Caring, supportive, collaborative

Doctors’ vision for change in the NHS

Interim report prepared for ARM 2019
Foreword from Dr Chaand Nagpaul

"What needs to change to improve the working lives of doctors in the NHS?"

This is the question I asked when we launched the Caring, supportive, collaborative project in early 2018. I issued a call to our members to share their experiences, views – and critically, solutions – for a new blueprint for the NHS; one that is underpinned by adequate funding and terms and conditions for doctors. One that puts a caring and supportive culture, collaborative working and high-quality patient care at its centre.

As the only medical organisation that represents doctors and students from across the entire breadth of the profession and with access to the experiences of over 150,000 members working in today’s health service, we are uniquely placed to influence government and policy-makers with proposals that reflect the true voice of doctors.

Our backdrop is a health service that is grossly underfunded, under-doctored and under-bedded. Doctors feel that they are increasingly expected to treat patients in an unsafe, unsupportive environment, in which a persistent culture of fear and blame stifles learning. This is contributing to a vicious cycle of low morale and poor rates of recruitment and retention, resulting in endemic workforce shortages.

These were the findings from the BMA’s all-member survey, published in September 2018, of the views of almost 8,000 doctors working across the health service:

- nine in 10 doctors say they work in an environment in which they are fearful that systemic pressures and lack of capacity will cause them to make an error
- even worse, more than half of doctors worry that they might be unfairly blamed for such an error and, as a result, nearly 50% say they practise defensively
- 60% of doctors surveyed say the quality and safety of patient care is compromised as a result of problems and barriers between primary and secondary care – and yet over nine in 10 doctors in England want GPs and hospital doctors to work more collaboratively and in a coordinated manner.

These results provided the basis for consultative workshops with BMA members across the UK; from Plymouth to Newcastle, Leeds to Birmingham, Cardiff, Edinburgh and Belfast, we asked doctors to help us develop innovative solutions to the key issues facing our health systems. I would like to thank all elected and grassroots members who participated in our events. This report is a culmination of that work.

The report – and project – covers three core themes. To describe:

- an NHS that has a culture that is not rooted in blame but supports and encourages learning and improvement, and that is inclusive, with equality of opportunity and reward
- an NHS that has the right organisational systems in place to support collaboration across the interface between different settings, and where taxpayers’ money is spent on delivering patient care – not squandered on transaction costs, fragmentation and bureaucracy
- an NHS that values its workforce and supports doctors to be able to work safely at the top of their licence, with the right skill mix to support doctors to meet the changing needs of patients.

These ideas are just the beginning of our aim to set out clear, ambitious proposals for change in the health service. Drawing on the excellent work that has already begun through the BMA’s current campaigns – such as safe staffing and bullying and harassment – we will use this report to support our call for better working conditions for doctors, establishing a roadmap to an NHS that is truly caring, supportive and collaborative.

Dr Chaand Nagpaul, chair of council
## Executive summary

### A supportive culture

We know a supportive culture is key to providing safe, high-quality patient care. Health systems that support staff are also better places to work. Doctors have told us that the culture of the NHS needs to change if we are to achieve this. It means developing a culture that focuses on the wellbeing of doctors and all staff, and promotes learning. It is also an NHS where diversity is celebrated, everyone feels included and valued, and there is equality of opportunity and reward.

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<td>– Ensure access to appropriate mentors and adequate peer support, particularly for those from minority or under-represented groups</td>
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<td>– Provide proper inductions for overseas-qualified doctors and ensure they have access to ongoing support</td>
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A valued workforce
The NHS is facing a workforce crisis, with too few doctors to meet the growing needs of patients. While the BMA will continue to call for increased resources and expanded recruitment, doctors have told us there are also measures that need to be taken now to improve retention, reduce workload and improve IT infrastructure. A valued workforce is one where everyone who works in the NHS feels part of a properly resourced team, working in harmony and with the right mix of skills and tools to do the job.

Our vision:

| No one should have to work in a consistently under-staffed and under-resourced environment |
| Doctors feeling valued, supported and fairly rewarded throughout their working lives |
| Doctors’ skills being used in the most effective way, as part of multi-disciplinary teams |
| The right IT, equipment and facilities to provide the best care for patients |

Making it happen:

| Make retaining staff a top priority, including dealing with excessive workload, offering flexible working opportunities, altering workload and removing barriers to older doctors playing a bigger role |
| Clarify accountability for safe staffing levels (including, where needed, through legislative change) in each nation of the UK |
| Ensure doctors have clear mechanisms to speak out when staffing has fallen below safe levels |
| Act swiftly to change NHS pension taxation rules that financially penalise senior doctors, ending the current situation in which experienced clinicians who decide to work extra hours are being hit with tax bills greater than the value of the hours worked |
| Set clear definitions and lines of responsibility for new clinical roles, so that these can be introduced in a way that relieves workload, does not impact on junior doctors training and allows doctors to focus on tasks where their expertise is most needed |
| Ensure that all MAPs (medical associate professionals) are regulated and awarded prescribing rights to ensure they can work safely within their clinical teams |
| Introduce non-clinical roles such as doctors’ assistants and medical scribes to help reduce doctors’ workload |
| Make sharing good practice between employers a system-wide priority whenever new roles are introduced |
| Make broadband available in all care settings and ensure the NHS is an early adopter of 5G technology |
| Invest in basic technological infrastructure as a priority to improve workload, morale, retention and patient outcomes |
| Make full digitisation of all patient records a priority to ensure that doctors can put new technology to full use |
| Provide clinicians with access to AI tools designed to support, but not replace, medical decision-making |
| Involve doctors in the design of new tools and provide adequate training in new technologies |
| Harness the workload-reducing potential of AI through tools that promote self-care, provide clinicians with crucial patient information and ease administrative burdens. |
A collaborative structure
Despite a growing need for care to be integrated around the needs of patients increasingly living with multiple morbidities, doctors say they are prevented from providing such joined-up care by bureaucratic barriers, communication gaps and competing organisational priorities. Working in silos is bad for both patients and doctors. Removing obstacles to collaboration can help doctors reduce their workload and cut down unnecessary waste of time and resources. A new, more collaborative approach is needed in each of the four nations of the UK, so that doctors and all NHS staff are empowered to work together across traditional organisational divides.

Our vision:
- Systems that encourage services to work together to achieve shared goals and outcomes, and funding flows that encourage collaboration
- Care pathways designed around patients, not organisational boundaries
- Compatible IT systems that support safe sharing of patient data to improve care
- Involving both those who work in the NHS and the public in decisions about how it is run
- Service planning informed by population and patient need, free from the restrictions of competition legislation

Making it happen:
- Bring together doctors, other healthcare professionals and patients to design systems built on trusting relationships between previously isolated parts of the NHS
- Change how NHS organisations are held to account, encouraging a whole-system approach over narrow organisational priorities
- Create more opportunities for doctors to experience training and working in different settings
- In England, scrap funding mechanisms that incentivise increased activity, and agree new models that encourage joint working
- Develop shared budgets for elements of care that cut across traditional divides between primary and secondary care, including joint prescribing budgets
- Provide funding and support for schemes designed to build professional and social connections between clinicians across traditional working divides
- Work with doctors to spread the use of dedicated phone lines and other forms of two-way communication between GPs and hospital clinicians
- Prioritise investment in fully interoperable IT systems, including a shared record and electronic communication between primary and secondary care
- Explore fully automated messaging and document checking services across health and social care services
- Create a programme of clinically led quality improvement, focused on supporting clinicians and other healthcare professionals to come together to input into service redesign
- Reform legislation in England to remove the requirement to put NHS contracts out to competitive tender
- Support public health services to play a central role in bringing all parts of local health systems together to assess the health needs of their populations and plan services.
1. Introduction

This report sets out the interim findings of the BMA’s Caring, supportive, collaborative project. Its purpose is to inform debate at the BMA’s ARM (annual representative meeting) in June 2019, after which a final report will be published.

The Caring, supportive, collaborative project was set up by the BMA in 2018 with the aim of establishing a vision for change in the NHS informed by the views of doctors across the UK, covering three key themes: culture, workforce and collaboration. This paper sets out that vision, alongside practical solutions, ideas and recommendations to make it a reality.

Asking doctors: what needs to change?

The findings of this report are underpinned by over a year of engagement with doctors of all branches of practice working on the front line of the NHS. We asked doctors across the UK what they feel needs to change in the NHS where they work to improve their working lives and enhance patient care. This programme of consultation included:

- an open session at the ARM in June 2018, at which delegates gave their views on the challenges facing the NHS across the themes of culture, workforce and collaboration
- a major survey of over 8,000 doctors and medical students across the UK, the findings of which were published by the BMA in September 2018
- a series of 15 local and regional consultative workshop events held in England between November 2018 and May 2019
- a workshop with members of the BMA’s UK council held in January 2019
- discussions at the BMA’s national councils in Scotland (March 2019), Wales (April 2019) and Northern Ireland (February 2019)
- input and feedback from UK-level branch of practice committee meetings
- extensive engagement online and through social media, including ‘vox pop’ videos of members putting forward ideas for change, and infographics setting out the findings of our survey report.

The aims of the project have also been taken forward through a range of initiatives across the four nations of the UK, including:

- work across the UK on safe staffing. This includes engagement with the Welsh Government and NHS Wales Employers through the Safe Staffing Levels Task and Finish Group and lobbying around new legislation, passed in May 2019, on safe staffing in Scotland
- the development of a vision document for secondary care in Scotland and a strategy for consultants in Northern Ireland, both due to be published later this year
- work across the UK on tackling bullying and harassment in the NHS, including a project on Promoting Positive Workplace Culture in Scotland
- ongoing work to influence the implementation workstreams for the inquiry into hyponatraemia-related death, particularly around the proposals on individual duty of candour with criminal sanctions, in Northern Ireland
- roundtable meetings on each of the three themes of the project in England with senior representatives from the Department of Health and Social Care, NHS England and NHS Improvement as well as NHS Employers.

