Creating a caring, supportive, collaborative workplace for doctors

Dr Chaand Nagpaul CBE
BMA Council chair

6 November, 2018

The challenges facing the NHS - underfunding

BMA

"If instead you think modern Britain should look more like Germany or France or Sweden then **we're underfunding our health services by £20-30 billion a year"**

Simon Stevens, November 2017

Even £10bn could pay for 35,000 more hospital beds and 10,000 extra GPs now

Under doctored and under-bedded

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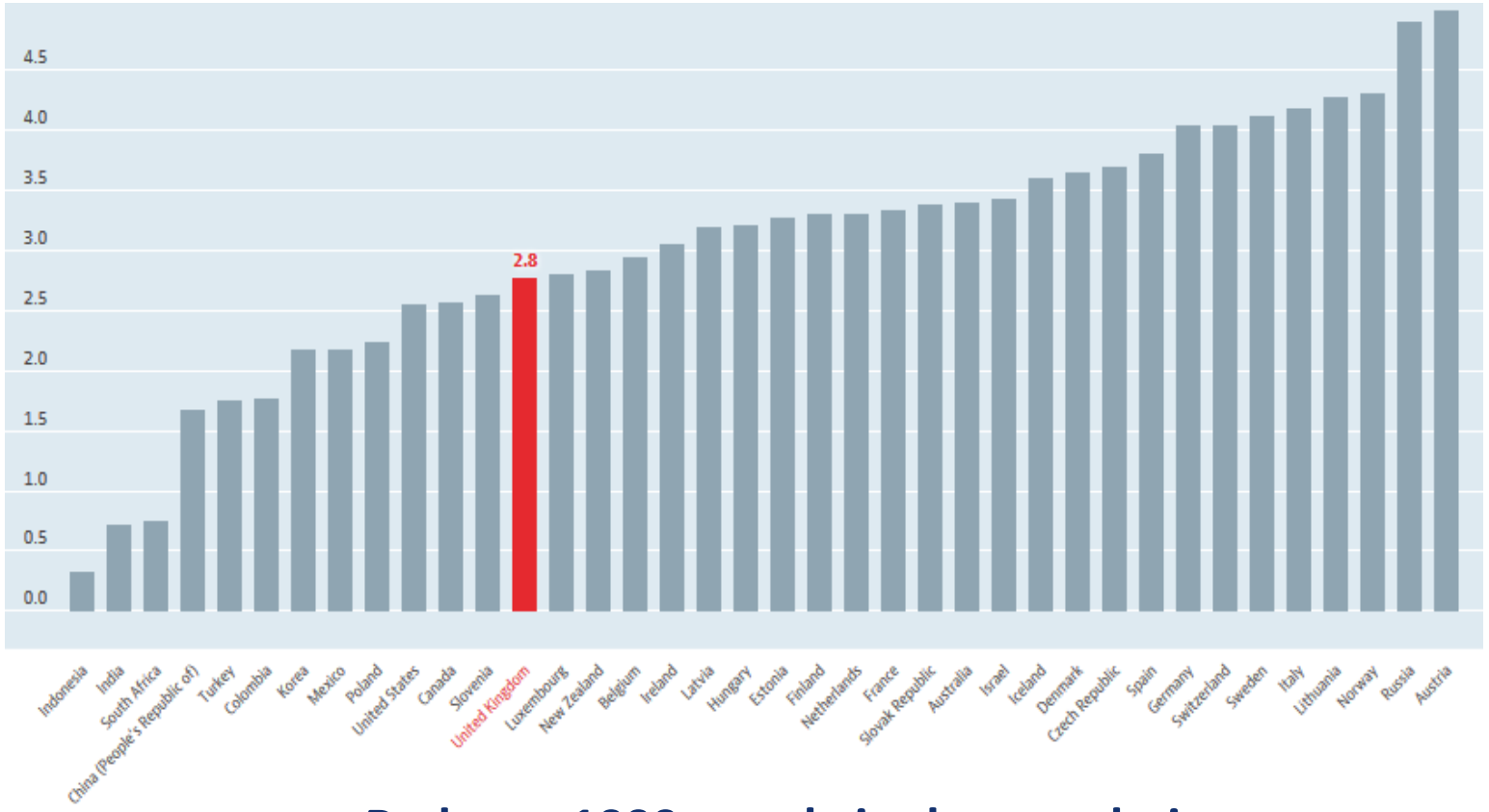
The UK has only **one doctor** for every **360 people.** The EU average is **one doctor** for every **288 people**.



Beds per 1000 people in the population

OECD, 2013

Between **2006/07** and **2015/16** the number of overnight beds has decreased by **over a fifth.**

1/5

Unless stated otherwise, all data is published by NHS England

Workforce: recruitment and retention

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Fewer people are choosing medicine as a career, with a drop off at each stage of doctors' training, and growing number of clinical vacancies across the NHS

- Fewer applications to medical schools – 13.2% decrease since 2013
- Fewer applications to specialty training and only 50% of F2s progressing directly into specialty training
- 75% of all medical specialties had unfilled training posts in 2016
- 69% of trusts are actively recruiting abroad for doctors or nurses
- 31% of practices were unable to fill GP vacancies in the last year
- 1 in 3 GPs intending to retire in next three years
- No. of hospital doctors taking early retirement increased from 164 in 2008 to 397 in 2018 (from NHS pensions data)

This is leading to rota gaps in hospitals and impacting training opportunities for junior doctors:

2/3 junior Drs in BMA survey reported rota gaps.

Five year funding and 10 year plan for NHS

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In June 2018, Prime Minister announced:

- NHS in England will receive a funding increase totalling £20.5bn in real terms by 2023/24 - average increase of 3.4% a year from 2019/20
- Some areas of spending not included e.g. public health, capital investment, medical education and training
- Therefore overall increase closer to *3 per cent*
- Is lower than 4% annual increase proposed by independent thinktanks
- We will still lag leading EU averages in health spend

