasonably held accountable for clinical negligence concerns.

Knowledge sharing

Developing initiatives that enable doctors with different levels of experience to share their expertise and learn from each other should help to secure future generations of senior doctors, as well as retain older doctors, by giving them the flexibility of both clinical and non-clinical NHS roles. Similarly, this can be applied to other clinical and non-clinical professions and is key to maintaining training standards and workforce supply through mentoring, coaching and the presence of role models.

21 [NHS Payments to General Practice, England, 2016/17](#)

3. How can we ensure the system more effectively trains, educates and invests in the new and current workforce? Areas to explore may include:

Improved workforce planning

The workforce planning process must be robust for the system to effectively train, educate and invest in the new and current workforce. High quality care depends upon having the right mix of people, with the right skills and qualities, in the right place at the right time. The system should aim to provide a reliable and affordable supply of sufficient numbers of staff across the range of professions that make up the modern NHS workforce.

The Local Workforce Action Boards (LWABs), which are responsible for the workforce elements of STPs, must have coherent and properly resourced workforce plans for care delivery in their area. This should account for long lead times for training of staff, especially doctors, combined with changing social and technological practices. As previously mentioned, for LWAB's to develop robust workforce plans, they require accurate workforce data to support future staff projections and the planning of training, education and CPD capacity. This will also help to define the requirements for medical, clinical and non-clinical training and education provision in each area.

Differential attainment in medicine

Our work on differential attainment has reinforced that the medical training model is still largely based on a standardised learning experience, which can put BME students and trainees at a disadvantage. Greater work needs to be done to make medical training pathways more inclusive for students of all backgrounds – for example:

- helping clinical teachers and supervisors in developing supportive educational relationships with their students and trainees, particularly those from minority ethnic backgrounds;
- early intervention and support for students who are struggling with medical training – e.g. facilitating mentoring, study groups, and networks for BME medical students.

The GMC's focus on equality and diversity in its new standards for postgraduate curricula is welcomed, and we hope that both national and local medical and training bodies will reflect this priority in new curricula and training programmes.

BMA focus groups with student and trainee doctors have identified that female doctors, particularly those in specialties where there are low numbers of women, would value more mentoring to encourage progression in their careers. Both men and women also stated that they would value information and support early in their medical careers about options on training and working LTFT (less than full time) and taking parental leave.

Foundation programme

While the work that HEE has highlighted on the foundation programme is welcome, the degree of variability regarding placements in specific specialties is damaging to the aspiration to recruit to set specialties, e.g. in psychiatry foundation placements doctors often work on a general medical rotation. Many simply find themselves providing the medical care of these patients, e.g. doing necessary blood tests, performing ECGs, reviewing chest pains, treating chest infections etc, rather than gaining important experience in psychiatric presentations. Ensuring that foundation doctors are given high-quality and enriching placements through a greater degree of quality assurance will ensure that outcomes are cost effective for the NHS.

Education and training reforms

We have worked constructively with HEE, the GMC and the AoMRC to address educational concerns that have affected junior doctors' training and working conditions in England. This has culminated in a range of projects to improve doctors' NHS training experience, which were set out in HEE's 2017 [Enhancing Junior Doctors Working Lives](#) report.

This work, which is ongoing, has made progress in several areas, although further improvements are necessary. These include, but are not limited to:

- Providing greater transparency around the administration of the revised study budgets system to ensure allocated funding is used entirely for medical training;
- Taking forward step-on, step-off training to improve flexibility. Improving the ability for trainees to take breaks from training while maintaining clinical competence through working will reduce pressures on other areas where there are breaks in training. This would also enable SAS and trust-grade doctors to re-enter training and work towards filling consultant vacancies where they choose to do so;
- Giving educational supervisors more time and support to mentor junior doctors. This will include careers guidance, ARCP (Annual Review of Competence Progression) advice and wider personal and professional support;
- Improving flexibility and access to training benefits patients, doctors and the NHS; this should not be reserved exclusively for doctors in training. Improving education, training and flexibility for all doctors is crucial to solving issues in the medical workforce.

