CALL FOR EVIDENCE BY THE NHS WALES WORKFORCE REVIEW

Response from BMA Cymru Wales

The British Medical Association (BMA) is an independent professional association and trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 150,000 across the UK, which continues to grow every year. In Wales, we have a membership of over 7,000 from every branch of the medical profession.

The association welcomes the opportunity to respond to the NHS Wales Workforce Review call for evidence. We look forward to providing oral evidence to the pane later this month.

As set out in the Nuffield Trust report ‘A decade of austerity in Wales’, an ageing population combined with a difficult public spending environment poses a major challenge for the provision of health and social care. A co-ordinated system is required that can cope with the range of needs associated with demographic and epidemiology changes; this needs to cover community, residential and hospital health and social care, as well as public health.

We welcome the review panel’s statement on fully engaging with all those who have an interest in the future of the NHS in Wales. The medical profession, as a significant constituency of the NHS workforce, will not only be affected by the implementation of any recommendations proposed by the review, but will also be key to their realisation. Therefore full engagement with the profession and its representatives is fundamental to the success and sustainability of any proposals. We were surprised, however, that the Review Panel did not include any trainee doctors, secondary care doctors, public health doctors or clinical academics. BMA Cymru Wales recommends that the lack of medical representation on the Review Panel is addressed; for instance a professional medical reference group might be established to advise the Panel as it begins to draw together its conclusions. We would hope that the views of medical students have also been sufficiently sought by the panel.
There is mounting evidence of the medical workforce crisis that has grown increasingly dire in the NHS in Wales - with frequent reports of failures to recruit to medical posts; unfilled training positions; GP practices closing; long-term medical vacancies; an aging workforce, morale at rock bottom and worryingly excessive workloads. This is not a new phenomenon, as we have been pressing for action by Government and employers for several years, to little effect. Urgent action is needed to address this, given the obvious ramifications on the provision of timely and appropriate care to patients.

It is clear that the solution to this crisis is multifactorial; there is no magic silver bullet or flicking of a switch. BMA Cymru Wales has previously put forward numerous suggestions as to how the current situation may begin to be turned around, and how the medical workforce can be placed on a more sustainable footing. These have included both long and short/medium term measures. Enclosed at the end of this paper are copies of recent papers we have put together outlining some of these solutions – we would of course be happy to discuss these further.

How future of NHS Wales’s services, i.e. what, how and where services are to be delivered to best address patient and population need, will determine the make-up of the workforce. Therefore in this response we have reflected our views on the current medical workforce in NHS Wales and medical students, who are the future workforce, and what needs to be done so that appropriate and responsive services can be delivered, alongside overarching themes that should be considered for future workforce planning.

We note the lack of consideration in the consultation document on cross-border health provision. Any structural changes, such as health and social care integration, as well as policy developments, including efficiency and workforce changes, will need to consider the implications of well-established, as well as emerging, cross-border health provision. The review panel should ensure that any recommendations take account and explain the implications on cross border health care.

Fundamentally, in order to place the medical workforce across Wales, on a more secure longer term footing, it is absolutely essential that decisions are made with the full engagement of the profession, across all branches of medical practice. This full and open engagement should be established early on to the satisfaction of all parties, so as to create true ownership of the solutions. It should of course be a permanent feature of NHS Wales moving forward, and is essential in order to move away from the reports of an isolated, devalued and demoralised profession. It is also vital in making the NHS Wales environment an attractive place to train (which is key to addressing the current workforce problems), be employed, and develop a satisfying professional career.

Below is BMA Cymru Wales’ response, to the questions set out in the consultation document.
Integration of health and social care

Questions:

- How have other countries/health systems adapted to meet exponential increases in demand for health and social care provision?
- What factors have led to the increases in demand for provision within these countries/systems?
- What criteria have been used to assess degree to which integration of services has contributed to effective management of demand?
- To what extent can these models be replicated in Welsh system of health and social care?
- What barriers have been identified in inhibiting successful implementation of such models?
- How might such barriers be overcome within Welsh context?

These questions are extremely wide-reaching and complex. We do not attempt to respond to them all here; we do, however, highlight our key points and considerations on health and social care integration and would be happy to discuss them further at the forthcoming oral evidence session.

The closer integration of health and social care has been a goal of successive UK governments for a number of years. Various different methods have been suggested and tried, ranging from measures to facilitate joint working and sharing of resources to enabling full structural integration. Thus integration is a nebulous term, but one best defined through the eyes of the service user - rather than structures, organisations or pathways in place, or the way services are commissioned or funded. This is because integration is about individuals and communities having better care and support; therefore the individual must be the organising principle for services.

To many, the case for integration is clear. Across the UK there are increasing pressures on health and social care. Demographic and epidemiology changes combined with a difficult public spending environment pose major challenges for health and social care. As evidenced in the Nuffield Trust report ‘A decade of austerity in Wales’, the population in Wales is ageing; many of these people will live with significant, often complex, health and social care needs. These pressure are likely to grow and intensify. The evidence demonstrates the need for health and social care to work with a common aim to address these challenges.

We agree with the approach and language used in the report from the National Collaboration for Integrated Care and Support headline definition of integration, from the patient’s perspective:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me”
Yet, it is accepted that the current system does not always deliver the integrated care that people need and want, with gaps between different services and sectors, inefficient and unreliable transitions resulting in duplication, delays and missed opportunities.

The BMA does not believe that the full integration of health and social care (structures, budgets and staff) is either necessary or desirable. We believe that coordination is best achieved by creating longterm stability across the NHS and local authorities and allowing integrated care to become a priority, not by further reorganisation. Indeed, given the above definition, integration does not necessarily require high-level budgetary or structural integration, and results from membership surveys[^1] do not find that rearranging organisational structures through mergers to be absolutely necessary or even sufficient to produce genuine joint working and more coordinated care. Instead, the emphasis is often placed on good information sharing and effective, professional relationships across disciplines and organisations.