A decade of underfunding

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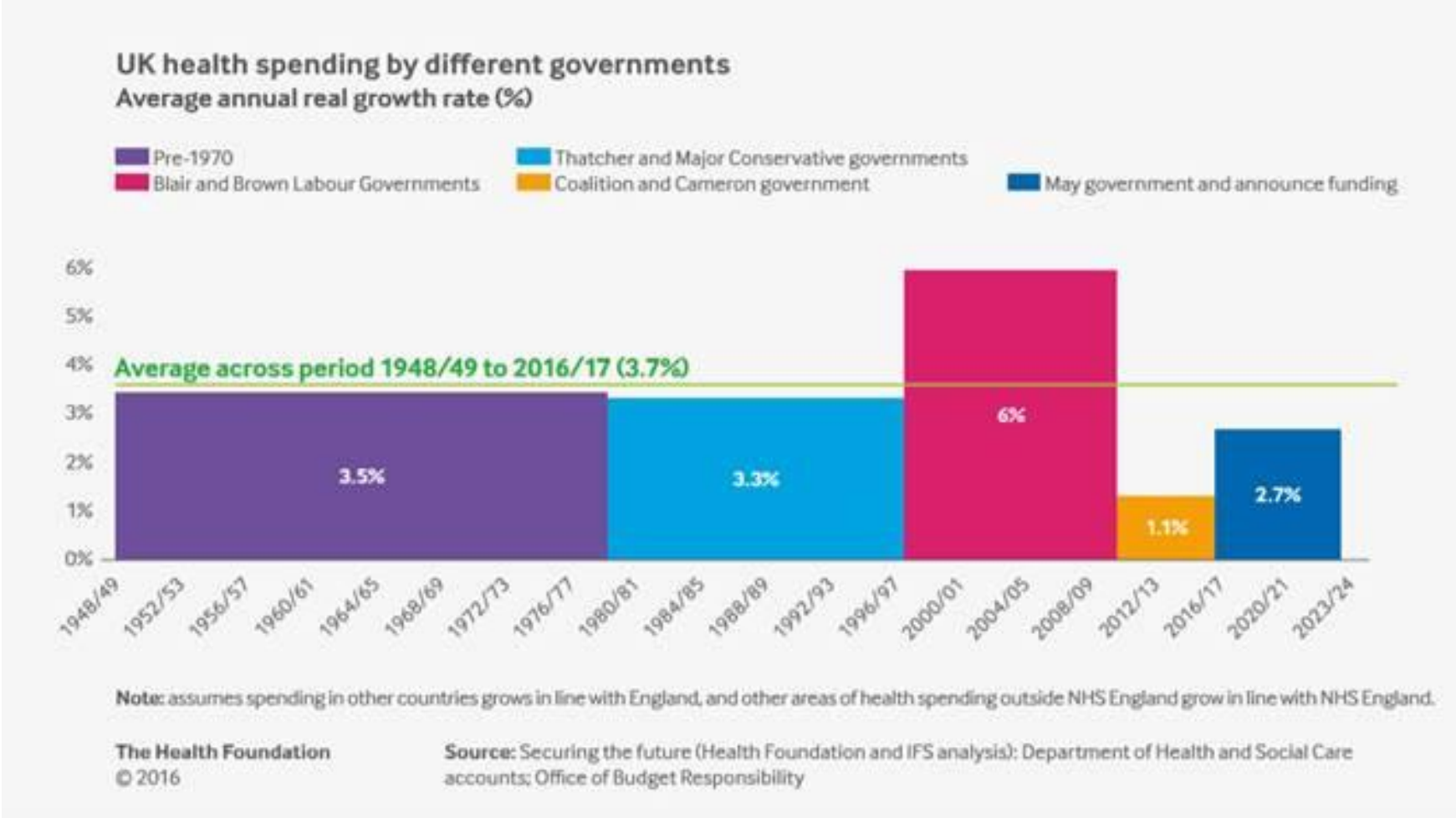

BMA vision for the future: Caring, supportive, collaborative

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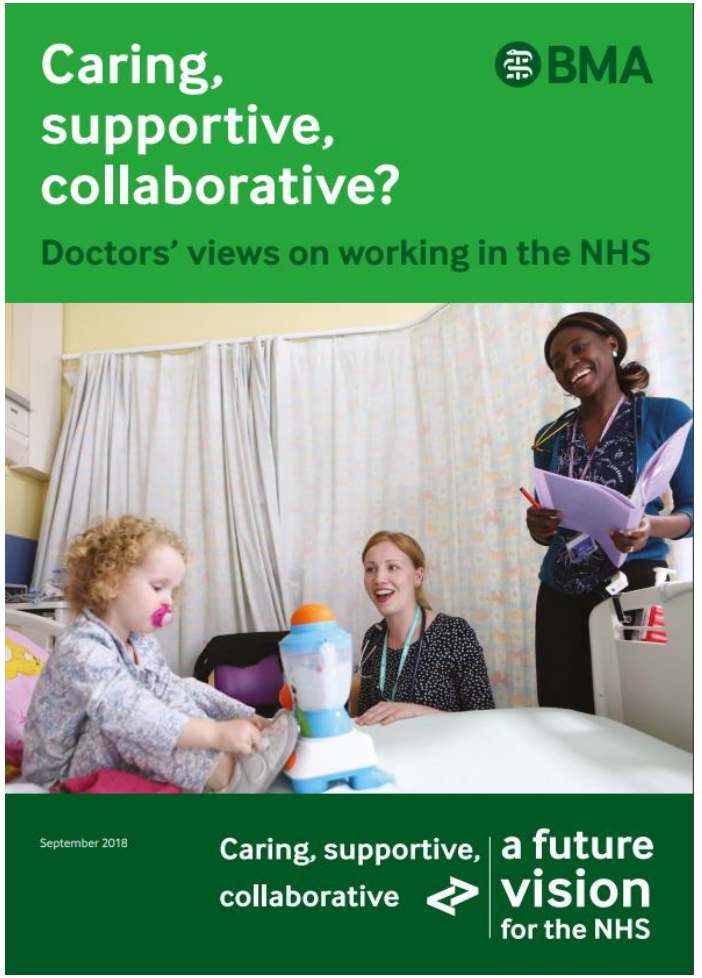
- What sort of future doctors want to work in
- BMA ideally placed – representing all doctors working in all specialties/sectors
- Iterative project – consultation with members
- Major all member survey, nearly 8000 responses
- Report launched Sep 2018
- Three themes:
  - Culture
  - Workforce and workload
  - Structures and collaboration



NHS resources affecting safe, quality care

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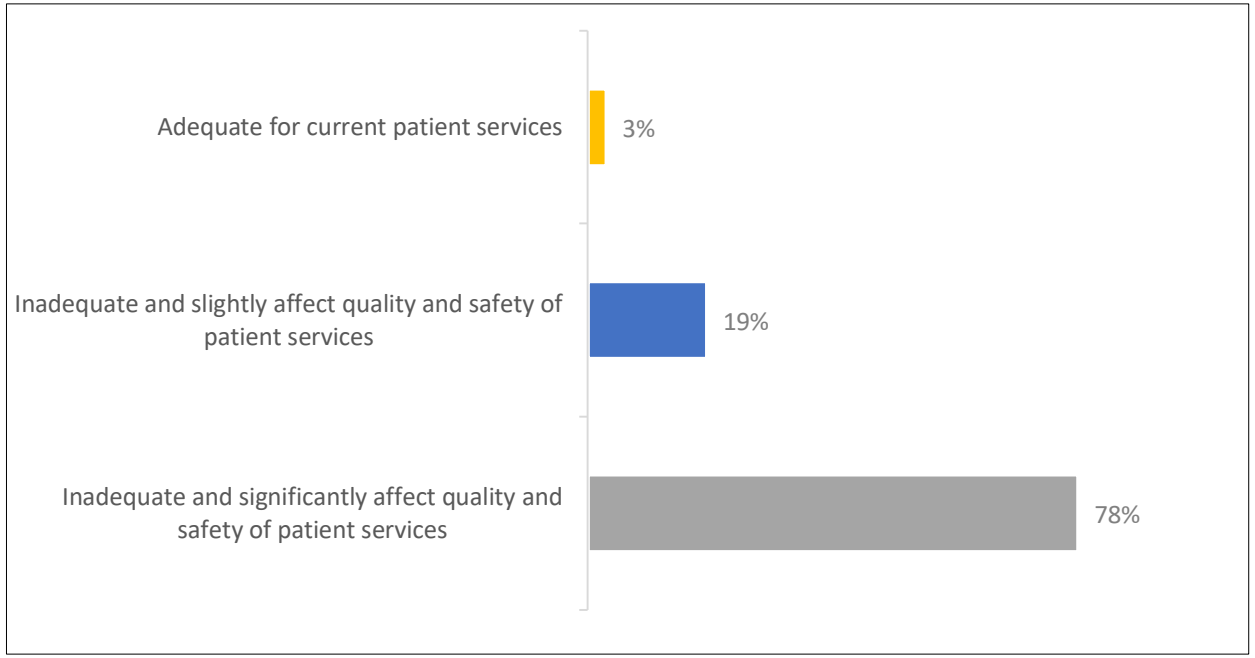
Which of the following statements best reflects your views about NHS resources in your nation?