In relation to HEE's support of the current 'modern firm' pilots, which are designed to enhance the supportive training environment, pastoral relationships and continuity of care associated with the old 'firm' structures, it is right to fully consider how such an approach could be utilised to allow for more meaningful relationships to improve training and supervision and foster a genuine sense of mentorship. However, there must not be a return to a system, based on old ways of working, where junior doctors routinely put in extremely long hours.

Although there has been some debate on the right name for doctors in postgraduate training roles, and the perceptions and implications of the title 'junior doctors', ongoing discussions should not distract from making genuine improvements to the working lives of these doctors. The morale of junior doctors and how they view their own position within the wider workforce will not be improved by simply changing terminology.

It is right that the consultation document notes that more needs to be done by NHS Employers, colleges, NHSI and the GMC to ensure consistent, full access to training opportunities, which meet the needs of junior doctors and the needs of the service.

SAS doctor workforce

We welcome the commitment to develop the existing workforce that may not be in training, although as already mentioned earlier in this response, defining doctors who work at this level in a negative way (Non-Training Non-Consultant) is counterproductive in terms of workforce retention and morale. Direct actions to support doctors to re-enter training, improve their scope of practice or develop their skills and competencies would be of great value to the NHS.

Exposure to specialties in training

We welcome the decision to increase the number of medical training places by 1500 and the subsequent [announcement](#) that new medical schools will open in under-doctored areas, i.e. Sunderland, Lancashire, Lincoln, Canterbury and Chelmsford. However, a comprehensive workforce strategy needs to ensure that the training experience provides the best opportunity of retaining doctors within the workforce and maintaining interest in the full range of medical careers on offer.

There is clear evidence that the future career decisions of medical undergraduates are heavily influenced by the frequency and quality of their exposure to training placements within the NHS. It is therefore important that training and education opportunities are both consistently funded, organised and not lost due to service provision demands. This has been recognised through the BMA's involvement with HEE's ongoing multi-agency workstream led by Professor Val Wass, which resulted in the *By Choice, Not By Chance* publication in 2016. We strongly support inclusion of the report's recommendations in the new national workforce strategy.

Specialties that struggle to recruit can suffer from entrenched misconceptions about the nature of the work and need to take steps address these views. For example, it is essential that the General Practice Forward view commitment to increase training exposure to general practice is implemented, as both medical students, nurses and other allied health professionals are more likely to consider a career in general practice and think positively about it as a specialty if they have had sufficient opportunity to experience the work.

Geographic variation in medical recruitment

As employers in shortage areas struggle to attract sufficient numbers of doctors, it is important to understand how doctors choose their career paths, both in terms of specialty and location, in order to identify solutions. We are aware that many medical graduates tend to continue to train and work in the region of their medical school, particularly during foundation years. However, certain parts of the country appear to be less attractive than others, which could impair the NHS' ability to train doctors in these areas. To support recruitment efforts, the strategy must recognise this and investment is needed to ensure that high-quality training placements are provided consistently across geographical areas.

Generalist training

The population of the England 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 broader generalist skills to treat complex patients in a holistic way.

There are already training programmes for specialist-generalist care, geriatric care and general paediatrics, and, like doctors in other specialities, a large proportion of physicians with general internal medicine training combine this with a specialist interest. The need for more generalist care should first be met by existing groups of doctors – GPs and hospital generalist specialities – with investment in and sensible deployment of these doctors.

Leadership

We welcome the plans to make the NHS the employer of choice for young people. While not everyone is suited to leadership roles or management, the idea of reinstating something like the NHS Academy/University NHS Staff College could be considered. For example, residential or day team building events could be offered at pinch points in a person's career. These would have a focus on career development, team issues and collective resilience and wider NHS problems.

Extended GP Training

We have previously expressed our support for the principle of enhancing and increasing GP training from three to four years. However, the implementation of this policy should preserve the high-quality nature of training posts and programmes tailored to training needs. GP trainees and their practice placements should continue to be supernumerary to prevent them from being used to fill rota gaps instead of receiving high quality training.

