Written evidence submitted by The British Medical Association (WBR0069)

About the BMA

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

This response to the Health and Social Care Select Committee outlines the experiences and views of the BMA and its members in relation to workforce burnout and resilience in the NHS following the outbreak of COVID-19.

Overview

- Consistent workforce shortages across the medical profession over many years has contributed to doctors being over worked. This in turn has impacted morale through increased and unnecessary, pressure and led to more staff leaving the NHS, thus making the situation worse. Even before the pandemic this situation was unsustainable and had to be addressed if patients' needs were to continue to be met.
- The pandemic has laid these existing workforce shortages bare, revealing their true extent and demonstrating to the wider public the extent to which the NHS is under resourced to deal with day-to-day need, let alone a pandemic situation.
- In a BMA survey carried out during the pandemic, nearly half of doctors' reported suffering from depression, anxiety, stress, burnout, emotional distress or another mental health condition[1]. Of those doctors currently suffering, the majority say their condition has become worse during the pandemic.
- The BMA's own mental health and wellbeing support services saw a 40% increase in use over March, April and May 2020, including from those feeling anxious about going to work and facing unknown and unprecedented situations.
- To address this situation occupational health services must be made accessible to all those who need them across all healthcare settings, including for all those working in GP practices, and these services must have the capacity to provide support when it is required.
- Government must ensure that healthcare staff who present with significant mental health conditions are able to access appropriate timely treatment when they need to. Such support will help to improve both the recruitment and retention of healthcare staff.
- Workplaces should also provide peer support and mentoring to ensure doctors are able to reflect on their experiences. Staff who need to take time off or would like to work flexibly should be supported to do so.
- A long-term strategy is also needed to protect and maintain the physical, mental, and emotional wellbeing of the workforce and must be implemented as a priority.
- To address workforce shortages a single national workforce dataset, which includes regional staffing levels and consistent vacancy data for all providers is required, to enable more targeted approaches to recruitment and retention.

1. How resilient was the NHS and social care workforce under pre-COVID-19 operating conditions, and how might that resilience be strengthened in the future?

[1] BMA, https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-analysing-the-impact-of-coronavirus-on-doctors

1.1 The combined total of FTE (full-time equivalent) doctor and nurse vacancies at the end of June 2020 was 46,099[2], whilst the overall NHS 'all staff total' was 83,591 FTE vacancies. This is a significant number, and these shortages, should they persist or increase further, will undoubtably impact the ability of the NHS to meet patient need. Despite the Government's plea to former clinical staff who had previously retired or left the NHS to return and help with the pandemic response, secondary care medical FTE vacancies only reduced by 60. This slight increase in workforce numbers does not begin to address the scale of growth needed, nor does it address the exponential rise in patient demand and complex multiple morbidities in recent years. Meanwhile, FTE qualified GP numbers are down 1,798 since September 2015. More must be done to overcome unsafe staffing levels across the NHS and our cares services.

1.2 Pre-COVID-19 NHS staff sickness absence rates were double the national average, placing major burdens on the NHS in terms of cost and continuity of care. While we are aware that a significant proportion of staff will also come to work when they are unwell, we consider that this demonstrates an at-risk workforce, who are more likely to be exposed to transmittable diseases, and who are also more likely to be subject to intense pressure and overwork, impacting overall health and wellbeing. In the most recent NHS Staff Survey 56.6% of staff reported attending work despite feeling unwell because they felt pressure from their manager, colleagues or themselves. Work-related stress is a significant contributor to NHS workers feeling unwell affecting 40% of staff[3]. According to the most recent data by NHS Digital, the most reported reason for sickness absence was anxiety, stress, depression, or other psychiatric illness[4].

1.3 Morale before the pandemic hit was low amongst the medical profession. The BMA has tracked the workload, wellbeing and morale of doctors over successive years and up to the end of 2019, morale across all medical branches of practice (BoP) was at best moderate. The morale of GPs has remained consistently below average and was the lowest of all BoPs throughout our surveys[5] . Even before the outbreak of the pandemic, workload was too high. In 2018 the BMA project *Caring, Supportive, Collaborative: A future vision for the NHS,* revealed that both GPs and hospital doctors reported working significantly more hours work per week than they were contracted for, with 75% of GPs providing additional hours and 43% of hospital doctors working additional hours[6]. Such continued overwork is likely to have a further negative impact on both morale and wellbeing.