- **97% of doctors reported that current NHS resources are simply inadequate and affecting the quality and safety of patient care**

- More worryingly, most doctors (75%) reported that some **services have worsened** in the past year including:
  - Waiting times for patients (76%)
  - Staffing levels (74%)

NHS culture: Francis inquiry and Berwick recommendations

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- Five years on from Francis Inquiry (Feb 2013) and Berwick report (Aug 2013):

  "NHS staff are not to blame – in the vast majority of cases it's systems, environment and constraints they face that lead to patient safety problems".

  "Operational targets and financial management have taken precedence over delivering high quality care"

  NHS needs "*a culture of learning*"

  "Fear is toxic to both safety and improvement"

Targets and patient care

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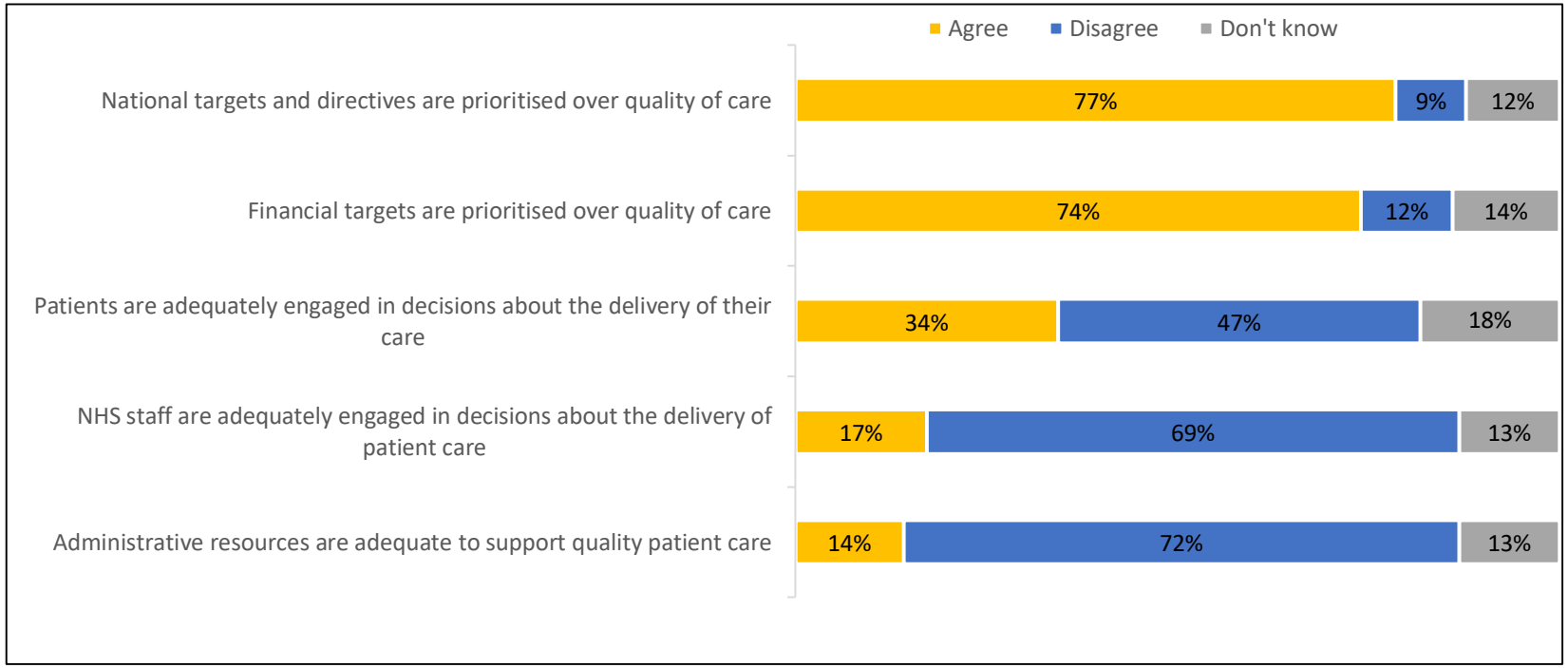

Culture: Fear, blame and error

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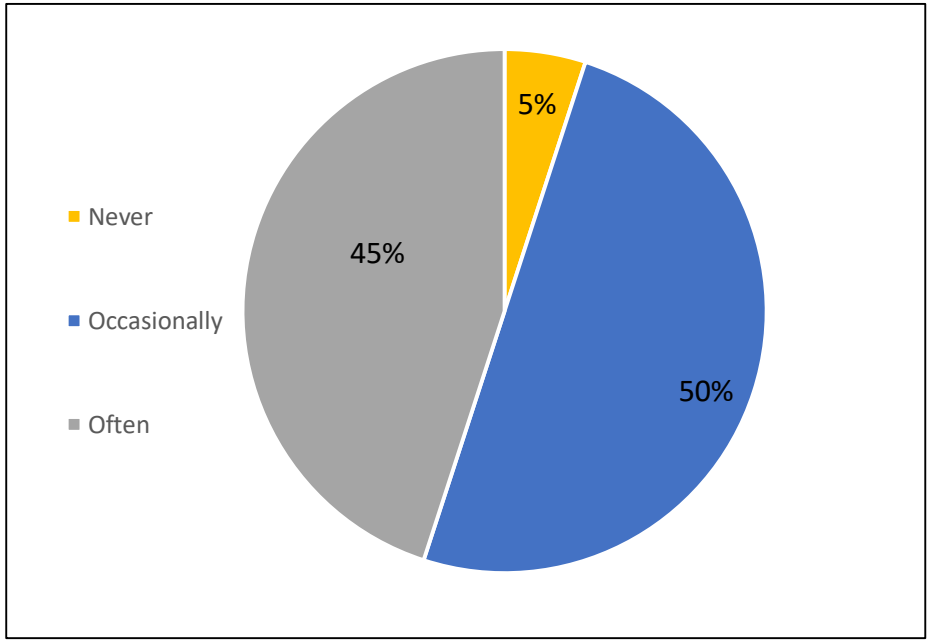
- Overwhelming majority of doctors say that they are sometimes or often fearful of making a mistake (95%)
- 55% say more fearful of making mistake compared to 5 years ago
- Over half of doctors fear being unfairly blamed for errors (55%) due to system failings and pressures of the workplace
- As a result, half of doctors practice defensively (49%)
- Just 40% feel content to report errors
- Just 40% feel they work in an environment of learning to prevent future errors
- 43% are cautious about recording reflective practice for fear it could be used against them (this is particularly the case for junior doctors)

Are you fearful of making a medical error in your daily workplace?