GP partnership training

There should also be adequate training and resources to allow GPs to develop the skills and confidence needed to go into partnerships. NHS England has publicly committed to supporting the GP partnership model, but it requires a much changed, more business orientated skillset that is not currently provided for during GP training.

We also need to give existing partners time and headspace to impart their wisdom to prospective partners, so they can learn the ins and outs of being a partner, understand the ways they can invest in premises and get help to place roots in local communities. This will require bold but value for money resource commitments that enable GPs to either rent affordable premises or access affordable financial lending support via their regional NHS England team. Rather than costing the tax payer money, modest returns could be recuperated over the long term, whilst GPs themselves would effectively be investing in premises that will increase in value throughout their careers.

CPD

During the workforce planning process individual CPD requirements should be aligned with the requirements of the service and of patients. However, there must also be consideration of individual aspirations as this can support retention in the medical workforce.

Delivering CPD and other education opportunities close to an employer's base site reduces travel time and cost. This requires planning and co-ordination between HEE and education providers, as well as ensuring that educational supervisors have access to information about the courses available in the local area.

Mental Health Training

There is no universal mental health training for different health professionals across the NHS, including practice nurses and midwives. For example, [2016 research by Mind](#) found that 82% of practice nurses said they felt ill-equipped to deal with aspects of mental health for which they are responsible, and 42% said they had no mental health training at all. In 2013, [29% of midwives](#) responding to an NSPCC survey²² said they had received no content on mental health in their pre-registration training.

HEE should raise staff awareness of mental health by offering courses that increase knowledge of mental health problems and enhance the skills required to care for patients with mental health problems.

PHE and HEE should improve mental health prevention training in the public health workforce, by ensuring that a substantial part of their training has a focus on promoting public mental health. We welcome the embedding of prevention into the curricula of all health professionals, and investing more in the public health workforce will also facilitate this.

Public Health Workforce

There is a need for greater planning and investment in the public health workforce. We would support an easier mechanism for doctors to maintain dual accreditation as a public health and clinical specialist. This would maximise their contribution to the health of the population while maintaining their own career prospects.

Given the important role these doctors play in the prevention of and protection against ill-health, it makes sense for them to work closely with NHS colleagues across general practice and primary care to keep patients well. This would also give them opportunities to take up clinical sessions as and when they wished. Giving them a remit to consult across GP practices to help streamline processes for dealing with outbreaks of flu, for example, could save valuable clinical time and resources in both primary and secondary care and ensure patients in greatest need get timely treatment.

We also believe that a single organisation should hold honorary contracts for academic doctors working in public health. This issue needs to be resolved as quickly as possible. Public health academics who undertake research related to the NHS need to be properly supported to do this through new contractual arrangements and fair terms and conditions.

22 NSPCC, [Prevention in mind All Babies Count: Spotlight on Perinatal Mental Health](#) (2013)

Technology

The NHS turns 70 this year. Since its inception, new findings and innovations have consistently transformed the way care is delivered. However, the digital revolution has changed healthcare faster and more dramatically than at any other stage. Yet digital healthcare is not a requirement of medical training or education at any stage for doctors who work in the NHS.

Digitalisation, artificial intelligence, genomics, big data, robotics, virtual reality, tissue engineering and 3D printing are all already in use in the NHS, as well as countless other innovative tools. It is very likely that in the next 10 to 20 years the use of these tools will increase, but we are not currently preparing our medical workforce for these changes.

During their education and training, the doctors of the future must be exposed to these emerging technologies so they are familiar with them when they start providing patient care. This is particularly important in an age where patients have greater access to information about their treatment, and treatments that are available or in development. Medical schools are well positioned to provide this exposure, which in the long term will significantly benefit doctors and patients.

HEE funding

We remain concerned that continuing DHSC (Department of Health and Social Care) cuts to HEE's budget will have a significant negative impact on general practice and specialty training. As a result of the reduction in its administration and education support budgets, HEE has had to free up resources to reinvest in its priorities. Any funding cuts to medical training will have an immediate and long-term impact on the health service and the profession. In terms of general practice, many surgeries already provide training at a financial loss, with the current trainers' grant unable to support the costs associated with GP training.