Doctors’ vision for change

Throughout this, doctors have told us that radical change is needed if we are to build an NHS that is truly caring, supportive and collaborative, where doctors are valued, and patient safety is prioritised. Informed by our engagement with doctors across the UK, the BMA has developed a vision for the future of the NHS, set out below, which articulates the key changes doctors want to see.
The BMA’s vision for change

A supportive culture, where doctors work in an environment that supports their wellbeing, promotes learning and encourages the development of systems which improve safety and quality of care – and where diversity is celebrated and there is equality of opportunity and reward. This means:

– a shift in culture to recognise that staff wellbeing is essential to good patient care
– a learning culture in which staff are genuinely engaged and feel able to raise concerns without fear or blame, knowing that these will be acted on to improve care and safety
– a compassionate working environment in which staff treat each other with respect
– a fair and proportionate system of regulation that understands context and is part of a culture of learning and improvement
– a focus on improving patient care, not hitting financial or political targets.

A valued workforce, where everyone who works in the NHS feels part of a properly resourced team working in harmony and with the right mix of skills to do the job. This means:

– no one should have to work in a consistently under-staffed and under-resourced environment
– clinical teams providing care within manageable workloads
– protected time for professional development, innovation and research
– the right IT, equipment and facilities to provide the best care for patients
– doctors’ skills being used in the most effective way, as part of multi-disciplinary teams
– doctors feeling valued, supported and fairly rewarded throughout their working lives.

A collaborative structure, where doctors and all NHS staff are empowered to work together across traditional organisational divides, so that patients receive seamless care. This means:

– systems that encourage services to work together to achieve shared goals and outcomes, and funding flows that encourage collaboration
– compatible IT systems that support safe sharing of patient data to improve care
– care pathways designed around patients, not organisational boundaries
– full involvement of both those who work in the NHS and the public in decisions about how it is run
– service planning informed by population and patient need, free from the restrictions of competition legislation
– a focus on ensuring patients are cared for in a setting appropriate to their needs.

All underpinned by sufficient funding and resources to do the job, in line with the growing needs of patients.

The following sections of this report set out the ideas and solutions that doctors have proposed to help achieve this vision in each of the three areas: culture, workforce and collaboration.
2. A supportive culture

We need to move away from blame towards a learning and supportive culture

We need an NHS where doctors can work safely and are supported to do their best for patients. This requires a learning environment rather than one in which doctors are fearful of being blamed when things go wrong. There should also be equality of opportunity, respect for diversity and inclusion for all staff.

Unfortunately, our survey revealed that this is currently not the case. An overwhelming majority of doctors (95%) say they are sometimes, or often, fearful of making mistakes. Many (55%) say they are more fearful than they were five years ago. Doctors tell us that the main reason is growing pressure and lack of capacity. Rather than feeling supported while trying to do the best for patients in such pressurised environments, doctors tell us they increasingly fear being unfairly blamed for errors that may occur (reflected in the reaction to the case of Dr Hadiza Bawa-Garba). Half of doctors say this culture of blame is making them practise defensively. A minority (40%) say they are content to report errors. Just over two-fifths say they are now anxious about recording reflective practice.

Box 1: Cath Dixon, GP, Knaresborough, at a BMA member event

'It’s very difficult to keep practising when something’s gone wrong… or when you’ve had a complaint… You’re distracted and it can be incredibly difficult. There’s a big blame culture – trying to find the person to blame for something that’s gone wrong. Unfortunately, in medicine, lots of things don’t go to plan and that’s not because anyone hasn’t tried. As doctors, we are committed to trying to do our best for our patients.'

In his 2013 report on patient safety in the NHS, Professor Don Berwick stated that ‘fear is toxic to both safety and improvement’. He pointed out that in the vast majority of cases it is not individual staff that are to blame when things go wrong, it is the systems, environment, procedures and constraints that they work under. He called for greater transparency, openness about sharing data, and for the NHS to become a learning organisation. To facilitate this, staff need to be trusted and supported to learn, patients need to be listened to, and the safety and quality of care needs to be the overriding priority.

Inadequate resourcing impacts on culture

The impact of the lack of resources and staffing shortages on culture must be recognised and addressed as a patient safety issue. 78% of doctors say that lack of resources is affecting safety and quality of care. Nine in 10 doctors say that pressure or lack of capacity in their workplace is the main reason they are anxious about making errors. Working in a system under pressure also impacts on human interactions and behaviour. It takes its toll on staff wellbeing and mental health. It makes it harder for people to exercise good judgement and be open to collaboration. People being under pressure was the top reason given by doctors (65%) for why bullying or harassment is a problem in their workplace. Workload pressure was also the top reason (59%) for why they did not feel confident raising concerns about patient care.

Proposed solutions

Governments must:
- recognise the link between resourcing and patient safety, and the duty they have to ensure adequate resources.

Creating a culture focused on quality of care starts from the very top

Quality of care and patient safety must be the clear overriding objective for the NHS. As Robert Francis QC said when introducing his report into failings at Mid-Staffordshire, it should be ‘patients – not numbers – which counted’. He found that a high priority had been placed in that organisation on the achievement of targets. Three-quarters of doctors tell us that they believe national targets and directives, or achieving financial targets, are still prioritised over the quality of care. The pressure to hit targets or other national directives...
sometimes creates perverse incentives and can lead to a cascading culture of pressure and anxiety, as well as undermine the provision of safe, good quality care.

Targets, directives or interventions from the top need to be clinically led. They need to take into account the challenging and complex environment in which staff are working, and be effective in supporting them to maintain good quality care or deliver improvements. Reorganising the same resources to try to achieve more – and more challenging – targets yields diminishing benefits over time. When organisations are already struggling, more support is needed so they can reach ambitious goals.

**Proposed solutions**
Governments and NHS organisations need to:
- abandon crude financial targets and replace them with financial assessments that recognise the context in which local providers are working
- prioritise developing better metrics on quality of care, staff engagement and culture, and encourage more of a focus on them
- replace performance targets with plans that reflect the context within which the organisation is operating
- focus on supportive, evidence-based interventions for under-performing organisations rather than on judgements and ratings which can exacerbate pressure and demoralise staff
- disseminate good practice across the whole system, identifying examples of teams or organisations that have improved in a range of different settings, so that those facing similar challenges can find relevant examples to learn from.

**Psychological safety is key to creating learning cultures**
Learning from errors and quality improvement cannot happen unless staff feel safe in being open, reporting errors and raising concerns. Various steps have been taken to encourage greater openness and transparency in the NHS in recent years, such as the introduction of duties of candour, reporting systems for patient safety and, in England, guardians for speaking up.

However, doctors have told us they are still afraid or discouraged from speaking up in many workplaces. They fear they will be blamed for errors they report and are anxious about how the information will be used – half say they are fearful that they might be unfairly blamed or suffer adverse consequences, and half say they are discouraged by the lack of feedback when they or colleagues have reported concerns. The processes often require persistence and resilience too – a majority of doctors (59%) say that workload pressures make it difficult to find the time to report concerns.

An open and learning culture is one characterised by high levels of psychological safety and low levels of interpersonal risk, ie people are not afraid of being punished or humiliated by others when they speak up. Creating safe spaces and protections for reflective practice will help give the reassurance that doctors and healthcare staff need, by assuring them that openness is being encouraged to enable learning rather than seeking to apportion blame.

Strong and supportive working relationships with colleagues are also key to creating greater psychological safety at work. BMA members in our local engagement events have reflected often on the lack of time and opportunities, as pressures have increased, to regularly meet with colleagues (eg in weekly team meetings or informally during coffee breaks). They feel that working relationships are more distant and not as good as a result. Greater investment in staff facilities and ensuring staff have adequate time to rest and meet colleagues away from immediate work pressures and patient-facing environments should be recognised as key to creating a more open and learning culture.

Leaders, managers and senior staff have a key role to play in creating a climate in which people are not fearful of voicing concerns or questioning practices. In the NHS, there is growing recognition that there needs to be a more collaborative, compassionate and inclusive leadership style to help define that climate of open communication and learning. This is not easy to deliver in such a complex and pressurised working environment, with
entrenched hierarchies and boundaries between professions and organisations. Not all doctors will become medical or clinical directors, but many will lead teams or become supervisors or managers at some stage in their careers. Leading multi-disciplinary teams, educating and developing the next generation, managing people and dealing with conflict at work are not simple tasks, and are not often part of undergraduate medical training. It is therefore not surprising that some doctors feel there is a lack of support and little or inadequate training to help them in these roles.

Doctors also need protected time for learning and professional development activities as well as study leave funding. It is concerning that half of doctors say they do not currently have adequate time for this. Only a fifth of GPs agree they have sufficient time for learning and development activities. This has consequences for quality improvement, safety and staff retention. The GMC’s annual training survey has also highlighted the pressures on trainees and trainers, with half of trainees saying they regularly work beyond rostered hours, and as a result 30% say training opportunities are being lost due to rota gaps. In addition, a third of doctors with training responsibilities say they find it hard to find the time to fulfil their educational roles.