Why do errors occur?

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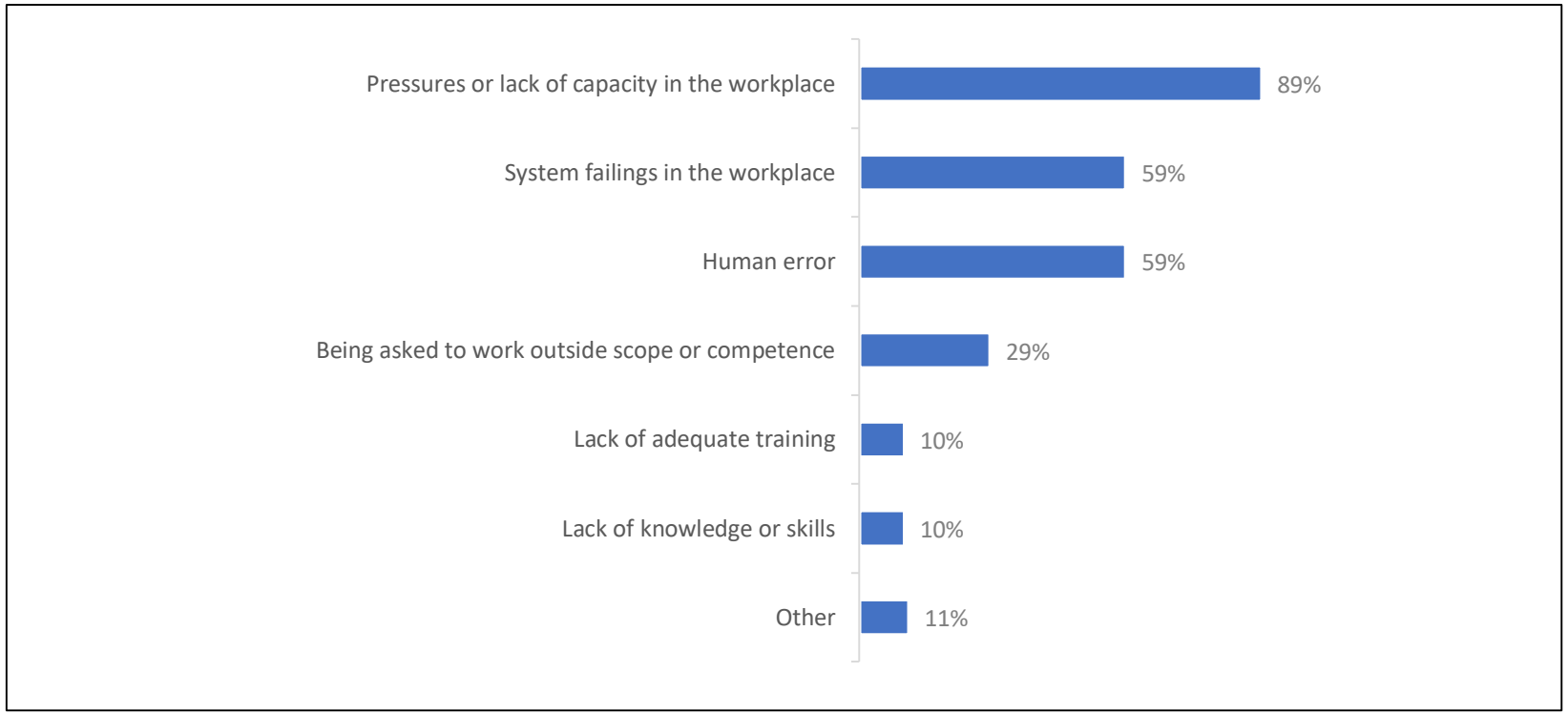

In England, it is therefore concerning that just 9% of doctors say CQC inspections take into account system pressures, with 71% saying that these inspections add to fear and worry amongst staff.

Systemic factors affecting safe care

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Q: Which of these factors (may not all be relevant to your setting) affect your ability to deliver safe patient care in your main place of work?	All UK working doctors, who feel prevented by system pressures	UK working GPs	UK working Hospital doctors
Being pressured to attend to multiple tasks simultaneously	68%	83%	59%
Lack of time to attend to patients	63%	86%	50%
Lack of doctors/unfilled vacancies/rota gaps	62%	53%	68%
Lack of nurses and other health professionals	55%	36%	66%
Fatigue caused by working long hours	39%	54%	31%
Lack of beds	35%	9%	51%
Lack of administrative support	33%	21%	39%
Operational rules and organisation in the workplace	28%	17%	35%
Limited access to diagnostic and other facilities	22%	29%	17%
Being pressured to work outside scope of practice or competence	16%	28%	9%
Lack of equipment	9%	3%	13%
Other	6%	8%	5%

Raising concerns

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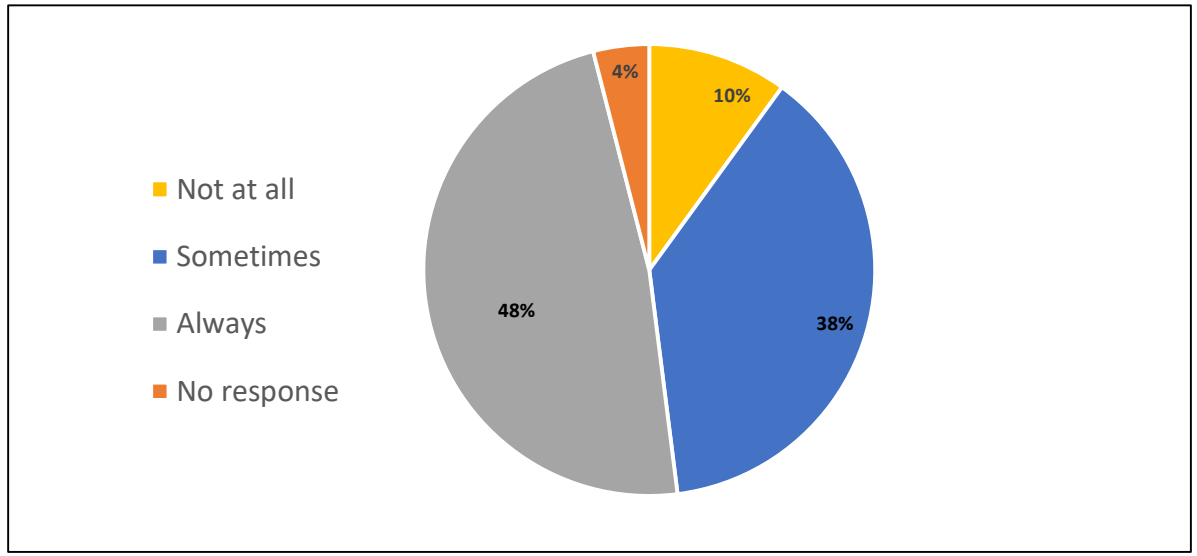
If you had concerns about patient care within your main place of work, would you feel confident in raising them?