The overall cuts that have been made could threaten the viability of existing regional structures, including the basic administration of training and critical targeted interventions provided by professional support units. This comes at a time when local offices are being asked to do more. Realising commitments made as part of discussions arising from the junior doctor contract negotiations will take time and effort, e.g. progress towards meeting deployment notice targets that are critical to enabling employers to provide adequate notice of rotas to trainees, and local offices will also be required to actively manage the quality of training places, which is becoming ever more challenging with growing services pressures.

4. What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

Ways of working

The consultation includes a welcome focus on the idea of the NHS providing 'careers' rather than 'jobs'. Providing prospective doctors and staff with a framework for career progression will have a positive impact on recruitment and retention, particularly where it can be combined with opportunities to work flexibly or to pursue portfolio careers.

Ever-increasing workload and the push to work more antisocial hours to manage demand has an additional impact on women, single parents and working couples, as they also face spiralling costs of childcare and limited access to out-of-hours childcare.

LTFT (less than full time)

LTFT training assists in the recruitment and retention of trainees and leads to increased satisfaction with training ([Less than full time training and the National Training Surveys, 2016, GMC](#)). LTFT doctors describe having "increased enthusiasm for work" and a "better work life balance" ([Do part time women doctors make a positive contribution to the NHS? \(BMJ, 2015\)](#)). 91% of less than full time trainees are female. The vast majority of those trainees say that they chose less than full time training due to childcare commitments, disability, illness or health conditions ([GMC, 2017 NTS Survey](#)).

LTFT is also increasingly popular. More men and women doctors would like to work more flexibly and identify work-life balance and control over workload as a priority in their careers ([Review Body on Doctors and Dentists Remuneration Report 2017, BMA Sessional GP survey 2017](#)).

More work needs to be done to remove the barriers to working on a less than full time basis. HEE's own 2017 report highlights that training issues include "limited opportunities for doctors to train flexibly, including structural and cultural barriers to less than full time (LTFT) training". Difficulties highlighted by trainees include:

- completing a complex application process, fitting into restricted criteria and having their application assessed. They can only work LTFT if their application is passed by the HEE local office
- the 'slot share' training arrangement, which ties trainees to a rigid proportion of FTE (full time equivalent) training, and creates difficulties for trusts needing to make up the rest of the hours. This does not allow doctors to work more/less hours when needed, e.g. during term-time when children reach school-age or when their health improves (for doctors with a fluctuating health condition/disability);
- the ability to do locum work when time permits (see above) – whilst regulatory restrictions have been removed, trainees continue to report barriers at HEE local office level;
- experiencing major difficulties to working on an LTFT basis in some specialities, e.g. stigma, undermining behaviour and negative attitudes from staff and managers.

Consultants also describe struggling to work less than full time ([Flexibility and Equality Survey Results 2012, Academy of Medical Royal Colleges](#)). Barriers include multiple roles and workload preventing reduction in working hours, and the inflexible attitudes of senior colleagues and managers.

Many SAS doctors and consultants have told us that they would like to work on a more flexible basis later in their careers and potentially delay retirement. This could significantly help in alleviating staffing problems. Members have also raised concerns about the intensity of workload/out of hours working and the pensions implications of delaying retirement/returning to the NHS after retirement. It is positive that HEE, NHSE and NHSI "plan to

improve flexible working offers for staff nearing retirement”, and we are keen to work with others to establish more national and local initiatives as soon as possible.

We support the increased flexibility offered through the LTFT pilot in emergency medicine²³, specifically the creation of a category 3 for LTFT training, where no reason needs to be given to qualify for flexible working, and want to see the pilot extended to other specialties.