Box 2: Schwartz Rounds
The Point of Care Foundation promotes and supports Schwartz Rounds in NHS organisations. They provide a unique forum for clinical and non-clinical healthcare staff to come together to reflect on the emotional and psychological impact of their work. Rounds have been found to benefit participants, with the process of sharing and reflecting on experiences increasing empathy for patients and each other, reducing feelings of isolation and improving communication with colleagues. Evidence shows people who attend rounds are less stressed and in better psychological health than their non-attending colleagues. It also identifies ripple effects for the organisations hosting rounds, including reduced isolation, improved teamwork and improved communication.

Box 3: Lucy Henshall, GP Health Service Clinical Lead, East of England at a BMA member event
‘One of the questions we’ve been discussing is how to make the culture of the NHS a better place. I think it boils down to some very fundamental human behaviours. Somewhere along the line, not just our profession but the NHS itself has forgotten kindness, civility, and good behaviours toward each other. I think if we were to reinject those very simple behaviours on a day-to-day basis we would enable our colleagues to feel more supported... On top of that we should be adding supervision, mentoring, space and time to learn, time in which to debrief and share the emotional burden of the work we do... And my call to action to my colleagues is: look sideways, look across the room in your workplace, take care of your colleagues because what you give you will get back, in spades.’

Solutions
NHS organisations should:
− create opportunities and protected time for staff to meet, share experiences and build strong and supportive relationships
− improve the physical environment so that staff have proper rest facilities (see the BMA’s fatigue and facilities charter) and a space to relax and meet with colleagues
− consider adopting Schwartz Rounds or other safe spaces for staff to meet, reflect and share experiences of working in healthcare to help break down hierarchies or professional boundaries
− demonstrate the value placed on openness and learning within organisations by using past incidents, especially from leaders’ own practice, in training exercises, where possible involving patients and carers too
— ensure positive patient feedback is shared so that learning comes from reinforcement of positive behaviours and outcomes too
— provide sufficient protected time for learning and development, including in the GP contract, as well as resources for educational course and conference costs, so doctors can develop professionally and support quality and safety improvements throughout their careers.

Those responsible for workforce at a national level should:
— review and ensure adequate provision of management and leadership training, mentoring or coaching so that those with managerial, leadership or supervisory responsibilities are supported in taking a non-punitive, compassionate and collaborative approach
— develop a professional code of conduct as well as accountability of NHS managers for patient safety and a learning culture in their organisations.

Effective and consistent interventions are needed to address bullying and harassment
The BMA’s project on bullying and harassment has identified endemic problems in some parts of the profession and NHS. It is clear that formal policies and procedures that rely upon individuals formally reporting incidents for investigation are insufficient to address the problem. Those who are bullied or harassed are often in a weak and isolated position and feel anxious about putting their head above the parapet. In some instances, they may be actively discouraged from saying anything with threats to their future career, or being told that they should just put up with things, as raising concerns would make matters worse or not achieve anything.

There needs to be clarity about values and behaviours. Treating people with compassion and respect, being inclusive and collaborative, and actively listening when people do speak up, needs to be consistently demonstrated by senior leaders, managers and staff. More encouragement, support and routes for raising concerns about bullying and harassment are needed – not just on an individual but a collective basis. If behaviour goes unchallenged and the silence around it persists, then it becomes tolerated and spreads. There needs to be greater focus on early intervention to address unprofessional behaviour that may escalate to bullying or harassment, and upskilling of staff and managers so they can do that effectively. Organisations also need to ensure they act on the underlying causes of bullying and harassment, including the fear, anxiety and pressure in the system.

Proposed solutions
NHS organisations should:
— make sure there is clarity about standards of behaviour, so people know when they are justified in raising concerns, and when things like performance management or banter risk crossing the line into bullying and harassment
— provide designated contacts within the organisation that people can speak to informally and in confidence if they have concerns about bullying or harassment
— use anonymous surveys and other feedback sources to gather information about the prevalence and nature of bullying and harassment concerns, and ensure senior leaders consider in detail and are held accountable for acting upon the findings
— encourage bystanders to be more active and give people the tools to challenge effectively when they see or experience bullying or harassing behaviour
— improve how formal complaints are handled in practice in the NHS, ensuring sufficient resourcing, capacity and independence of investigations
— encourage and enable early intervention to tackle unprofessional behaviour, and provide better training and support for those with managerial and supervisory responsibilities
— embed human factors in medical selection, education, training and work practices so people understand the paramount importance of good interpersonal communication and teamwork to deliver effective patient care.
Box 4: Case study: Sturrock review of ‘bullying culture’ in NHS Highland, Scotland

In September 2018, four doctors in NHS Highland (three GPs and a consultant radiologist) publicly alleged a decade-long bullying culture within their NHS board and called for an independent inquiry. The Scottish Government listened, and in November 2018 John Sturrock QC was commissioned by the cabinet secretary for health and sport to carry out a full independent external review into allegations of a bullying culture at NHS Highland. In his final report, he asks:

‘For those who have been affected, how will [we] move from fear to safety, from anger to compassion, from blame to kindness, from shame to dignity?’

He notes:

‘Whatever procedures and policies are available, they are unlikely to be effective unless people are civil to one another, especially when under pressure. This comes from the top and cascades through the whole organisation.’

Among the specific proposals made by Sturrock in his report are:
- a need for people-centred leadership; a need for civility and respect at all levels; daily contact between management and frontline staff
- adequate facilities for staff to rest, reflect, meet and talk to colleagues away from immediate work pressures and patient-facing environments
- a clear and concise definition of bullying and harassment
- a carefully designed, comprehensive training programme so that people are more able to manage differences and have difficult conversations in real time
- and consideration of the Francis Report on how to encourage a culture where people have freedom to speak up.

In a section entitled ‘Clinical Engagement in the Contemporary NHS’ Sturrock also recommends:

‘Reassessment of the relationship between clinicians and management seems to be an essential part of building a collaborative and mutually respectful and supportive culture. Apparently, evidence from around the world shows that improved clinical outcomes follow greater clinician involvement in management. Thus, there should be reflection on the manner and benefits of clinical involvement in leadership. This may entail changes of attitude and behaviour for some as they move towards a more collaborative approach.’

The benefits of diversity need to be realised through inclusive workplace cultures

The medical profession and wider NHS workforce are increasingly diverse but the experiences of staff and the opportunities for development are not equal. A striking finding from the BMA all-member survey was that only 55% of BME doctors think there is respect for diversity and a culture of inclusion in their workplace compared to 75% of white doctors. There is a similar ethnicity gap in the proportion of doctors who agree there is effective teamwork in their main place of work (57% of BME doctors compared to 72% of white doctors). BME doctors are also almost twice as likely to say they would not feel confident raising concerns about patient care. Given that over a third of GPs and two-fifths of hospital doctors are from BME backgrounds, this suggests a significant proportion of the medical workforce lacks a sense of belonging, safety and respect at work. The barriers that BME doctors who qualified overseas face are often compounded by poor induction and support, and a lack of curiosity or recognition of the experience they bring from their previous practice. Recent research has shown that BME consultants earn 4.9% less than white consultants on average.
Doctors with disabilities or long-term health conditions have shared experiences through the BMA’s bullying and harassment project and local engagement events on disability. They face difficulties in accessing the support and adjustments they need to perform to the best of their ability and serve patients effectively – or even to remain in work. There is a frustration that they are most often seen as a problem in the workplace, with a focus on what they cannot do, rather than on the abilities, insights and benefits that they bring to the profession and patient care.

Women, especially those who have taken time out or worked less than full time, also highlight how difficult it can be to challenge assumptions about their commitment and ability, and to access the same progression and development opportunities of male or full-time colleagues. The interim findings of the independent review of the gender pay gap in medicine shows there is a pay gap of 17%, with women being under-represented among consultants, GP partners and in higher-paying specialties.

The BMA and GLADD (Gay and Lesbian Association of Doctors and Dentists) have found many LGBT doctors routinely experience undermining comments or harassment linked to their sexual orientation or gender presentation.

Diversity in the profession and NHS brings significant dividends. If the workforce reflects the diversity in the population they serve, it is likely there will be greater understanding, compassion and civility in all staff-patient interactions. Diverse teams have also been shown to outperform non-diverse teams as they benefit from different perspectives and a wider range of experiences and skills. But these dividends will only be fully realised if the culture is one in which everyone feels included, valued and able to speak up.

**Box 5: Rajeev Gupta, paediatric consultant in Barnsley and Yorkshire regional council chair, at a BMA member event**

“One of the important things that is increasingly being recognised is how diversity can be seen as a problem. So a simple thing is to give people a voice so people who are from a BME background shouldn’t fear raising concerns. The second thing is to set up a BME network in each hospital… The third thing would be to have a body that constantly provides background support and mentoring to these doctors, because there’s a disproportionately low number of the BME doctors compared to their white counterparts in leadership positions. If we provide a more diverse NHS… we will have a more powerful NHS.”

**Proposed solutions**

NHS organisations should:

- provide proper inductions for overseas-qualified doctors, for example by encouraging and giving them time to attend GMC ‘Welcome to UK practice’ courses, and by ensuring there is ongoing accessible support with orientation and living and practising in the UK

- ensure peer support and mentoring is routinely available to all medical students and doctors, ensuring those from minority or under-represented groups have access to appropriate mentors that can relate to and support them through the particular challenges they may face

- ensure there is early identification of those who may be in need of additional or more tailored support, which may be throughout their careers or at certain stages, and ensure this is provided in an effective, timely and positive way

- develop and promote more flexible career pathways and improve the support for less than full-time working options and return to practice after periods of leave or careers breaks

- develop and deliver effective training and development for all doctors, medical students and non-medical managers on the value of diverse teams and the importance of inclusion, giving them the skills to manage and work effectively within them, and emphasising that supporting fellow doctors is a shared responsibility

- make skills that support inclusivity a core part of leadership development in the NHS, with inclusion seen as a core competency that leaders are expected to demonstrate and will be accountable for.
Replace the blame culture with a ‘just culture’ approach
When patient safety incidents occur, the first question should be what went wrong in the system rather than who was to blame. This is a natural follow-on from the recognition that many errors in the NHS are due to multiple factors and systems as opposed to pure individual culpability, as the Berwick report identified. Organisations should not rush to formal investigations of individuals but instead should start with examining the system factors that may have played a part, and how they can make changes to prevent errors or failings happening again.