1.4 The NHS' blame culture has also contributed to low morale. Prior to the pandemic doctors reported a culture of fear across the NHS, where blame stifled learning, contributing to a cycle of low morale and poor rates of recruitment and retention[7]. Doctors were leaving the profession due to a feeling of being undervalued and this situation needed to be addressed urgently for the NHS to continue to meet the needs of patients.

1.5 To address this situation, it is imperative that the NHS increases staffing levels across all settings and specialties, while simultaneously developing better wellbeing services, including occupational health and mental health support. The BMA recommends implementing the blueprint from our report *Caring, Supportive, Collaborative: A future vision for the NHS* to embed a culture of learning and inclusivity[8].

2. What has the impact of the COVID-19 pandemic been on resilience, levels of workforce stress, and burnout across the NHS and social care sectors?

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[2] NHS Digital (August 2020), *NHS Vacancy Statistics England April 2015 – June 2020 Experimental Statistics*,

[3] NHS Staff Survey, https://www.nhsstaffsurveys.com/Caches/Files/ST19_National%20briefing_FINAL%20V2.pdf

[4] NHS Digital, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/april-2020-provisional-statistics

[5] BMA Quarterly Survey, available on request.

[6] Caring, Supportive, Collaborative: A future vision for the NHS, 2018, https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/the-future/caring-supportive-collaborative-a-future-vision-for-the-nhs

[7] Ibid

[8] Ibid

2.1 Our 2019 report, *Caring for the mental health of the medical workforce,* showed that doctors working the longest hours (51 hours + per week) were most likely to report experiencing symptoms of a significant mental health condition[9]. The findings also revealed that many doctors were unaware of how to access support for their wellbeing at work and a preference to seek support away from the workplace. For some doctors, stigma towards poor mental health was a significant problem, while perceptual barriers to seeking support remained for many.

2.2 While our in-depth research showed there are many intrinsic factors in being a doctor that can make their lives stressful, there were systemic issues which affected the profession. These included understaffing and rota gaps, increased pressure to do more with less, including having less time for patients themselves. Many doctors said a lack of flexibility in their roles made achieving a positive work-life balance especially difficult.

2.3 The pandemic has made matters worse. During the COVID-19 pandemic, the BMA has conducted a regular COVID tracker survey, to better understand doctors' experience and the impact of COVID-19 on their working conditions. Nearly half of doctors have reported suffering from depression, anxiety, stress, burnout, emotional distress or another mental health condition. Of those doctors currently suffering, the majority say their condition has become worse during the pandemic[10]. The pandemic has also had a disproportionate impact on BAME communities and healthcare workers and we have heard anecdotally from our BAME members that this has been immensely stressful for them.

2.4 The pandemic has had the effect of shining a spotlight on existing workforce shortages, waiting times and resource shortages across the NHS. With this additional pressure, it is no wonder that so many doctors are reporting to the BMA that they feel overwhelmed and that their mental health has suffered as a result. The BMA's own wellbeing support services saw a 40% increase in use over March, April and May 2020, including from those feeling anxious about going to work to face unknown situations.

2.5 In May 2020 the BMA asked members to discuss and provide examples of pressures they were under. We received over 2000 testimonials from doctors across the NHS detailing how they had been impacted by the pandemic[11]. A snapshot of these testimonials is available here. Examples of some the comments we received included:

> *"I signed up to be a doctor. But my family didn't choose this career path, I feel like I've forced the risk on them and I can't get away from the guilt."*
>
> *"At times it felt completely relentless without an end in sight. The most traumatic part was the stress on patients, and even more so, their relatives."*
>
> *"The fatigue after wearing PPE all day cannot be underestimated. It impacts on what I physically and mentally could do after a shift of work."*

2.6 Our engagement with members has illustrated the variety of challenges that doctors are experiencing and the diversity of responses that are needed to ensure that they are supported targeting a variety of needs – from meeting basic practical needs (ensuring psychological and physical safety, access to spaces to rest and nutritious food) to meeting emotional needs (through peer support, mentoring, coaching), through providing to more formal interventions (such as access to psychological support and occupational health services). Our mental wellbeing

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[9]BMA, Caring for the mental health of the medical workforce, October 2019, https://www.bma.org.uk/media/1365/bma-caring-for-the-mental-health-survey-oct-2019.pdf

[10] BMA Tracker Survey, https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/covid-19-analysing-the-impact-of-coronavirus-on-doctors

[11] BMA survey, 01 June 2020, https://www.bma.org.uk/bma-media-centre/personal-impact-of-the-covid-19-pandemic-on-doctors-wellbeing-revealed-in-major-bma-survey

charter highlights the actions that should be taken to prevent the causes of ill health but also ensure doctors have access to support if they are struggling.