- Less than half of doctors (48%) always feel confident in raising concerns
- BAME doctors almost twice as likely as white doctors to say that they would not feel confident in raising concerns (14% compared to 8%)
- 50% doctors say they feel they will be unfairly blamed or suffer adverse consequences if they raise concerns
- BAME doctors also more likely to say they feared being blamed or suffering adverse consequences (57% vs 48% of white doctors)

Bullying and harassment, and inclusivity

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- BMA SAS doctors survey 2016 highlighted significant bullying and harassment
- 2018: Two-fifths of doctors said that bullying, harassment and undermining is often or sometimes a problem in their main place of work
- BAME doctors more than twice as likely to say that there is often a problem with bullying, undermining or harassment (18% vs 7%)
- Only 55% of BAME doctors said there was respect for diversity and a culture of inclusion in their workplace compared to 75% of white doctors
- Only 57% of BAME doctors agreeing there is effective team working in their workplace compared to 72% of white doctors.
- Roger Kline study – bullying costs NHS estimated £2.3bn
- BMA 2 year project; Bullying and Harassment conference November 2018

Race inequality in the NHS

BMA

- **Differential attainment in medical education and training** - 75.8% pass rate among UK white medical graduates vs 63.2% for UK BME medical graduates, 41.4% pass rate overseas Drs outside UK/EU
- **Unequal opportunities to progress -**7% NHS senior managers BME backgrounds
- Most consultants are white British - BME doctors more likely to be in SAS grades
- RCP report **today**: white CCT holders more likely to be shortlisted for a post (80% versus 66% for all other ethnic groups)
- White CCT holders more successful at being offered a post (77% vs 57% other ethnic groups)
- **Ethnicity pay gap** – BMJ Sep 18: white consultants paid nearly £5000 more than those from BME backgrounds
- **Disproportionate cases of complaints, disciplinary action and fitness to practise proceedings**
- BMA race equality summit July 2018

Time to learn?

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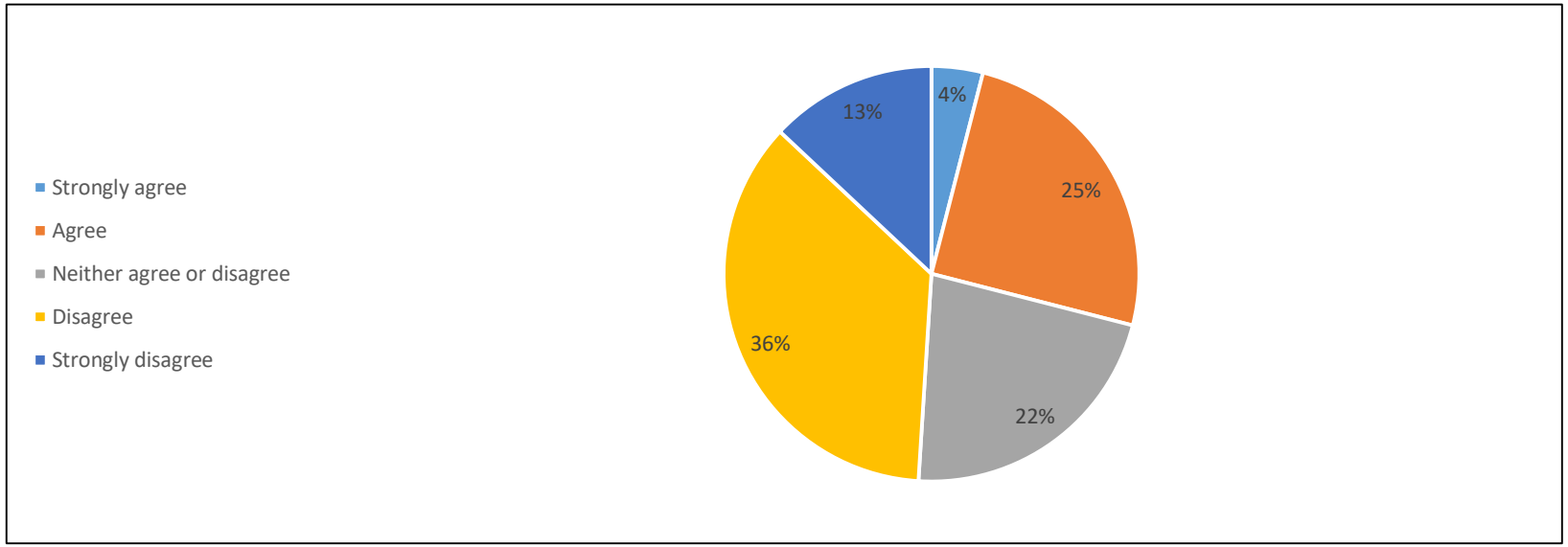

- Almost half of doctors (49%) said they do not have adequate time to learn and develop professionally.
- Only 3 in 10 said they do.
- SAS doctors: development funding constraints

Working beyond contractual hours

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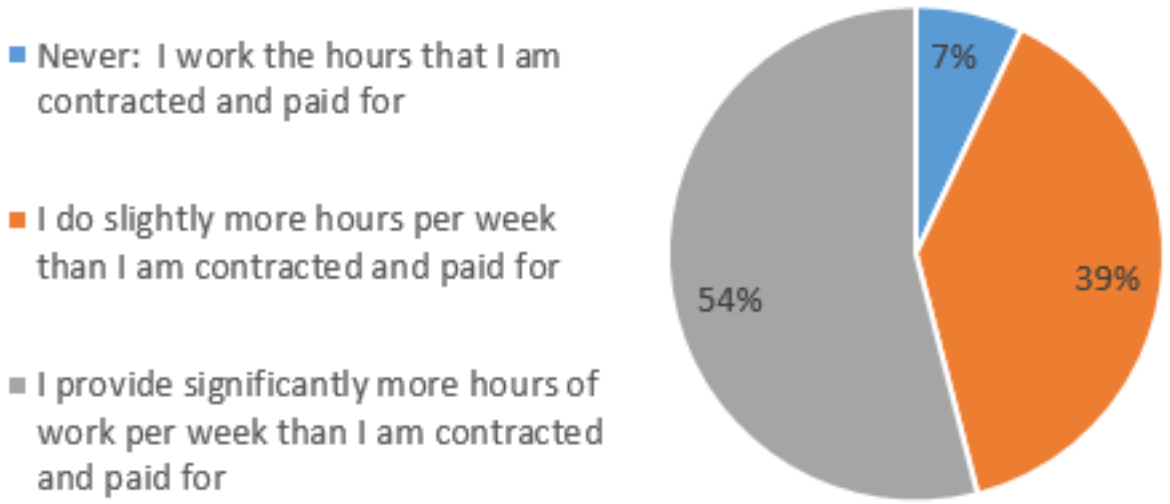
On average, do you work unpaid beyond your contractual hours?