Flexible working and careers

Plans to increase flexibility in medical careers are welcome. We support the extension of these arrangements to other specialties where trainees struggle to work flexibly. The GMC’s [State of Medical Education and Practice 2017](#) report shows a wide variation in LTFT training within specialties – pediatrics (21% of trainees worked LTFT in 2017), general practice (17%) medicine (11%) and surgery (5%). BMA research highlights that career and specialty choices are heavily influenced by perceived control over workload and opportunities to work flexibly, particularly for women ([BMA Sessional GP survey 2017](#) [BMA cohort study 2017](#) [BMA Junior Doctors Career Survey](#)).

However, it is critical that doctors are taking the decision to work flexibly for positive reasons and are not compelled to do so by rising workload. A King’s Fund survey highlighted that the most commonly cited reasons for GPs not working full time were workload pressures and the “intensity of the working day” not “family commitments” or work-life balance. ([Understanding pressures in general practice](#), King’s Fund, 2016).

Understanding and addressing issues such as the gender pay gap, equality and work-life balance is key to the profession’s ability to recruit and retain the future workforce. As the latest findings from the BMA’s cohort study demonstrate²⁴, junior doctors are increasingly making changes to their careers, including switching specialty, opting for a career break and leaving the NHS. Ensuring the NHS is able to retain its medical workforce requires a long-term system of rewards and benefits, which address the need for more doctors to train on a flexible basis, to work part time or take time out of their careers at certain stages in their lives without being unfairly penalised for doing so.

GP retention

Recognising the trend amongst retirement age GPs to undertake portfolio careers, and the tendency for newly qualified GPs to undertake locum and sessional work, a virtual practice model could be developed that draws on elements of the GP chambers model and the success of the Somerset model from the GP Career Plus Scheme pilot. This model would provide GPs with flexibility, control of their working life and the ability to experience a range of work (in and out of hours) across multiple practices and health providers.

We have recently submitted a more detailed proposal for the virtual practice model and other GP recruitment and retention ideas to NHS England and the Secretary of State. These include:

- ensuring there is parity of funding for medical training and education across both primary and secondary care;
- providing a comprehensive NHS-wide occupational health service for all medical, clinical and non-clinical staff who are working under intense and pressurised conditions to keep them healthy, fit and in work; and
- developing a scheme that enables both
 - prospective GP partners to learn the ins and outs of partnership and
 - existing partners, who generally work long hours, to take time out of practice for respite and tailored professional clinical or non-clinical development.

²³ HEE, [Higher Emergency Medicine LTFT Pilot](#)

²⁴ British Medical Association (2017) BMA cohort doctor study, available at <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/cohort-study>

GP practices also require funding and organisational development support to adequately develop medical, clinical and non-clinical practice staff. This includes investment to cover the costs of professional indemnity for new clinical roles. In turn, staff members need time away from patients to undertake development opportunities. This means practices will need greater access to suitable alternative provision for patients during day time hours.

Working Time Regulations

It is vital that the UK's decision to leave the EU is not used as an opportunity to weaken or repeal important laws that protect doctors from being overworked. Namely, the WTR (Working Time Regulations) and the limit of a 48-hour average working week, rest breaks and statutory paid leave. Provided rotas are planned properly, it is perfectly possible to deliver high quality training without needing to break the 48-hour average weekly limit. In an increasingly pressured system, any attempt to recover positive elements of the 'firm' training structure must not be done at a cost to the safety of both doctors and patients. Excessive fatigue and burn out are all too common among doctors and other NHS clinicians, and removing legal safeguards risks making medical and clinical professions less attractive to staff who are rightly not prepared to sacrifice their own wellbeing and time with family for their job.

Bullying and harassment

As the strategy identifies, there is a need to ensure all health professionals are protected from bullying and harassment. The scale of workplace bullying and harassment in the NHS is a significant issue. 22% of hospital doctors and dentists say they have been bullied, harassed or abused by a manager or colleague in the last 12 months (NHSE Staff Survey 2016). Broken down by branch of practice, this affects:

- 24% of SAS doctors
- 23% of consultants
- 20% of trainees

Our three-year project on bullying and harassment is now in its second year. We are seeking to raise awareness, help drive culture change, improve support for individuals and identify better resolutions when issues arise. We have endorsed the NHS Social Partnership Forum's 'Collective Call to Action', along with employers and other trade unions at national and regional levels, and also work collaboratively with Royal Colleges on actions/campaigns to address bullying and harassment in medicine. We hope to engage with HEE and others on ways in which medical education and training providers can contribute to changing culture and ensuring that bullying and harassment are no longer tolerated in the profession.