2.7 It may take some time for staff to realise the full impact of the COVID-19 crisis on their mental wellbeing. It is, therefore, essential that the support put in place by the NHS for staff working through this time is sustainable and adequately resourced. More support for doctors suffering with poor mental health and wellbeing is needed including access to comprehensive occupational health and mental health services. There is a real concern that with NHS mental health services already over-stretched and facing increased demand, staff will not have access to the necessary timely support that they desperately need which must be addressed. Workplaces should also provide peer support and mentoring to ensure doctors are able to reflect on their experiences. Staff who need to take time off or would like to work flexibly should be supported by their employer to do so.

3. What is the current scale of workforce burnout across NHS and social care? How does it manifest, how is it assessed, and what are its causes and contributing factors? To what extent are NHS and care staff able to balance their working and personal lives?

3.1 A survey of the profession, by the BMA, published in 2019 revealed high proportions of doctors across all BoPs were experiencing burnout[12]. At that time, burnout was most likely to be driven by physical exhaustion. However, these findings may be harder to compare with doctors' recent experiences of COVID-19 and the additional risks to psychological health some doctors may have been exposed to.

3.2 COVID-19 has threatened the wellbeing of many doctors in ways that are unprecedented in the modern NHS. Many doctors may have sustained significant moral injury, arising from psychological distress which violates someone's moral or ethical code, and for a proportion this may contribute to poorer mental health in the future[13]. The situation across the NHS was undesirable pre-COVID. Post COVID, with the additional stress and increased likelihood of mental health trauma, including PTSD, it is vital that dedicated resources are made available and continue to made available to support the health and wellbeing of healthcare workers across the NHS.

4. What are the impacts of workforce burnout on service delivery, staff, patients and service users across the NHS and social care sectors?

4.1 Given existing workforce shortages across the NHS, and the increasing backlogs for core services, due to the COVID-19 pandemic, it is vital that staff retention is prioritised. Prior to the pandemic the NHS and patients were facing record waiting times for many services, including A&E and cancer services. If current workforce staffing levels are not dramatically increased, patient services and safety and the wellbeing of staff will continue to suffer.

4.2 If the mental health and wellbeing needs of the medical workforce are not met, we are likely to see an increase in burnout and a subsequent decrease in workforce levels placing further pressure on those remaining staff. We know that mental illness is a huge contributor as to why NHS staff are taking time off sick. As we have cited earlier, according to NHS Digital, the most reported reason for sickness absence was anxiety, stress, depression, or other psychiatric illness[14].

4.3 Doctors were already reporting severe negative impacts from rota gaps two years prior to the pandemic. Our 2018 report, Medical rota gaps in England[15], confirmed that more than three in

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[12] BMA report, Caring for the mental health of the medical workforce, 2019, https://www.bma.org.uk/media/1365/bma-caring-for-the-mental-health-survey-oct-2019.pdf

[13] BMJ, Analysis Managing mental health challenges faced by healthcare workers during covid-19 pandemic, 26 March 2020, https://www.bmj.com/content/368/bmj.m1211

[14] NHS Digital data, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/april-2020-provisional-statistics

[15] BMA, 2018, Medical Rota Gaps in England, available on request

four survey respondents said that individuals are encouraged to take on the workload of multiple staff. Over half of respondents said that SAS doctors were asked to both act up and act down to cover rota gaps. Just over one third of respondents said their employer asked consultants to act down to cover shifts, whilst two in three respondents said medical trainees are pressured to take on extra shifts. Around one in three respondents stated that their employer, their educational supervisor or their clinical supervisor has discouraged exception reporting. Finally, just under one third of respondents said their employer has redesigned a rota they work on to include fewer doctors.

5. What long term projections for the future health and social care workforce are available, and how many more staff are required so that burnout and pressure on the frontline are reduced? To what extent are staff establishments in line with current and future resilience requirements?

5.1 Across the UK the NHS does not accurately know how many FTE (full-time equivalent) health and care staff it has, how many clinical and non-clinical hours are available to services, how many hours are needed in relation to patient demand, how many staff vacancies there are or how many / the types of staff we estimate are needed in the medium to long term. The FTE number is far more important than the headcount number because many staff choose to work flexibly, in many cases because of caring responsibilities, but also because current workload intensity leads to poor wellbeing and burnout before retirement age when working full-time hours. Staff report to us they are already frequently expected to work beyond contracted hours whether working full-time or less than full time, which is an undesirable situation[16].