This approach will facilitate a more positive climate for speaking up as staff will be more likely to openly and willingly engage with investigating and learning from incidents. It is also likely to focus resources on learning and improvement rather than on individual disciplinaries, suspensions and the direct and indirect costs associated with litigation and defensive practice.

Proposed solutions
In response to a patient safety incident, NHS organisations should:
- acknowledge that multiple system and human factors will always be at play and consider these as part of any investigation
- recognise the impact on staff of a patient safety incident; they should be provided with support rather than made to be fearful of investigation and punishment (most will already feel devastated and upset to have been involved in something that has caused harm)
- signpost support for staff going through any investigation, disciplinary or fitness-to-practise process (such as that provided by the BMA or other bodies)
- investigate incidents promptly, and look to resolve cases involving individuals quickly, without the need for formal procedures if possible and appropriate
- involve patients, their carers and relatives at the early stages of investigations, keeping them informed of developments, learnings and outcomes
- share the learning from the case as widely as appropriate, including to national learning databases and reviews, to maximise any positive outcomes from these inherently negative incidents.

Box 6: Case study: a just and learning culture approach at Mersey Care
Mersey Care is an NHS organisation that has realised learning cannot happen from mistakes if employees are too afraid to report those mistakes. Its work to embrace ‘a Just and Learning Culture’ has centred on the desire to create an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. In the case of an adverse event, it instinctively asks ‘what was responsible, not who is responsible’. It is not finger-pointing and not blame-seeking. But it is also not an uncritically tolerant culture where anything goes. It says that would be as inexcusable as a blame culture.

Regulation needs to encourage improvement and support a learning culture
Professional regulation
The primary role of the GMC is to protect patients. It does this by setting the standards doctors need to follow throughout their careers and by acting to prevent a doctor from putting patient safety at risk.

It has recently announced a programme of work to address the issues doctors have raised about the environments in which they work, and the impact of system pressures on medical practice – this includes improving support for doctors to raise and act on concerns, and making sure all doctors referred to it are treated fairly. All GMC fitness-to-practise decision makers, case examiners and clinical experts will now receive human factors training so that the role of systems and workplaces in events is fully considered. The GMC has also pledged to introduce steps designed to reduce the number of single clinical-incident investigations it carries out.
However, the GMC has acknowledged that its fitness-to-practise processes are slow, inflexible and heavy-handed, and many doctors are aware of how stressful they can be, especially for those who may be vulnerable or unwell. Regulatory reform is necessary to deliver improvements, with the BMA supportive of the GMC’s efforts to seek legislative change. More can be done to reduce both the burden and fear that come with being a regulated healthcare professional.

**Proposed solutions**

The GMC should:

– ensure its processes and procedures are fair, timely and proportionate, and are streamlined to reduce the personal impact of investigations on doctors — it should employ a supportive, explanatory approach at tribunals as opposed to an adversarial one

– work to reduce the personal workload associated with medical appraisals and revalidation, ensuring these support reflection and professional development

– use its voice to highlight to Government and health service leaders the underlying causes of a system under pressure, and robustly advocate for change

– become a repository for learning, sharing good practice and continually encouraging improvements.

**Provider regulation**

Although there are differences in the specific approaches taken by the UK’s system regulators (the Care Quality Commission in England, the Regulation and Quality Improvement Authority in Northern Ireland, Health Improvement Scotland and Healthcare Inspectorate Wales), doctors and healthcare workers throughout the UK feel overwhelmed with the regulatory requirements placed on service providers, which they feel often takes them away from caring for their patients. While attempting to assess whether healthcare services provide safe, high-quality care, existing regulatory approaches fail to recognise that wider system issues significantly affect delivery of care. Doctors also tell us that system regulators, when assessing employing organisations, often fail to place enough weight on the importance of staff wellbeing. Doctors feel this simplistic and judgemental approach by regulators does little to support and encourage improvements in patient care.

**Proposed solutions**

All system regulators should:

– ask employing organisations to demonstrate that all health service staff, whether in the NHS or other organisations, work in an environment where they are engaged, feel supported, are confident in raising concerns in a spirit of learning, and have equality of opportunity

– demand employing organisations take robust and proactive steps to ensure workplaces are fully inclusive and free from a culture of bullying, undermining and harassment

– require employing organisations to put in place measures that support and encourage staff wellbeing, for example by hospitals and trusts providing appropriate rest facilities with access to food and drink

– ask employing organisations to demonstrate that doctors are aware of and feel comfortable in using mechanisms that exist to support raising concerns (eg exception reporting and safe working guardians in England)

– ensure employing organisations provide accurate pictures of staffing needs so that issues can be addressed quickly and effectively, as poor workforce planning has a detrimental effect on staff wellbeing and patient care

– acknowledge and understand current workforce pressures and provider budgetary constraints to support bespoke solutions and improvements to be considered and implemented at a local level

– engage directly with doctors and other healthcare professionals at all levels before, during and after inspections, providing powerful opportunities to drive improvement in the quality of care delivered locally and nationally

– be prepared to robustly use the powers they hold to enforce standards to uphold safety.
The CQC (Care Quality Commission)
In England, GP practices and hospital and community providers are assessed by the CQC, which gives providers a rating of inadequate, requires improvement, good or outstanding.

Our member survey findings strongly suggest that CQC regulation is contributing to an already stressful working environment for doctors. 79% of doctors say inspections divert time and resources away from patient care, while 71% feel they add to fear in the workplace. These figures are much higher among GPs.

It is particularly concerning that so few doctors (just 9%) feel inspections consider system pressures, given that these are now having an increasingly damaging impact on providers in the NHS all year round.

In addition, the overall ratings used by the CQC cannot capture the quality of individual services provided in a hospital or GP surgery, nor the complexities of delivering healthcare. Aggregate ratings risk misleading patients with simplistic judgements and can demotivate staff providing high-quality services within an overall negative rating. Conversely, they conceal areas of poorer care in providers with a high overall rating.

Proposed solutions
In England, the Government and CQC should:
- remove aggregate care-quality ratings of providers
- remove pejorative terms such as ‘inadequate’ in the judgement of quality of services
- provide reports based on a matrix of the range of services provided
- provide recommendations for change that are tailored to each service inspected, offering advice and support for achieving improvements rather than simply identifying areas of under-performance
- introduce a fully reformed and proportionate regulatory system based on targeted assessments of essential standards and quality assurance processes and reduce the time required by providers in preparing for and participating in an inspection
- overhaul the bureaucratic nature of its registration system which, for example, unnecessarily duplicates much of the work GP practices are required to report on to NHS England. Regulatory registration requirements and processes must be tailored to the specific services being delivered by providers.

The wider regulatory landscape
Both professional and provider regulators are part of a wider system that investigates patient safety incidents. This now includes HSIB (the Healthcare Safety Investigation Branch) tasked with investigating incidents, disclosing information to others where appropriate, and sharing learning across the system. Regulation also overlaps with the criminal justice system and over the last 18 months, the Government and GMC have conducted their own reviews of the law on gross negligence manslaughter.

There are gaps in the wider systems, and our members question whether managers – not currently regulated – should be subject to some form of accountability, and what form this should take.

Finally, as statutory bodies, existing regulators lack the flexibility to adapt to a changing context which can hamper initiatives to improve processes.

Proposed solutions
All governments should:
- ensure that the legislative framework gives professional regulators enough flexibility (provided there is appropriate accountability in place) to adapt their approach to the needs of the professions they regulate. In England this would require a radical reform of the CQC inspection process and rating system
- introduce a regulatory mechanism for holding senior non-clinical managers to account, with the appropriate scrutiny of individuals seeking to work in senior management positions
– create UK-wide legal ‘safe spaces’ (like those adopted by HSIB as part of their investigation process) in which doctors and other healthcare professionals are supported in disclosing information and the learning from an incident is available to the system
– fully implement the recommendations of the Williams review into gross negligence manslaughter in healthcare to reduce the criminalisation of medical errors
– given the professional sanctions in place, an individual duty of candour with criminal sanctions should not be implemented in Northern Ireland.
3. A valued workforce

Doctors across the UK are working in a health service that is underfunded, under-doctored and over-stretched. There are simply not enough doctors to look after patients safely – of the European OECD countries, only Poland and Slovenia have fewer doctors per head of population than the UK\(^6\). Nine in 10 respondents (91\%) to our survey of BMA members confirmed this, telling us that current staffing levels are not adequate to deliver safe, high-quality patient care. More than seven in 10 say this has worsened in their main place of work over the last 12 months. This means nine in every 10 respondents now work more hours each week than contracted and paid for. Even though so many doctors go the extra mile, nearly a third say their hospital or GP practice cannot usually provide cover for doctor absences or unfilled vacancies.

Training more doctors is part of the solution, but it will take time

We must increase the number of doctors working across the UK. 53\% of GPs and 68\% of hospital doctors responding to our survey highlighted the lack of doctors, rota gaps\(^7\) and vacancies as a factor affecting their ability to deliver safe patient care. We must create more medical school places and ensure that medicine is an attractive career prospect for children from a young age. However, it will take over a decade for increases in medical school places to provide relief to overstretched services. To support doctors now with their current unsafe workload it is clear that we need more immediate solutions.