Volunteering abroad

There are many benefits²⁵ to volunteering for healthcare professionals; for themselves, their careers, their patients, the NHS and the country to which they choose to go. The UK has a long history of international healthcare initiatives, particularly in developing countries, with UK doctors contributing their knowledge to healthcare systems around the world. This ongoing commitment and support is vital for developing nations, which continue to improve thanks to the willingness of doctors to share their skills and experiences and contribute to the education and training of colleagues in developing countries.

With an increasingly ethnically diverse population, the NHS benefits, in both the long and short term, from having staff with cross-cultural experience and awareness. Voluntary positions give doctors exposure to a diverse spectrum of diseases, experience of working in small multidisciplinary teams and the opportunity to gain skills in allocating resources and planning and monitoring healthcare initiatives. These are useful and transferable skills needed to work in the NHS.

25 [BMA guidance on volunteering abroad](#)

However, despite these benefits, healthcare professionals can face barriers when trying to pursue volunteering opportunities. This includes not being granted time out from training/employment or obtaining formal recognition of volunteering for professional development purposes²⁶. To make careers more attractive and help retain talented and engaged individuals, it is important that the appropriate infrastructure is in place, including investment and training, to support volunteering activities and enable doctors to pursue these valuable opportunities.

Academia

It is in each patient's interest that all doctors understand research and research methodologies, and it is in the interests of the NHS workforce that all doctors have the opportunity and time to undertake or participate in research if they wish to. Opportunities for doctors to pursue research opportunities can play an important part in ensuring that the NHS is an attractive prospective employer. Similarly, it is vital that medical academic staff are retained to maintain the quality of education for medical students and trainees. These ideas are expanded on in the BMA publication *Every Doctor a Scientist and a scholar*.²⁷

Accessibility

The move by HEE to improve the accessibility of training for disabled doctors, doctors with a medical condition and doctors who are caring for disabled relatives is very welcome. We would like to see greater flexibility in the system of IDT (inter-deanery transfers) and moving between placements within a deanery / local HEE team area. Under the current process, trainees have only two windows per year to apply for a transfer. If trainees or their relatives for whom they care experience a sudden deterioration of health, they are forced to put their training on hold whilst waiting for a transfer window. This does not always result in a transfer either, so we are keen to see requests for reasonable adjustments approved more frequently.

Maternity/paternity/childcare

The provision of greater opportunities for doctor spouses/partners to train in the same region is also welcome. It should be noted, however, that other changes to the training/working environment would also support doctors who have children, e.g. increasing the incentives for parents to take shared parental leave and providing access to quality, affordable out-of-hours childcare. HEE can also provide leadership and facilitate culture change to overcome the barriers that many women and men wanting to work LTFT still experience, including being able to leave work on time and receiving more notice of rotas to work around childcare/caring commitments ([Maternity/Paternity Survey Results](#), The Academy of Medical Royal Colleges, 2016).

²⁶ [Academy of Medical Royal College statement on volunteering](#)

²⁷ [Every Doctor a Scientist and a Scholar, 2016](#)

5. How can we better ensure the health system meets the needs and aspirations of all communities in England? Areas to explore may include:

Locally Integrated care

As locally integrated care continues to develop through STPs, ICSs and potentially ACOs, NHS workforce roles are changing and boundaries between sectors are blurring. The extent to which this happens will vary between STP footprints and wider areas, including devolution areas such as Manchester and the Surrey Heartlands.

Depending on the degree and scope of local integration, as well as political imperatives, certain areas will also have different requirements compared to others. As a result, it is important that the national workforce strategy recognises the potential for regional variation in the needs and aspirations of communities. This will necessitate comprehensive engagement with local services, as well as the integration of local planning through LWABs.