5.2 In short, the annual resources Health Education England (HEE) are currently given are insufficient to ensure health and care staffing supply is safe now or in the future. HEE undertakes detailed population analysis, staff supply and patient demand modelling, while the General Medical Council and Royal Colleges also hold workforce data of varying degrees of granularity. In addition to this, NHS England and NHS Improvement undertook workforce analysis and modelling during the pandemic response. All of this data is valuable and we are currently working with those bodies to gain a greater understanding of the additional staffing needed for the service to become more resilient. We feel that there is a clear need for more central analysis and understanding at a national level to support this work, to ensure a resilient future workforce.

5.3 The best way to improve real-time workforce monitoring and undertake regular health and care staff supply and patient demand projections is to have a single national workforce dataset, which includes regional staffing levels and consistent vacancy data for all providers. This will allow determination of how many staff we have, how many we are missing, and regional variations / deficits. Much better logistical planning will then be possible, especially when there is a need for flexibility, such as responding to crises, such as the current pandemic.

5.4 Greatly improving staff retention is essential, and so investment by NHS England and Improvement into staff retention schemes and improvements to working conditions, is of paramount importance. There is also a clear need to train more students to become doctors. The government's recent decision to lift the cap on medical school places is a welcome first step here, albeit it will need to be matched by sufficient clinical placements, foundation programme places and also resources and staff in medical schools to deliver all the extra training required, especially in the current COVID environment. The most recent intake of medical students, which due to COVID-19 and the use of predicted grades, was a particularly high intake, must be provided with adequate support now and throughout their training.

[16] The Mirror, https://www.mirror.co.uk/news/uk-news/nhs-heroes-forced-work-free-22381586

6. Will the measures announced in the People Plan so far be enough to increase resilience, improve working life and productivity, and reduce the risk of workforce burnout across the NHS, both now and in the future?

6.1 The NHS People Plan 2020/21 includes many encouraging commitments, including setting expectations for how NHS staff should be supported both in the short and long term. While there are many positive initiatives for addressing workforce shortages, we still lack a coherent national workforce strategy that is based on reliable data and backed by substantial new investment. In addition, the plan does not include investment commitments for general practice, leaving GPs and practice staff feeling undervalued and excluded.

6.2 The plan calls on employers to focus on health and safety, this must be a top priority, especially now following the pandemic. Urgent action continues to be needed to protect our most vulnerable staff, including those from BAME backgrounds and those who have been shielding. We asked the PHE review in to the impact of COVID-19 on BAME communities, to ensure it properly considered the cultural, occupational and workplace risk factors that could lead to disproportionate impacts on BAME staff or other vulnerable and what more could be done to control or mitigate them effectively.

6.3 We must also do more to protect the psychological health of our workforce. Initiatives such as the appointment of wellbeing guardians, boosting the mental health workforce, tackling violence against staff and improving occupational health standards, with provision specifically made to address the lack of resourced occupational health service access for general practice staff, will make an important difference to the lives of staff and the development of a more open and inclusive culture.

6.4 The plan's focus on equality and diversity is especially welcome. Diverse and compassionate leadership is essential to an inclusive, person-centred culture. Concerningly, a 2018 BMA survey[17] found that only 55% of BAME doctors think that there is respect for diversity and a culture of inclusion in their workplace compared to 75% of white doctors. Working in an inclusive environment is essential for wellbeing. The impact of the pandemic on BAME doctors has highlighted concerns about inclusivity and systemic biases in NHS workplace culture. For example, our COVID-19 tracker surveys consistently found that BAME doctors were more likely to say they had felt pressured to work without adequate PPE.

6.5 It is encouraging that the plan emphasises equality and diversity and sets out ambitions to increase placements for clinical leaders and enhance training and skills for leaders across the NHS.

6.6 The Plan outlines the wellbeing 'offer' aimed at NHS staff during the pandemic including a dedicated confidential helpline, free access to wellbeing apps, guides, webinars, group and one-to-one support, coaching/mentoring which have been well received. However, the Plan does not specify to what extend these will be provided in the long-term.

6.7 To ensure staff are supported to work safely it is vital that they have access to comprehensive occupational health services that meet the needs of users. While the Plan states that improved OH support with a wider wellbeing offer will be piloted, it does not address our long-standing concerns that basic provision for staff is not even funded in some parts of the NHS.