- Doctors work overtime and are doing work they could delegate
- The majority of doctors (92%) report that they are working over their contracted hours

Workforce: Providing cover

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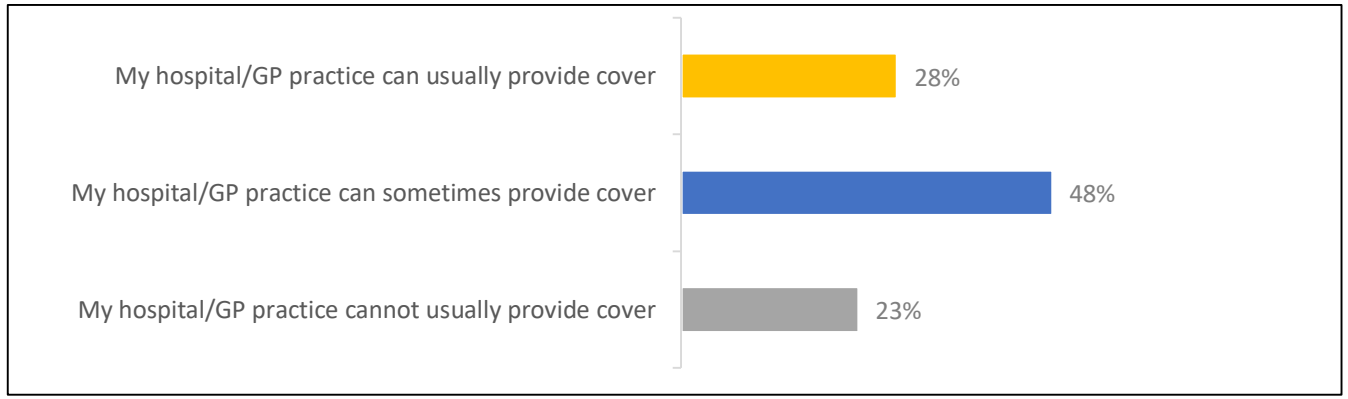
Which of the following statements best reflects the approach in your main place of work to providing cover for doctor absences or unfilled vacancies (locum or overtime)?



Less than 1 in 3 hospitals/GP surgeries can usually provide cover

Why cover was not provided?

- A lack of locums in their area (54%)
- **The organisation not being able to afford the cost of locums or overtime due to financial pressures (52%)**
- Doctors being unwilling or unable to work additional overtime in their area (44%)

Work that could be delegated: non-medical clinical staff

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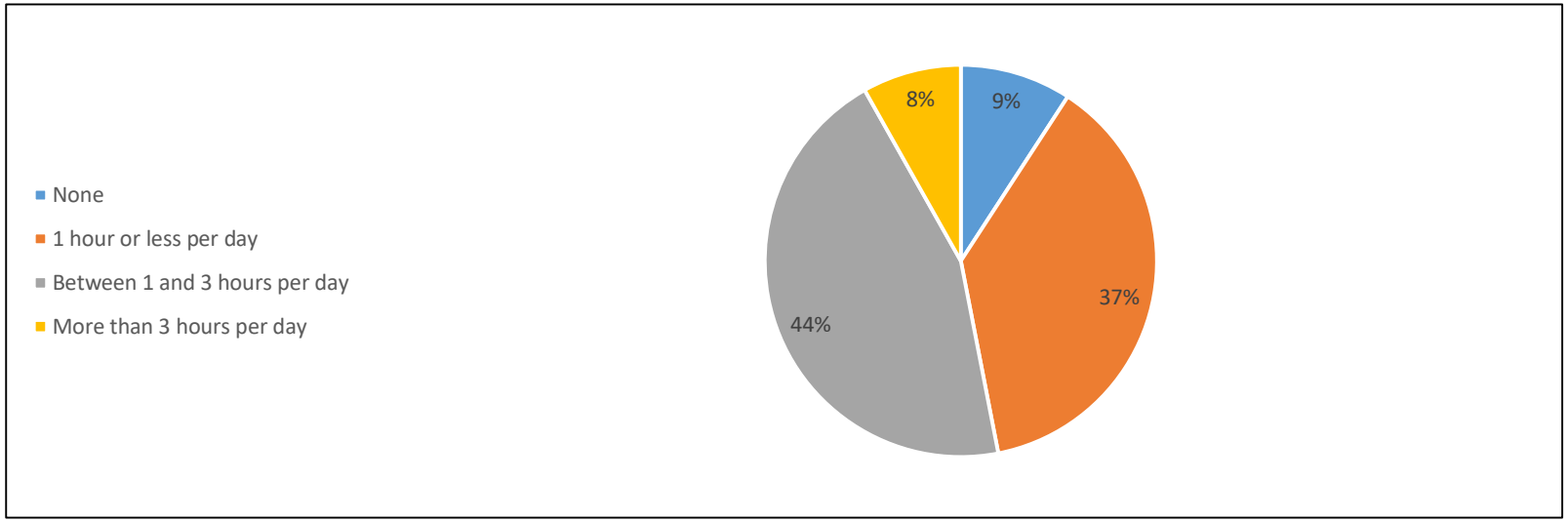
How much time on average do you spend on work that could/should be done by: another non-medical clinical professional

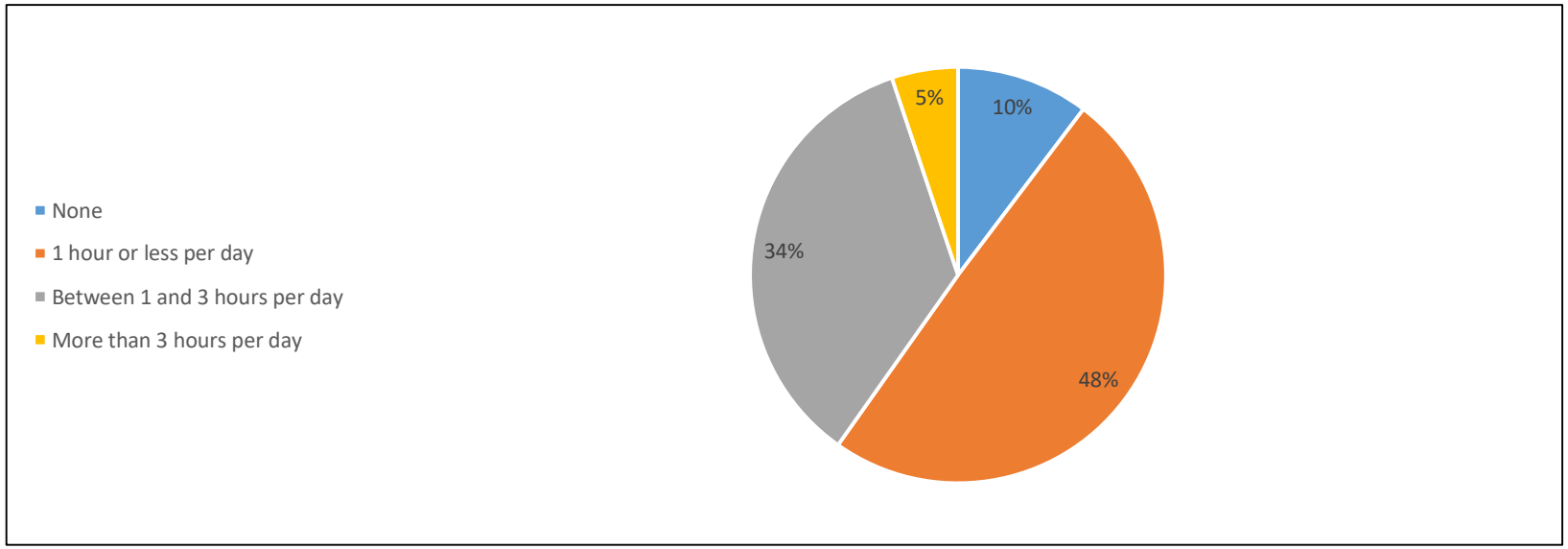


- At least half of doctors said they spend over 1 -3 hours on work daily that could be done by another non-medical clinical professional (52%)

Work that could be delegated: non-medical administrative staff

BMA

How much time on average do you spend on work that could/should be done by: another non-clinical staff



- 39% say they spend over 1 -3 hours on work daily that could be done by a non-clinical member of staff.