Efforts must be made to retain current staff

In an environment in which we do not have enough doctors, we cannot afford to lose any more. Six out of 10 consultants intend to retire from the NHS before or at the age of 60\(^8\), while four in 10 GPs intend to quit general practice in the next five years\(^9\). Retaining existing staff is crucial. Respondents to our survey told us that current difficulties with retaining staff are due to:

- excessive workload pressures (78\%)
- a blame culture with increased risk of prosecution or GMC referral compared to other nations (50\%)
- and a negative workplace culture with a lack of valuing and respect for staff (49\%).

Unsatisfactory pay and working conditions (47\%) and a system that does not support work-life balance and non-traditional career paths (47\%) also featured highly. In short, many doctors currently work in unhappy environments, causing them to want to leave. Older doctors who are considering leaving or have left the profession because of burnout, to seek a better work-life balance, or retirement, still have a lot to offer and can be incentivised to continue to work by offering flexible working opportunities, altering their workload (see Box 8) and tackling unfair pensions tax rules (see Box 9).

If a doctor wishes to reduce their clinical workload, they can still play a crucial part by taking on roles in management, teaching, research or as appraisers. Barriers that prevent doctors taking on these roles when they are not clinically active should be reassessed and where possible removed\(^10\). Where doctors have already left the profession, more can be done to ensure that retraining, GMC registration requirements and appraisal and revalidation are not seen as prohibitive, while better workplace culture would help make returning to work an attractive prospect.

Solving these issues and boosting retention will take time. Taken together, the recommendations on workforce, culture and collaboration set out as part of this report will address these issues and should start making health services across the UK places where doctors enjoy working and want to continue to work.
Box 7: Gary Marlowe, GP and London regional council chair, at a BMA member event

“We have a very demoralised workforce that does not feel valued. From talking to hospital colleagues: the fact that they have very little ability to forward plan because they can’t see their rotas in advance, the fact that they can’t get a hot meal if they’re working late at night. Those very simple things make us feel valued and I think will improve the morale of the workforce without being massive financial costs.”

Box 8: Source: the BMA’s Supporting an ageing medical workforce report (February 2019)

“I am a GP and last year I left the practice where I had been a partner for 30 years. I had always planned to retire from my practice at the age of 55 due to the fact that my job was highly pressurised and I thought this was a reasonable aim for my own wellbeing, and I made my financial plans accordingly. However, when it came to it, I took the opportunity instead, at 53, to reduce my clinical commitments to the practice. This has made continuing to 59 sustainable.

‘In my later years my stamina was not the same. I began to find it harder to draw on the necessary reserves of emotional energy to give top-class engagement to all my patients. On the other hand, I had also reached a level of skill and insight where I could try different consultation styles and put more truly in to practise shared decision making. Without the opportunity to reduce my hours in the practice I would undoubtedly have left before 59.

‘I remain on the Performers List as a GP and I would like to continue to be active locally, for example in helping service design/commissioning and teaching medical students. Now I am nearly a year out of clinical practice I do not think I will return to the workforce; sadly many opportunities to work in local health service development or teaching require applicants to be currently engaged in clinical work.’

Box 9: Current pensions tax rules are unfairly penalising senior doctors

Urgent action is needed to change current pension taxation rules that financially penalise senior doctors for working additional hours. The current rules mean that experienced clinicians who decide to work extra hours are at risk of breaching annual and lifetime pension allowance limits and therefore being hit with large unexpected tax bills, sometimes in excess of their earning from the additional time worked. Six out of 10 of the 4,000 consultants in England who responded to a BMA survey in early 2019 said they were planning to retire early, with many citing this issue as a chief driver.

Career breaks are increasingly the norm – the system must adapt

Doctors take breaks from full-time NHS work at different stages of their career and for a wide range of reasons. Some gain valuable experience working abroad in different health systems or for NGOs in developing countries, and these doctors are often discouraged from returning to work in the NHS by difficulties in regaining their licence to practise. Instead, we must encourage and facilitate their return and make it clear that the NHS wants and needs their contribution.

Each year, the number of F2 doctors progressing directly to specialty training reduces; it was 71% in 2011 and 38% in 2018. With doctors’ increasing desire to take a gap year at this stage, it is important to recognise that the NHS is in competition with a range of career options and health services around the world; 45% of respondents in our member survey say ‘better opportunities to work as a doctor elsewhere’ are a major retention problem. Part of tackling this is about developing a good working culture (see section 2, ‘A supportive culture’), but we also need a flexible career structure which makes it easy for doctors in training to take a career break and then return.
Other professionals can help ease the burden on doctors

One area where we can make a difference now is excessive workload pressure. Doctors are currently over-worked. At least half of doctors (52%) say they spend 1-3 hours per day on work that could be done by another non-medical clinical professional.

While they cannot and should not be a substitute for doctors, other clinical professionals can help support doctors, and there is a significant level of support for this among the profession, with nearly half of doctors (47%) supporting the expansion of the non-medical clinical workforce to ease pressures (compared to 25% who disapprove of this approach).

Roles such as clinical pharmacists, medical associate practitioners (including physician associates) and advanced nurse practitioners are already providing valuable clinical care in some settings to complement doctors. Employers should work with doctors to review which parts of their workload could be carried out by these other members of the team, keeping in mind the need for safeguards and risk of overloading senior doctors with a workload consisting entirely of high-intensity work.

Safeguards are crucial to getting the most from new clinical roles

While new clinical roles should not be seen as replacements for doctors, they can help to support doctors. To ensure they are genuinely able to do this and do not add extra pressure or undermine the role of doctors, several important safeguards are needed:

– **Ensure new roles are not considered as cheaper options for care provision in place of doctors’ expertise.** Patient care must not be compromised. 50% of our survey respondents were concerned about the risk of lowering standards due to non-medical practitioners providing care that doctors are better placed to provide.

– **Ensure that doctors’ training is not compromised.** With MAPs (medical associate professionals) being employed in permanent roles within teams, they naturally over time earn the confidence of senior doctors and are often chosen over junior doctors to assist on work that would be essential experience for a doctor in training. All departments and care settings must take measures to balance the service provision benefits of MAPs with the training priorities of doctors in training. It is also crucial that the training of non-medical practitioners does not negatively affect junior doctor training, a concern raised by 39% of our survey respondents.

– **There must be regulation and clarity around accountability for the new professions.** More than seven in 10 respondents to our survey were worried that doctors would be carrying responsibility for the non-medical clinical workforce, who often currently lack accountability for their actions. This is further complicated by the fact that some non-medical practitioners currently work unregulated (raised by 51% of survey respondents). All clinicians should be regulated appropriately for the tasks they perform, which is why we have called for statutory regulation for each of the MAPs. Regulation has been announced for PAs (physician associates) and AAs (anaesthesia associates); this needs to be implemented swiftly, and regulation expanded to the other MAPs (surgical care practitioners, advanced critical care practitioners). Once PAs and AAs are regulated, these clinicians should be awarded prescribing rights to ensure they provide the maximum contribution to their teams and are genuinely able to take pressure off doctors. Clarity is needed regarding how MAPs’ status as dependant practitioners can be reconciled with prescribing rights and clinical lines of accountability.

– **It is important that patients, the public and other clinicians have a better understanding of the roles that MAPs perform.** Every member of the multi-disciplinary team needs to have a clear understanding of their colleagues’ scope of practice, lines of accountability and supervision responsibilities. We are currently working on good practice guidance on how MAPs work with doctors and as part of the clinical team. Alongside this it is crucial that employers share good practice with each other whenever a new role is introduced, and that the roles display some degree of consistency between different employers.
The establishment of MDTs (multi-disciplinary teams) can make a real difference

In parts of the UK, programmes are underway to more formally embed MDTs into the system (see Box 10), presenting a real opportunity to reduce doctors’ workload and improve patient outcomes. Box 11 describes the introduction of clinical pharmacists in primary care, and Box 12 shows how MDTs can also benefit secondary care environments, if the right safeguards are in place.

Box 10: How the UK nations are tackling workload with workforce and MDT innovations

The first-ever Scotland GP contract (2018) committed to reducing GP and GP practice workload, with new staff being employed by NHS boards and attached to practices and clusters as part of MDTs. Alongside reducing GP workload, the new staff were intended to increase protected time to allow GPs to maintain and develop their training and skills.

Reflecting on the first year in his local area, GP Chris Black from Ayrshire and Arran local medical committee said: ‘We’ve seen some good progress in the first 12 months of the new contract. We’re now in a position where almost every practice in Ayrshire and Arran has, or soon will have, access to a pharmacist. This has had a huge impact on GP workload for the better.’

In Wales, the Pacesetter Programme is testing new approaches to MDTs with a range of locally determined projects. In England, the 2019 GP contract included the development of primary care networks which plan to add 22,000 staff in primary care, including clinical pharmacists, social prescribers, first contact physiotherapists, physician associates and community paramedics. Pilot funding has also been provided by the Department of Health for the establishment of primary care MDTs in Northern Ireland to help address the pressures identified by their GPs.

Box 11: How a clinical pharmacist helped GPs save time and become safer prescribers

Karen Acott has been a clinical pharmacist at the Wallingbrook Health Group in Devon since 2004. She is a full partner in the group, and as a prescribing pharmacist, she sees patients in clinics and delivers phone consultations, handling all aspects of medication management. Her work has reduced the need for patient GP appointments by 30%, making a significant impact on GP workloads and patient outcomes. A 2016/17 audit of workload impact showed that having a pharmacist working four sessions a week resulted in over 400 hours of GP time saved over the course of the year. Diana Wielink, senior partner at the practice, says: ‘Having a pharmacist in our organisation has enabled our health group to become safer and a more cost-effective prescriber.’