6.8 The plan represents a positive first step in improving working conditions and will hopefully start to transform the NHS into the employer of choice for those wishing to pursue careers in healthcare (both at home and abroad), but it is not a complete blueprint for transformation and more detail is needed particularly with regards to recruitment and retention in order to increase NHS capacity and to reduce pressures on the existing workforce.

6.9 The NHS simply cannot afford to lose any more doctors, nurses or other healthcare staff to burnout or because they feel that they are not supported by their employers or the system to care for their patients. COVID-19 has highlighted how the NHS can innovate to work differently,

[17] BMA, A charter for medical schools to prevent and address racial harassment, https://www.bma.org.uk/media/2030/bma-med-school-charter-implementation.pdf

yet it has also exposed significant gaps in workforce supply. In the months and years ahead, we need a renewed focus on growing the workforce, both through new recruitment and retention and by making the NHS the best place to work.

7. What further measures will be required to tackle and mitigate the causes of workforce stress and burnout, and what should be put in place to achieve parity for the social care workforce?

7.1 There are a number of areas where action by the government can help reduce pressure on doctors, including reducing administrative burdens on doctors, improving IT and the introduction of a lighter-touch, risk based regulatory system.

7.2 For example, we should not return to previous heavy-handed regulatory models, instead establishing system regulators who are duty bound to acknowledge and understand current workforce pressures and provider budgetary constraints and support tailored solutions and improvements for implementation at a local level.

7.3 A recent BMA report on how the NHS can take forward lessons from the COVID-19 response in general practice found that GPs want to see greater use of remote consultations (88%), want to have less paperwork (82%), reductions in the frequency of appraisal (60%) and for CQC inspections to end or be reduced (54%)[18].

7.4 Given the scale of the backlog of care now facing the NHS, we also need to see a focus on supporting clinicians across traditional primary, secondary and community care divides to work together to reduce unnecessary duplication and unplanned transfer of workload. For example, establishing joint prescribing budgets and allowing more secondary care doctors to issue prescriptions for more than seven days would reduce instances of patients having to return to their GP for a prescription after hospital care. Secondary care clinicians must be given rapid access to electronic prescribing. We also need to see a rapid expansion of community diagnostic capacity, so that clinicians in primary, secondary and community care can request requests test for patients without having to ask clinicians in another part of the system to do this.

7.5 Provision of appropriate modern IT hardware and software, within both secondary care and primary care, would ease the burden placed on staff to access, retrieve and share patient data and to work more effectively from a remote setting.

7.6 The provision of iPads to care homes via the NHS@home programme is a welcome development and will reduce burdens on staff in that setting. However, adequate thought must be given to internet connectivity within care homes, both in the context of this tranche of hardware and more broadly.

7.7 Measures already taken to improve data sharing between primary and secondary care, such as enhanced sharing between summary care records and GP Connect, have already had a positive impact for staff. However, more must be done relating to consent for data sharing as the emergency legislation arrangements cannot simply be rolled forward indefinitely. We must look beyond the immediate period to consider what we will carry over into the post-Covid-19 future.

7.8 The stigma associated with mental health means that doctors are often hesitant to disclose any problems and suffer in silence. Every employer should lead by example and encourage staff to speak up about any mental health issues. Further steps are outlined in the BMA mental wellbeing charter, including how to create healthy workplaces and developing wellbeing strategies. Employers should also ensure that staff are supported to maintain their physical health, such as encouraging regular breaks and providing access to 24/7 food and rest facilities, as outlined in the BMA fatigue and facilities charter [19] .

7.9 Wellbeing support services should be equally available for all doctors and medical students working across all healthcare settings and these wellbeing support services must be inclusive

[18] Trust GPs to lead: learning from the response to COVID-19 within general practice in England: https://www.bma.org.uk/media/2652/bma-report-trust-gps-to-lead-june-2020.pdf

[19] BMA Facilities Charter, https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/creating-a-healthy-workplace/fatigue-and-sleep-deprivation

and accessible to all NHS doctors. NHS staff working in different settings should not be disadvantaged in terms of support they can access. Not only are the current services often not known, they can be disjointed and vary locally, regionally, and nationally in terms of what is available. The NHS also needs to consider the diversity of staff and their different experiences related to mental health, and ensure support is tailored.

7.10 Finally, but most crucially, government must ensure that healthcare staff who present with significant mental health conditions are able to access appropriate timely treatment when they need to. Such support will help to improve both the recruitment and retention of healthcare staff, allowing them to better meet the demanding challenges of the job, and to support and care for patients across the NHS.

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