Workforce and workload: doctors views on non-medical clinical workforce

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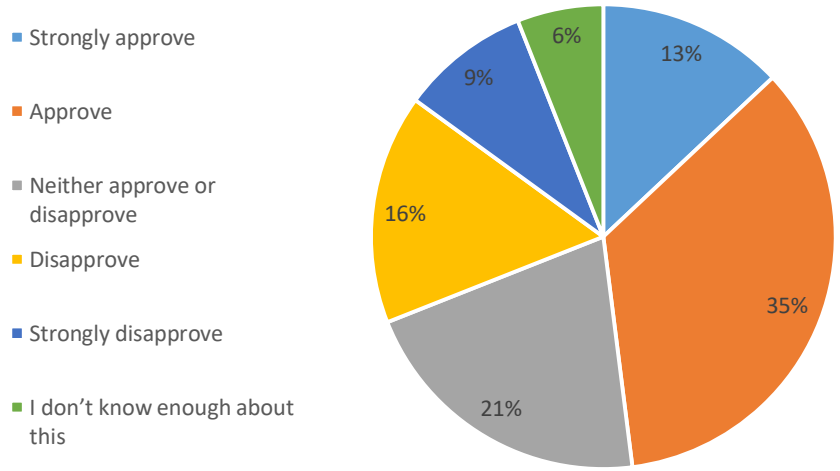
- Some doctors support expanding the non-medical clinical workforce to ease pressures, with 48% saying they approve of recent trends in this area
- GPs are more likely to approve (53% vs. 45% hospital doctors)

To what extent do you approve of the current focus on expanding the non-medical clinical workforce (e.g. surgical care practitioners, advanced care practitioners, physician associates, general practice pharmacists)?



Workforce and workload: What changes do doctors want?

BMA

What workforce changes would improve your day-to-day working life?	All UK working doctors
Guaranteed safe levels of medical staffing	57%
More effective IT systems that are interoperable	53%
Limit number of consultations per session to a safe number	47%
Improved systems and processes for the primary and secondary care interface	43%
Additional support from non-medical clinicians (e.g. physician associates, primary care pharmacists)	42%
More favourable pay, terms and conditions of service	40%
Additional support for patient related administration	35%
Patient empowerment to self-care/ manage	34%
More flexible working options	26%
Visible and accessible senior management who engage with the medical profession	26%
Improved facilities (e.g. rest, food, etc.)	21%
Greater use of new technologies	18%
Better access to health and wellbeing services (including occupational health)	14%

Structures and collaboration: Primary/secondary care interface (1)

BMA

Which do you agree with regarding the primary/secondary care interface?	All UK doctors (n=7535)	UK GPs (n=2313)	UK Hospital doctors (n=3967)
Organisational barriers between primary and secondary care are resulting in increased bureaucracy and administrative costs	73%	84%	67%
There is unfunded workload shift from one sector to the other	66%	92%	52%
Quality and safety of patient care is being compromised due to barriers between primary and secondary care	60%	74%	52%
Organisational interests take priority over patient services	57%	60%	52%
There is a good relationship between GPs and hospital doctors	28%	24%	29%
There is duplication of staff and services in primary and secondary care	21%	25%	19%
There are clear channels of communication between primary care and secondary care	16%	13%	19%
Patients experience co-ordinated care between hospitals and general practice	9%	6%	11%

- Across the UK, **73% of doctors** say that organisational barriers between primary and secondary care are resulting in **increased bureaucracy and administrative costs**
- **60% doctors believe quality and safety compromised quality and safety of patient care** as a result of problems at the interface between primary and secondary care
- **unfunded workload shift (66%) and organisational interests (57%) taking priority over patient services.**

Structures and collaboration: Primary/secondary care interface (2)

BMA

Q: Do you agree or disagree with the following statements concerning how doctors work together across primary and secondary care?	All working, overseas and retired doctors in England
Patient data should be shared between primary and secondary care for the purposes of direct patient care (with appropriate information governance safeguards)	95%
Collaboration between primary and secondary care doctors will improve the quality of patient services and experience	94%
GPs and hospital doctors should work together more directly in a collaborated and coordinated manner	93%
There should be shared pathways across primary and secondary care, with resources fairly directed to where care is delivered	92%
Hospital doctors should be able to prescribe medication that can be collected at a patient's community pharmacy	90%
Collaboration between primary and secondary care doctors will reduce bureaucracy and transaction costs	82%
There should be system-wide incentives that encourage doctors to work more collaboratively	80%
Hospital doctors should be able to directly arrange investigations to be done in the community	75%
There should be protected funding for schemes designed to promote closer joint working	70%
Doctors across primary and secondary care should be employed by the same organisation	35%

Example of primary/secondary care collaboration

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East London Community Kidney Service – January 2018

Neil Ashman – Kidney Physician, Sally Hull – GP and CEG lead
Helen Rainey – Clinical nurse specialist for Kidney Disease
Nicola Thomas– Kidney Nurse and Professor of Kidney Care

1. Rising rates of End Stage Renal Disease (ESRD) in East London –4% annual growth costing about £6m.
2. Gaps in primary care identification and CKD management.
3. No systematic CKD self management/education for patients
4. Long delays to see kidney specialists.

Barts Health NHS Trust

ceg Clinical Effectiveness Group

NHS Tower Hamlets Clinical Commissioning Group

London South Bank University

What are we doing about this?

BMA

1. Community CKD e-Clinic
Community-based nephrologist does e-clinics in EMIS Web. All reviews and opinions recorded in EMIS Web
Locally relevant guidelines.

E-referrals
Shared record and local guidelines

2. Education: patients and practitioners
Patient one-to-one and group education.
Practice based education for clinicians.

Community based education

3. Community CKD overview in primary care
CKD Prevalence searches to find un-coded patients.
CCG/Practice dashboards with KPIs 'Trigger tools' to alert GPs to patients with a falling eGFR.