Box 12: How PAs helped reduce workload and freed up time for training junior doctors

A junior doctor at Guy’s and St Thomas’ in London described how physician associates had a positive impact in his department, freeing up doctors to do ward rounds and spend time with patients in a way that has been missing for many years. In the department, the presence of the PA picking up the more day-to-day burden of work has increased training opportunities for doctors. In this department there were clear lines of supervision, with a ‘lead PA’ acting as the PAs’ direct supervisor and although it had not been communicated formally to the team, the PAs’ scope of practice was consistent and clear.
New non-clinical professionals can play a part in reducing doctors’ administrative burden

A huge amount of doctors’ time is taken up by non-clinical work, such as making notes, filling in forms, dealing with correspondence, writing discharge summaries and completing mandatory coding and compliance sections on computer systems. This work is essential, but much of it does not require the attention of a highly trained medical professional. Instead this work could, and should, be carried out by dedicated members of non-clinical staff, such as medical scribes and doctors’ assistants. 44% of respondents to our survey said that between one and three hours of their work each day could be carried out by a non-clinical member of staff.

Box 13 describes a doctors’ assistant role which is being piloted in secondary care to free up junior doctors’ time.

**Box 13: Can doctors’ assistants free up time for secondary care?**

In East Sussex, a trial is underway in secondary care for a new doctors’ assistant role designed to support junior doctors with a combination of clinical and administrative tasks. The role is being trialled in direct response to the fact that junior doctors spend 40-70% of their time on administrative tasks and in recognition that this is not the best use of their time. In the role, tasks such as discharge summaries, patient notes and booking follow-up clinics sit alongside some more basic clinical tasks, such as phlebotomy, intravenous cannulation, ECG recording and dementia screening.

In the long term, guaranteed safe medical staffing levels are needed

We want working conditions for doctors that are safe at all times. In primary care this is about limiting the number of consultations per session to a safe number. In secondary care, comprehensive e-rostering systems are essential to ensure doctors are not overworked and can take leave as necessary. Electronic job planning, where functioning effectively and used as part of a collaborative approach, will be a useful tool for planning and managing doctor activity too.

Yet even in the best MDTs, staffing levels sometimes fall short. Where clinicians feel that staffing levels in their care setting have fallen below a safe level, it is important that they are able to call this out. There must be clear lines of accountability for staffing levels, from employers up to health ministers across the UK, and concerns must be acknowledged and acted upon. Processes such as exception reporting must be consistently applied across all employers and accessible to all, so that doctors can raise concerns about unsafe staffing.

Once more immediate concerns have been addressed about the shortage of doctors and improving the management of supply and demand, minimum staffing levels will, in the longer term, help secure appropriate working conditions for all doctors and NHS staff. Nearly six in 10 respondents to our survey said guaranteed safe levels of medical staffing would improve their day-to-day working life. In Wales, the Nursing Staff Levels (Wales) Act has already come into force, setting a precedent for enshrining minimum staffing levels into law. In Scotland, safe staffing legislation (see Box 14) will provide a legal basis for addressing the concerns our members identified in our 2018 survey.
On 2 May 2019, the Scottish Parliament passed the Health and Care (Staffing) (Scotland) Bill, which places a legal requirement on NHS boards and care services in Scotland ‘to ensure appropriate numbers of suitably trained staff are in place, irrespective of where care is received’. The legislation includes several key amendments sought by BMA Scotland, notably the inclusion of a clear requirement for a system of escalation of concern for any member of staff who is working in what they believe are unsafe levels of staffing; and risk monitoring. The Act includes a duty for boards to have real-time staffing assessment in place, and a duty to have risk escalation processes in place. The Bill is now an Act, and BMA Scotland will provide input to follow up ministerial guidance on implementation. This will be a key opportunity for the BMA to influence practical and innovative ways to support safe staffing and to help shape the guidance in a way that maximises support to the profession.

We have recently launched a project on safe staffing levels, which will include qualitative research with doctors, a proposal to introduce a safe working charter, and recommendations for consistent and effective doctor escalation processes and clear employer accountability. The project will also look in further detail at ways to reduce administrative bureaucracy.

**Proposed solutions**

Governments and national NHS authorities must:

- take urgent measures to retain staff, including dealing with excessive workload, offering flexible working opportunities, altering workload and removing barriers to older doctors playing a bigger role (see also Supporting an ageing medical workforce, BMA, 2019)
- act swiftly to change NHS pension taxation rules that financially penalise senior doctors, ending the current situation in which experienced clinicians who decide to work extra hours are being hit with tax bills greater than the value of the hours worked
- set clear definitions and lines of responsibility for new clinical roles, so they can be introduced in a way that relieves workload and allows doctors to focus on tasks where their expertise is most needed
- ensure that all MAPs are regulated and awarded prescribing rights where appropriate to ensure they can work safely as important contributors to their clinical teams
- introduce non-clinical roles such as doctors’ assistants and medical scribes to help reduce doctors’ workload and allow doctors to focus on tasks where their expertise is most needed
- encourage sharing good practice between employers as a system-wide priority whenever new roles are introduced. Employers should also work with doctors to review whether the work they currently do day-to-day is the best use of their time, keeping in mind the risk of overloading senior doctors with a workload consisting entirely of high-intensity work
- create clear lines of accountability for safe staffing levels. Doctors must have clear mechanisms to speak out when staffing has fallen below safe levels
- ensure public health doctors are free to move between organisations without detriment to their terms and conditions and without medical public health capacity in those organisations being compromised.

**Better IT systems can reduce workload and give doctors more time to care for patients**

While on the one hand AI is steadily making its way into health service provision, on the other, the NHS still often lacks basic IT. A BMA survey and focus groups on NHS IT in 2018 showed there are serious deficiencies in current IT systems. Examples cited as part of this work and the local events undertaken for our Caring, supportive, collaborative project include: the use of obsolete technology such as fax machines, broken printers, a lack of broadband, incompatible systems with multiple logins, both within the same care setting and between care settings (an attendee at one of our events cited 36 different systems in use in his hospital, which while still separate, had at least now been brought together onto a single website by his trust), as well as frequent system failures (such as the recently publicised delay of test results being sent to primary care, with significant risks to patient safety).
These deficiencies result in additional workload, stress and compromised patient safety. Over half (56%) of respondents to our 2018 IT survey reported that the current IT infrastructure significantly increases their day-to-day workload, with over a quarter (27%) losing more than four hours a week because of inefficient hardware and systems.

Investing in basic technological infrastructure must now be a priority and the process of updating systems be treated as an ongoing running cost for the NHS. This would mean increased productivity, more time for patient-facing activities and better staff morale. Nearly three quarters (72%) of respondents to our IT survey said the main barrier to good IT in healthcare is a lack of funding. For further details and recommendations on how basic IT in the NHS can and should be improved, see Technology, infrastructure and data supporting NHS staff, BMA, 2019.

**Digitising patient records will allow new workload-reducing technology to flourish**

Not all patient records are currently in digital form. This undermines any system that relies on knowing a patient’s entire history, as well as hampering collaboration between clinicians working across the primary/secondary care interface (an issue explored more fully in section 4, on collaboration) and between physical and mental healthcare. The full digitisation of all patient records and funding to make this happen must be a priority to ensure that new technology can be put to full use. Clinicians should be able to see patients’ records, observations, results and background notes from any location, ideally in real time. Not only will this help with emergencies, where the SCR (summary care record) should already be readily available, but the ability to remotely add information to a file would save an enormous amount of collective time and effort across the NHS. More than half of respondents to our survey (53%) say they want to see more effective IT systems that are interoperable and that this would improve their day-to-day working life.

**Interoperability would improve doctors’ working lives**

Doctors have been clear about their priority for improving basic systems. They need to be interoperable. The lack of interoperability can mean unnecessary duplication of effort and time wasted in asking patients to repeat information already provided in other care settings. 53% of respondent to our survey say ‘more effective IT systems that are interoperable’ would improve their day-to-day working lives (see also section 4 on collaboration).

To ensure a speedy move to interoperability but allow for local flexibility, clear standards for interoperability should apply to all future systems procurements across the NHS, and doctors and other clinicians should be consulted on the usefulness of proposed changes before expensive systems purchases are made.

For systems to be more interoperable, it is essential that they can connect to the internet. Incredibly, services in some parts of the UK are still hindered by a lack of broadband, while many care settings do not have wi-fi. The NHS should be an early adopter of 5G internet access, which should allow these connectivity problems to be overcome.

**AI (artificial intelligence) can transform the NHS for doctors and patients**

There are many areas in a doctor’s daily work where technological advances can help reduce workload and improve patient outcomes. Developments in the realms of AI and ‘big data’ have, over time, the potential to significantly transform the NHS for doctors and patients. Broadly speaking, AI refers to computing technologies whose processes bear some resemblance to human intelligence, such as reasoning, learning, sensory understanding and interaction. More recently, technological advances have brought about ‘machine learning’ capabilities, where systems ‘learn’ and make decisions from data without being explicitly programmed to do so.

AI is still in its infancy in healthcare, so it cannot solve all the problems the NHS currently faces. However, there is a significant opportunity through this developing technology to support doctors, provided proper consideration is given to the patient safety, educational and ethical implications.
AI can give patients tools to look after their own health and as a result reduce demand on doctors. AI is already at work in self-care tools such as wearable fitness trackers (described in Box 15), an arthritis virtual assistant giving personalised information and advice about medication, diet and exercise, and apps for diabetics which give bespoke advice based on blood sugar readings. Just over three in 10 respondents to our survey said greater patient empowerment to self-care would improve their day-to-day working life.