New care models also raise the possibility of contractual change to reflect new organisational structures created through integration. Whilst we do not believe that staff contractual change is required to deliver integration, whatever changes do occur must retain NHS terms and conditions for future doctors and clinicians.

Self-care

To shift NHS focus towards preventative healthcare rather than expensive responsive crisis treatment, we need a health literate population that understands when to care for itself, when to seek medical or clinical advice/treatment and where to visit. Without investment in educating the public, e.g. national campaigns, signposting to online advice etc, simply stating that the focus should be on prevention will mean this remains only an aspiration.

Differential Attainment/Widening Participation

Medicine is still behind other professions in attracting students from more diverse and lower socio-economic backgrounds. 73% of doctors are from privileged backgrounds; just 6% come from working-class backgrounds. This compares to 12% of chief executives and 12% of journalists ([State of the Nation 2017: Social Mobility in Great Britain](#), Social Mobility Commission).

Socio-economic status is inextricably linked to race in the UK. 75% of Britain's BME community live in 88 of Britain's poorest wards ([The Black Manifesto, 2010](#)). Longitudinal studies have also made this link amongst medical students. 15% of black applicants and 31% of Asian applicants to medical school with parents in professional/managerial occupations resided in areas recognised as the most affluent, compared to 72% of white applicants ([Monitoring the widening participation initiative for access to medical school: are present measures sufficient?](#) Medical Education 2006).

There is strong evidence that doctors and medical students from minority ethnic groups have poorer educational outcomes on average compared to their white counterparts, even after accounting for a range of other characteristics, including academic performance prior to beginning medical school ([Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis](#) Katherine Woolf et al BMJ, 2010).

There is work to be done to ensure national and local/regional initiatives are complementary, e.g. Aspiring Professional Programmes, Black Medical Society, Melanin Medics and Medlink Free. Further consideration needs to be given to the range of factors that prevent people from poorer or more diverse backgrounds studying medicine – including financial and cultural factors, as well as academic constraints ([The Right Mix](#), BMA, 2015).

Carers and volunteers

As the consultation notes, workforce planning must give more consideration to the important role that carers and volunteers play in health and social care. While the BMA agrees that they should not become a substitute for professional staff, there is scope for more creative thinking in this area.

The workforce strategy needs to look at ways in which the focussed, innovative use of non-professionals can have wide reaching impact. Emphasis should be put on the potential of social prescribing. As highlighted in an NHS England case study of the Rotherham Social Prescribing Service, there can be significant benefits for patients from having access to additional non-clinical support options via GPs, as well as reductions in A&E attendance, outpatient appointments and inpatient admissions.²⁸

Given the high percentage of adult social care jobs carried out by the voluntary sector and the predictions of a “workforce demand increase of 14%” by 2025, a comprehensive NHS workforce strategy need to consider how this voluntary contribution can be optimised for the future. This applies to areas such as the ‘5 Year Forward View’ priority to “support people to live with and beyond cancer” and ‘End of life care’ particularly for people dying at home.

The contribution that charities make in this area can be enhanced by providing them with the opportunity to carry out better planning, for example year-to-year funding for wellbeing co-ordinators is too precarious to allow them to reach their full potential and longer contract periods should be offered.

28 [NHS England, 10 High Impact Actions, case study 68](#)

6. What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?

New clinical roles and skill mix

We agree that '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 with regard to 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. That is not to say that other longer term "on-the-job" learning routes to becoming an advanced clinician should be dismissed, but standards, competencies and regulation must be consistent.

Apprenticeships

The national plans for apprenticeships have caused anxieties among medical professionals. Junior doctors have particular concerns about how this may impact on their education, training and future career opportunities. Whilst we recognise that it is important for apprenticeships to offer graduates attractive clinical roles with clear career progression opportunities, some of the apprenticeship standards indicate clinical roles with total autonomy and responsibility for patient care episodes. Such scenarios, where clinicians across the multi-disciplinary team are not led by a doctor with ultimate responsibilities for patient diagnosis and treatment, could well make the medical profession a less attractive proposition to both under and postgraduates from the UK and overseas. For some, they fear this could exacerbate recruitment problems further still and reduce medical expertise vital to high quality patient care and recovery.