Find and code cases

Practice safety alerts

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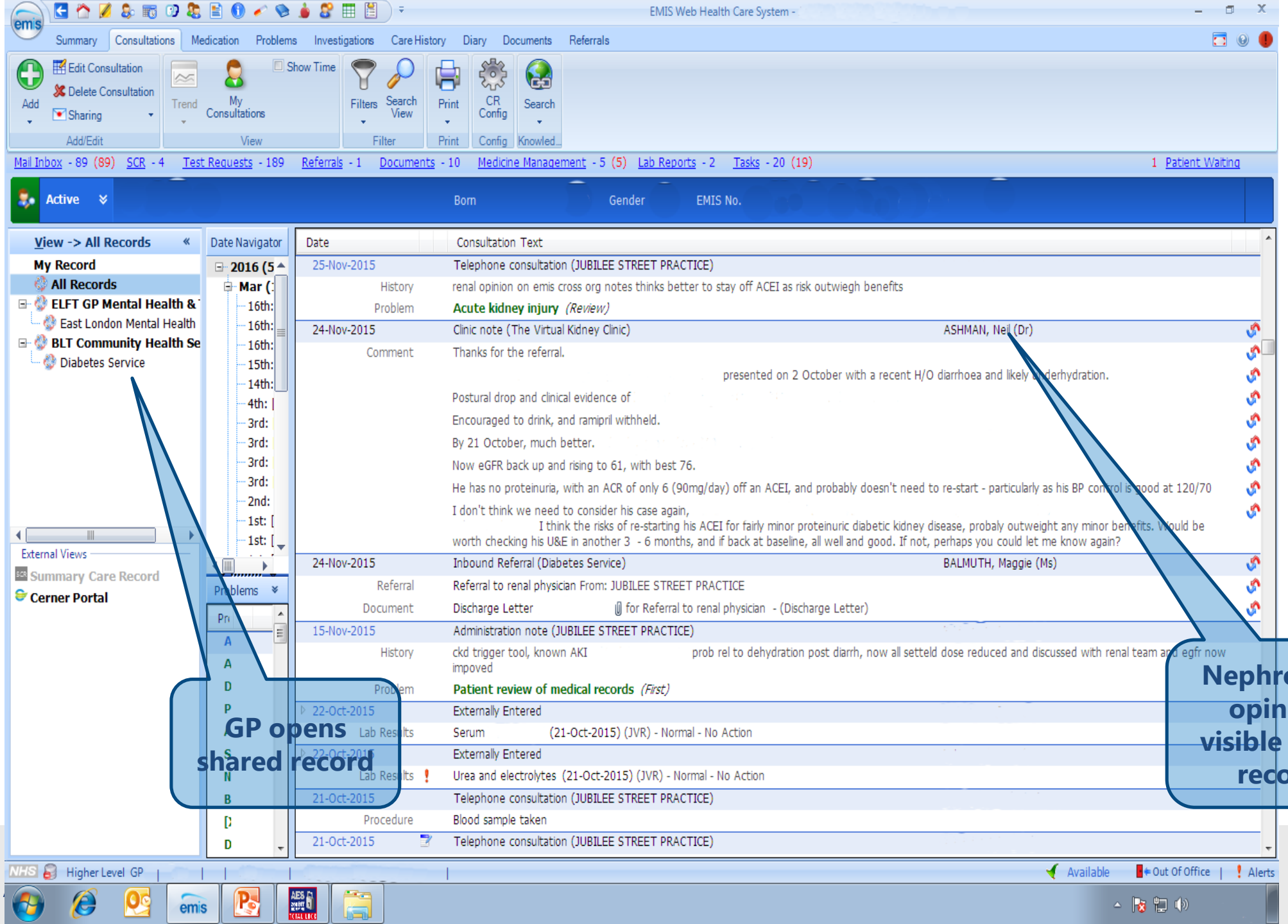

Results from the e-clinic: Tower Hamlets 2015/16

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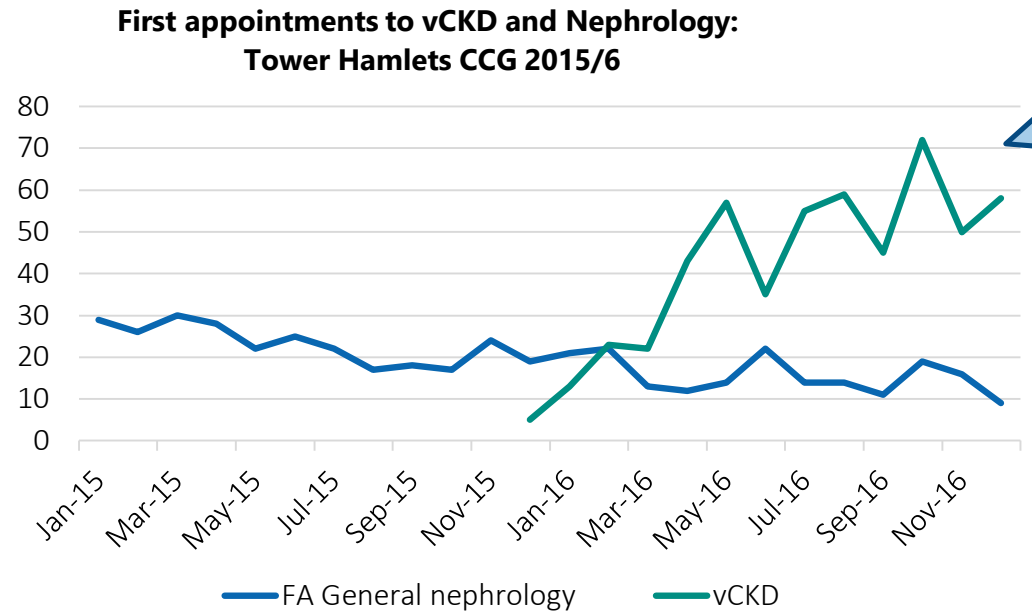
Waiting times for outpatient advice slashed!

- The pilot period demonstrated simplicity of use, with rapid buy into the service.
- Over 70% of referrals are managed without the need for patients to attend a hospital appointment.
- In 2015 the average wait for a renal clinic appointment was ***64 days***. With the e-clinic the time to get nephrology advice is ***5 days.***

GPs say...
A model for future care happening right now in Tower Hamlets!



Only 20% of patients require a face to face appointment

Clinic Outcomes 2016	No.	%
OP F2F Appointment	111	21.5
Discharge to GP	255	50
Review in vCKD	143	27.5
Other	5	1
Total	**514**	**100**

Creating a caring supportive collaborative NHS

BMA

1. **What sort of culture?** What does good look like in your workplace? What needs to change
2. **What sort of workforce?** How do we cope with an under-doctored workforce with escalating demand. The role of non-medical clinician.
3. **What would a collaborative NHS look like?** How can doctors across primary/secondary care work as one team? What needs to change?

BMA consultation with members and stakeholders 2018-2019 - a future vision for the NHS

SAS doctors

BMA

- The backbone of specialty services in the NHS
- **Caring, supportive, collaborative -what it means for SAS doctors:**
  - Supportive caring culture
  - Equal opportunity
  - Fair recognition
  - Fair rewards
  - Future role of SAS doctors in collaborative models of care
- Realising full potential of SAS doctors key to addressing workforce challenges, a better NHS and improved patient care
- SAS charter; associate specialist role
- New NHS investment

Thank you!

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