Box 15: How self-care AI can help patients monitor their health and reduce doctors’ workload
One in seven adults in the UK owns a wearable fitness tracker. These wearables can monitor a range of health-related information, such as heart rate and exercise. AI can use this information to give people up-to-date information about their health and wellbeing, and suggest health-improving modifications to behaviour. The app Noom, for example, uses AI to analyse a person’s exercise and eating habits and suggests bespoke diets and fitness plans. Wearables can also be used to detect early signs of deterioration in patients living at home and prevent hospital admission.

Alongside this, there are AI tools that directly reduce pressure on doctors. For example, software is already available to automatically populate letters and forms, while more sophisticated applications can carry out the analysis of medical imaging to identify diseases such as pneumonia, breast and skin cancers or eye diseases. Making this technology available across the NHS will have a huge impact on the amount of time spent on more mundane administrative tasks, as well as reducing workload and freeing up doctors to care for patients.

AI cannot replace a doctor’s expertise, but it can improve clinical efficiency and save clinicians time by performing certain tasks thousands of times faster than humans can do them. Task-specific ‘decision support tools’ (such as ‘C the signs’ described in Box 16) which employ ‘machine learning’ could increase doctors’ confidence in managing cases of clinical uncertainty, or less familiar types of condition. There are now AI-controlled robotic tools that can carry out specific tasks like keyhole surgery, perform stitching or interpret anatomical data. AI also has the potential to support the early identification of infectious disease epidemics in public health, with earlier identification supporting quicker intervention and reducing pressure on the health service.

Box 16: How decision support tools can reduce workload and help doctors to reach the right outcome
Decision support tools such as ‘C the signs’ help healthcare professionals identify patients at risk of cancer early on. Unlike other conditions, there is no single symptom that can alert clinicians to a potential cancer diagnosis. The tool uses advanced algorithms combined with optimisation and prioritisation systems to reflect the natural decision-making process of doctors, translating complex research and guidelines into a simple and intuitive journey for the user. It is fast enough to be used during the consultation to speed up decision-making, ensuring at-risk patients are identified and access the right service at the right time for their clinical needs.

With so many opportunities presented by AI and new technology, it is essential that there is enough funding to roll out technology that works, and that clinicians are brought along on the journey. All staff should have dedicated time for training on new systems and this must be factored in during procurement and into job plans. Staff must be at the heart of the development of these new tools in the first place, to ensure they work and are genuinely able to support doctors and improve patient care.
Proposed solutions
Governments and NHS authorities should ensure:

- broadband is made available in all care settings, and that the NHS is an early adopter of 5G technology to overcome connectivity deficiencies and aid interoperability
- investment in basic technological infrastructure is made a priority, as this will have a positive impact on workload, morale, retention and patient outcomes
- the full digitisation of all patient records is a priority to ensure doctors can put new technology to full use and are able to work effectively across health service interfaces
- clinicians have access to AI tools designed to support, but not replace, medical decision-making. They should be involved in its design and receive adequate training in new technologies
- the workload-reducing potential of AI is harnessed across the NHS through tools that promote self-care, provide clinicians with crucial patient information and take on administrative burdens.
4. A collaborative structure

Across the UK, doctors say the NHS needs to be more collaborative

Despite a growing need for care to be integrated around the needs of patients increasingly living with multiple morbidities, doctors say they are prevented from providing joined-up care by bureaucratic barriers, communication gaps and competing organisational priorities. This affects the quality and safety of patient care. 60% of doctors say care quality and safety are being compromised by barriers between primary and secondary care, and only 9% say patients experience coordinated care between hospitals and general practice.

Working in silos is bad for both patients and doctors. Removing obstacles to collaboration can help doctors reduce their workload and unnecessary wastes of time and resources. Seven in 10 doctors say current organisational barriers between primary and secondary care are resulting in increased bureaucracy and administrative costs. Feeling connected to a wider team working across traditional divides also has the power to improve morale – just 16% of doctors feel there are clear channels of communication between primary and secondary care, causing frustration and making it difficult for clinicians and staff to feel part of the same team working together to improve care for patients.

Although the specific challenges differ between England, Scotland, Wales and Northern Ireland, these are issues that all four health systems need to tackle.

Health systems need to be designed so that they embed collaboration

To achieve a more collaborative health service, we must encourage the different organisations – such as hospitals, GP practices, public health, community services and others – involved in providing care to people in a defined geographical area to act together as one system. They should work to the same set of priorities focused around patient care, the promotion of wellbeing and the prevention of ill health. Too often, current NHS structures place an emphasis on individual providers meeting their own immediate organisational priorities, often reinforced through narrow financial and operational targets.

Moving beyond this requires change at all levels of the NHS, from overarching legal structures (such as the formal requirements placed on foundation trusts in England) to embedding a culture of collaboration and team working at a local level.

Proposed solutions

Governments and national NHS authorities should:
- encourage and incentivise all NHS bodies to work together as one system defined by agreed geographical boundaries. This will involve bringing together clinicians, public health specialists and other healthcare professionals and patients to design systems built on trusting relationships between previously isolated parts of the NHS. We have set out five principles to help guide this process in Box 17
- reform how individual NHS providers are held to account, focusing on encouraging behaviours that improve patient care in the health system as a whole rather than narrow
organisational priorities. In England, the Government should abolish the statutory requirements on foundation trusts and reform incentives that encourage trusts to focus on their financial performance above all other priorities

- support public health services to play a central role in bringing all parts of local health systems together to assess the health needs of their populations, plan services and inform local commissioning accordingly, with an emphasis on the prevention of ill health wherever possible

- create a programme of clinically led quality improvement focused on supporting clinicians and other healthcare professionals to come together to input into service redesign, backed up with investment to provide doctors with protected time to achieve this. This should take inspiration from the Buurtzorg, or ‘neighbourhood care’, model developed in the Netherlands (see Box 18), which emphasises the development of self-managing teams of health professionals. The experience of involving clinicians in system redesign in Canterbury, New Zealand (Box 19) also provides a useful model.

Box 18: Buurtzorg model of self-organising teams in the Netherlands

This pioneering model of home care is nurse-led, strictly non-hierarchical, and based around collaborative planning and delivery of care. The model is organised into small, independent and self-organising teams of up to 12 nurses, covering between 40 and 60 patients. Each team takes collective responsibility for co-ordinating the care they provide and focus on using technology and direct support to help patients better care for themselves. This approach has been highly successful, with high levels of both patient and staff satisfaction, reports of reduced acute care admissions, and strong financial performance. The approach is now being implemented in parts of the NHS, with Guy’s and St Thomas’ and Kent Community Health Trust recently adopting the model.

Box 19: Clinical engagement in Canterbury, New Zealand

Both doctors and non-clinical staff were heavily involved in the creation and implementation of a shared vision for integration in Canterbury, New Zealand. Senior leaders were given specific training to empower staff to lead change and a large-scale ‘Showcase’ programme, which ran for six weeks, brought over 2,000 staff together to discuss and devise solutions to the problems facing their health and care economy. Both approaches were considered successful in ensuring clinicians and frontline staff saw themselves as active participants in system transformation.

Payment mechanisms must deliver for patients

Current payment mechanisms result in perverse incentives for providers, encouraging workload and resource shifts between health settings. They also create unnecessary bureaucracy and transaction costs. Instead of providing financial incentives for NHS providers to increase activity, we should be moving to mechanisms that encourage health systems to work together to prevent ill health and reduce the need for patients to be admitted to hospitals wherever possible. They should also ensure there is sufficient capacity to meet patients’ needs in and out of hospital. Currently, in England in particular, hospitals are effectively penalised for helping to keep patients out of hospital, because much of their funding is linked directly to levels of activity. Some areas in England have already started to move beyond this (see Box 20).

Proposed solutions

Governments and national NHS authorities should:

- scrap activity-based payment models, such as the national tariff in England, which encourage NHS bodies to increase levels of activity in order to generate additional funding. These should be replaced with less complex funding arrangements – such as block contracts or shared funding mechanisms for specific service pathways – designed to empower NHS bodies to work together to plan how they will make best use of resources to meet the expected needs of patients in their local areas
encourage the development of shared budgets for elements of shared care that cut across traditional divides between primary and secondary care. As part of this, GP practices and hospitals should be encouraged to work together to establish joint prescribing budgets, which have the potential to reduce costs and unnecessary workload.

**Box 20: Block contracts: Northern, Eastern and Western Devon CCG**

Northern, Eastern and Western Devon CCG has stopped using the Payment by Results (national tariff) system, moving to block contracts instead. This move has enabled commissioners and providers to focus on how they proactively manage expected demand, rather than reactively responding to higher levels than expected, and the financial pressures these cause among providers or commissioners. The CCG was able to go from having the largest cumulative deficit in the NHS in England to breaking even in 2019.

Since this shift in contracting arrangements, the CCG has also been able to save £4m in operating costs. The organisational focus of the CCG has been narrowed to focusing on ‘delivering best value while servicing demand’ since moving away from payment by results. In addition, the move away from activity-focused contracts has reduced the bureaucratic burden for both commissioners and providers.

**The NHS should be free from wasteful competition rules**

Current competition rules in England are incompatible with creating a collaborative NHS. Rules requiring NHS services to be put out to competitive tender, and the artificial and inefficient purchaser-provider split have created unnecessary waste and misdirection of resources within the NHS in England. They have made it more difficult for health systems to develop the trusting long-term connections needed for more integrated ways of working.