Wellbeing services

Providing wellbeing services to a workforce inarguably helps to keep staff healthy and in work. Making cuts to such services, which has consistently happened across England since the introduction of the 2012 Health and Social Care Act, makes no practical or economic sense at all. Poor wellbeing leads to ill health, a need for staff to take time off work and increased requests for employed staff to take on extra shifts. This risks their health further still and can lead to increased locum use to cover staff rota gaps and vacancies. The intensity of workload pressures for doctors, clinicians and other NHS staff is currently such that the risk of staff needing crisis support, care and treatment is high. NHS England has recognised this through the creation of the NHS GP Health Service, but it is important that all NHS staff are able to access the health and wellbeing support they need to ensure the wider population continues to receive high quality care when accessing NHS services.

A comprehensive occupational health service delivered by specialists for all NHS staff is not only vital to keeping the workforce fit, healthy and in work, but also more cost-effective than lost sick days, staff rota gaps, extensive use of locum cover and early retirement / staff lost to other professions or nations around the world.

Generational trends and women in the workforce

Generalisations about the preferences of 'Millennials' or 'Generation Y' should not be used to divert attention away from long standing concerns about gender equality and the unequal distribution of caring responsibilities. In looking at generational trends around working hours, it is important to avoid making a simplistic evaluation of more long-term developments in society more widely, namely the increase in women's participation in the workforce.

The new national workforce strategy presents a perfect opportunity to recognise and acknowledge the effects changes to workforce arrangements may have on women. The historic gender disparity in the medical profession has been re-balanced, with women now making up 57% of junior doctors. This development has hastened long overdue consideration of how traditionally intensive medical training patterns can be made more flexible to allow trainees to combine work with caring responsibilities. Our cohort study findings show that women trainee doctors are far more likely than their male peers to work and train on a less than full-time basis because of children or other caring responsibilities. Women are also more likely to switch into the specialties that are most amenable to flexible and part-time working. Our evidence shows that, for many women, this switch is directly linked to having children. Men, on the other hand, are far less likely to switch specialty after they have children. Recognising and acting upon this will make workforce planning more reliable.

7. Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?

Integration

As integration is intended to break down barriers between existing care structures, NHS staff will need the training and capacity to be able to co-operate and communicate across traditional boundaries. This includes specific issues such as onward referral within secondary care, avoiding patients being unnecessarily referred back to primary care and wider improvements to the primary-secondary care interface.

Technology

As technology continues to change how healthcare is delivered, it is vitally important that we empower our medical students and trainee doctors to be ready for a medical landscape that operates very differently to the one they are graduating into. It is important to ensure they feel comfortable using new technology and can operate cutting edge technological advances. This will ensure the NHS remains a world health care leader. We would like to see the NHS Digital Academy expand beyond its first intake of 300 Chief Information Officers and Chief Clinical Information Officers so that the use of digital technology becomes part of business as usual rather than a separate part of the workforce.

Safety and training

The system would benefit from an update on the [Improving Safety through Education and Training](#) report. HEE, NHSI and other arms-length national bodies should articulate intervention strategies where the culture remains poor. The original report stated that 'healthcare staff involved in patient safety incidents can often become a 'second victim' if not supported emotionally by their organisation in the aftermath. Healthcare workers choose their profession because they want to improve the wellbeing of others. When their care results in patient harm, it typically leads to guilt and emotional distress'. If this remains the case, in a high risk, pressurised environment such as the NHS, this is likely to lead to further patient harm as overworked and stressed staff who do not receive appropriate support from their employers can make mistakes.

8. What policy options could most effectively address the current and future challenges for the adult social care workforce?

We have current policy on the child and adult social care workforce. This includes a commitment to working with fellow trade unions to secure a living wage for care workers and nationally agreed terms and conditions of service. We also support efforts to increase the number of care workers and we believe this also requires incentivisation. For example, since remuneration is currently insufficient, support with cost of living expenses would make the care worker role more attractive.

Policy Directorate

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