**Proposed solutions**

In England, the Government should:

- amend legislation based on NHS England’s proposals to revoke Section 75 of the Health and Social Care Act 2012 and remove rules requiring CCGs to put contracts out to competitive tender, and make NHS providers the default option under the new proposed ‘best value’ test.

**Better communication between primary and secondary care must be promoted**

Only 16% of doctors feel there is currently clear communication between primary and secondary care, and only 28% say there are good relationships across the divide. Organisational interests and perverse financial incentives lead to a situation where doctors from the same local health system work in silos. It therefore becomes more difficult to establish the professional relationships necessary to collaborate effectively. For example, doctors report a common frustration in not being able to make contact (eg by phone) with a named person elsewhere in the health system to discuss the best course of action for a patient. Setting out common rules and processes (such as the approach in Wales described in Box 21) can help to some extent, but more can be done to improve communication and relationships between different parts of our health services.
Box 21: Standardised communication between primary and secondary care, Wales

In Wales, a Health Circular from the chief medical officer/medical director of NHS May 2018 officialised the adoption of Bro Taf LMC’s standards as the All Wales Communication Standards between primary and secondary care. The guidelines give clarity on the respective roles and responsibilities of primary and secondary care when a patient is referred for treatment, with the aim of reducing problems that arise when these are not clear.

Since their adoption, BMA Wales has been monitoring their use across Wales to ensure changes happen in communication and collaboration across the interface.

Proposed solutions

Governments and national NHS authorities should:

– ensure organisational interests and perverse financial incentives are not hampering the ability of doctors to work collaboratively and the design of a seamless patient journey

– encourage more widespread use of dedicated phone lines and other forms of communication between GPs and hospital doctors, in both directions, and with other standalone community, mental health and social care services. These need to be developed in partnership with clinicians to ensure the potential workload impact is managed accordingly – eg that sufficient time is allocated to job plans and work schedules. These systems should be developed within the NHS, building on existing best practice

– maximise the use of shared records and electronic communication between primary and secondary care – eg electronic advice and guidance systems, and Skype consultations in which a patient and their GP can speak directly to a secondary care doctor

– support local health systems to develop and agree referral templates and pro formas to standardise information sharing

– enable hospital doctors to request investigations in the community and prescribe medications that can be collected in a community pharmacy, including provision of electronic prescriptions

– provide funding and support for schemes designed to build professional and social connections between clinicians across traditional working divides, building on existing liaison schemes (see Boxes 22 and 23).

Box 22: Connecting professionals: the BRIDGES initiative in Yorkshire, Lincolnshire and Humberside

The BRIDGES project focuses on building trust and relationships between those working across health and social care (clinical and non-clinical) across north and east Yorkshire, Humberside and Lincolnshire. Led by NHS Collaborate, it takes the form of a series of events, run outside of working hours and away from the workplace, in which participants are encouraged to build relationships, acquire new skill sets and develop a readiness to take on new ways of working and thinking. The project has received funding through the GP retention fund but is not aimed exclusively at GPs.

Mike Holmes, GP in York and Hull, co-founder of NHS Collaborate, and RCGP vice-chair said:

‘Essentially this is a peer-supported leadership development programme focussed on building relationships between colleagues across health and social care.

‘At our first event in May, we invited people to volunteer at a local charity for homeless and vulnerable people. We served food to 40 people. It was a really positive experience. Our observation is that when we are working together outside our comfort zone, relationships form very quickly. Our next events are planned in July.’
Box 23: GP-consultant liaison, Wessex

GPs based in Wessex have developed a low-resource and high-impact reciprocal exchange programme between doctors across primary and secondary care. The scheme, known as the GP-Consultant Liaison Scheme, first started in 2015 in Portsmouth and has since been replicated in Southampton and Basingstoke. Participating doctors are paired, spending half a day shadowing each other in their respective places of work, followed by reflections on quality improvement, appraisal and revalidation. Each scheme counts for about eight hours of CPD. Clinicians volunteer to take part in the scheme but often practices are provided with funding for backfill while hospital clinicians’ time is covered in SPA time.

Invest in IT systems that allow information to be shared securely

Lack of adequate IT infrastructure is one of the biggest barriers to creating a more collaborative NHS. Just like patients, doctors report frustrations with not being able to quickly and securely share vital information between primary and secondary care, as well as with other parts of the health service. Different parts of the healthcare system have developed IT systems largely in isolation, with the resulting lack of ‘interoperability’ meaning that patients often report a disjointed experience in navigating different parts of the NHS, which appear to struggle to communicate effectively with each other (see Section 3).

For collaboration to work, clinicians must be able to see patients’ records, observations, results and background notes from any location, ideally in real time. Box 24 gives an example where this has been implemented successfully in east London. However, although a number of areas are exploring solutions to the problem of interoperability, there is a risk this could create an uneven landscape with wide variation between areas in terms of the quality of interoperable IT systems available.

Box 24: Virtual e-clinic for kidney disease, Tower Hamlets

Specialist kidney doctors based at Barts Health Trust and GPs in Tower Hamlets, east London, are working together to provide more effective joined-up care to patients suffering from chronic kidney disease using a pioneering new e-clinic approach. Clinicians on both sides of the primary-secondary care interface have worked together to develop an interoperable IT system that gives consultants access to all patients’ health records and also sends automatic trigger alerts to GP practices about patients most at risk following routine blood test results. Under this new system, outpatient appointments have reduced significantly, with over 70% of referrals that can be managed without the need for patients to attend a hospital appointment. As a consequence, waiting times for patients who require a face-to-face appointment have also dropped significantly. In 2015, the average wait for a renal clinic appointment was 64 days; with the e-clinic, the time to get nephrology advice was reduced to five days on average by 2017.

Box 25: Rajeev Gupta, paediatric consultant in Barnsley and Yorkshire regional council chair, at a BMA member event

‘Doctors – whether hospital consultants or GPs – want to work together because we have a common motive of achieving better patient care. However, due to political reasons... there has been a division. To make the situation even worse, the computer systems of the two places don’t work together.’
Proposed solutions
Governments and national NHS authorities should:
- ensure primary and secondary care settings are digitised at the same time to enable interoperability to be built in by system developers
- explore the implementation of fully automated messaging and document checking services, eg NHS Digital’s NMAS, across health and social care services
- publish an assessment of the likely cost of achieving interoperability in the next five years and produce an ‘interoperability map’ to assess progress so far.

Embed collaboration into how we train doctors and other health professionals
Changing to a more collaborative way of working in the NHS will require changes to the way we train doctors and other health professionals. Current approaches to medical training remain siloed – having started their careers together in medical school and foundation training, doctors tend to fairly quickly split off into different professional groups. The result can often be different groups of professionals, with different cultures, who do not feel part of the same team. This is the case between primary and secondary care clinicians, in particular, and between public health doctors and other parts of the system.

There needs to be an assessment of how doctors’ and other clinicians’ training could be improved to support cross-sector collaboration and integrated care. In England, local training hubs could be a suitable vehicle for multi-agency integration and collaboration on both workforce planning and the delivery of training and education.

In addition, medical education, training and development must evolve alongside the population’s health requirements and ever-changing technological practices. 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 specialties, a large proportion of physicians with general internal medicine training combine this with a specialist interest.

Proposed solutions
National training authorities, NHS and employing organisations need to:
- conduct 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
- meet the need for more generalist care first through existing groups of doctors – GPs and hospital generalist specialties – with investment in and sensible deployment of these doctors
- work with doctors to redefine the role of GPs and specialists as co-providers of care – eg with specialists and generalists increasingly working together in the same settings.

Box 26: Jon Puntis, paediatric gastroenterology consultant (retired), at a BMA member event

‘For doctors, it seems basic really that we should be able to relay stuff electronically so that GPs can pick it up straight away on their computers... [It] shouldn’t be difficult for people to do a discharge summary, for example, electronically and then it’s immediately available to the GP practice.’
5. Next steps: making our ambitious vision a reality

After discussing the proposed solutions set out in this report at the ARM in June 2019, the BMA’s findings will be published in full this summer. We will then embark on a programme of lobbying policy makers at UK, national and local level to implement the changes doctors have proposed.

As outlined above, the work of promoting many of the emerging findings of the project has already begun, through initiatives such as our safe staffing campaign and work across the UK on combatting bullying and harassment. We have already started to engage senior policy makers through our series of roundtables in England and through high-level meetings in Scotland, Wales and Northern Ireland. This work will continue.

Following the ARM, we will also continue to engage the BMA’s members, asking for their ongoing insight into the pressures and opportunities facing doctors in the NHS. We will also be asking doctors to join us in putting pressure on policy makers to take action based on the proposed solutions outlined in this document.
References


5. Source: gmcuk.wordpress.com/2017/07/17/the-act-needs-action

6. UK has fewer doctors than most other OECD countries. BMJ, 2017

7. For more on this and recommendations, see the BMA document Medical Rota Gaps in England (2018)

8. BMA consultants pension survey 2018


10. For further detail on this and related retention recommendations, see also Supporting an ageing medical workforce, BMA, 2019

11. Source: Supporting an ageing medical workforce, BMA, 2019

12. The medical associate professions are physician associates, surgical care practitioners, advanced critical care practitioners and anaesthesia associates

13. Source: england.nhs.uk/gp/case-studies/wallingbrook-health-group

14. Source: esht.nhs.uk/2017/01/05/new-role-of-doctors-assistants-starts-at-east-sussex


17. Reform (2018). Thinking on its own: AI in the NHS

18. ‘BRIDGES’ stands for Building Relationships through Inclusivity to Develop HCV’s and HRW’s Stakeholder Groups to Lead Emerging Systems

19. In England, 95% of doctors agreed that patient data should be shared between primary and secondary care for the purposes of direct patient care.