Social care has significant crossover with healthcare; there is an obvious synergy with services such as nursing and care homes and end of life care for instance. There is often contention about whether an individual should be in receipt of health or social care and consequentially who should fund their care; the NHS or local authorities. The body responsible largely depends on the patient’s condition and there are many examples of disagreements between local authorities and health providers about who should be caring for a patient. This puts finance, rather that the patient’s need, front and centre – and can cause the patient and their relatives a great amount of distress (not least because of the huge sums a patient may be require to pay if their care falls under the remit of social care).

BMA Cymru Wales believes that patients should not perceive or experience any organisational barriers or restrictions while interacting with the various providers of their package of care. Our members place strong emphasis on improved clinical outcomes and better patient experience as the most important measures of success for integration. As such, a clear evidence base that demonstrates the longer-term clinical benefits would be necessary for doctors to support efforts to integrate.

Across the UK, integration of health and social care is variable. Northern Ireland has had an integrated structure for health and social care services since 1973. An important theme of the 2011 independent ‘Transforming your Care’ review was integration[^2]. The review identified a number of recommendations about what a future model of integrated health and social care in Northern Ireland should look like. In Scotland, the Public Bodies (Joint Working) (Scotland) Act 2014 introduced integrated adult health and social care. Full integration of services across Scotland is expected by April 2016. An example of why engagement and involvement of the

[^1]: BMA Membership Surveys, HPERU, August and October 2011
medical profession is so important can be found in the Audit Scotland report into CHPs (Community Health Partnerships). Audit Scotland reported that a failure to engage GPs was a fundamental factor in the failure of CHPs to perform as intended. In England, the integration of health and social care has also been a key policy focus for Government and NHS England. The Five Year Forward View vanguard sites are pursuing a range of approaches to integration, both horizontal and vertical, alongside the ongoing work of the BCF (better care fund). In addition, plans to devolve health spend and integrate with social care in Greater Manchester, will make the conurbation the holder of the largest single budget for health and social care in England. Clinical engagement and ownership from primary, secondary and community care, with significant public health input, will be essential in order for the new models of care to be successful.

If health and social care integration is going to be successful, any changes need to be evidence based. We have identified three important areas which should be addressed in planning for integration:

- Effective meaningful engagement and involvement of primary, secondary, community care doctors, as well as public health specialists. This will be an important factor in the success of an integration plan.
- Investment in building capacity in health, community and social care services. We have concerns about a single budget for health and social care. Also it cannot be assumed that funding can be solely found through the transfer of resources from secondary care. No matter how well primary or community based services are planned and delivered, many patients will still require hospital assessment and treatment. Consideration should be given to the overall cost envelope.
- Medical leadership and influence is an important factor in the success of an integrated plan. It will enable problems to be identified and efficiently resolved at a local level, as well as allowing best practice to develop. We believe that clusters hold potential to facilitate greater integration and local needs assessments – however that is a long-term consideration. It should be recognised that medical leadership is not constrained to those in health board hierarchies.

Doctors are an influential component of the NHS workforce. They are equipped with a unique and diverse range of knowledge and skills, whilst being ethically bound to act in their patients’ best interests. They have a deep understanding of the needs of the local community and their

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3 Audit Scotland (June 2011) Review of Community Health Partnerships Audit Scotland: Edinburgh

4 The NHS Reform (Scotland) Act 2004 required NHS boards to establish one or more CHPs in their area. The aim was to bridge the gap between primary and secondary healthcare as well as coordinate the planning and provision of a wide range of health services in the area.

5 The BCF requires CCGs (clinical commissioning groups) and local authorities to pool a portion of their respective health and social care budgets to jointly plan and deliver services. It is intended to join up care more effectively for older and disabled people, develop community services and prevent unnecessary hospital usage/stays. BCF programme began in April 2015.

6 More information on BMA’s views for England can be found at http://bma.org.uk/news-views-analysis/the-bma-blog/2015/july/five-ways-the-five-year-forward-view-must-meet-doctors-concerns
patients and, as such, can make a valuable contribution to improving and developing more integrated services, in the wider management and leadership of their organisations and in the NHS generally. Furthermore, doctors’ concern with clinical standards, outcomes, effectiveness and audit mean they can be relied upon to lead the drive to improve quality and are central to its assurance.

In conclusion

BMA Cymru Wales holds that collaborative cultures with shared values, good professional relationships and effective leadership are essential if integration is to get off the ground. As confirmed by doctors in our surveys, these elements are also vital to securing what should be the key measures of success of efforts to integrate - improved clinical outcomes and better patient experiences. Therefore the individual must be the organising principle for any changes. We believe that integration is best achieved through better integration of services where there is evidence to support change, rather than a top-down reconfiguration. Given the obvious attributes doctors bring to the health service and to the care and support of patients and communities, it is reasonable to suggest that gaining doctors’ support for a scheme to integrate would be beneficial to securing success.

Future workforce skill and skills mix

Questions:

- To what extent has service provision changed within NHS Wales and across social care in Wales over past 10 years?
- How has the composition of workforce changed within the same time period – numbers, type, location, etc?
- What are the key strategic drivers that will influence trends in service provision over next 10 years?
- What structural/organisational changes may be required to address such changes?
- What are the likely workforce requirements to meet such demands on service provision over next 10 years?
- What are the likely deficits in workforce supply over next decade?
- How can such workforce supply deficits be addressed?
- What policies are in place to address such deficits?
- What new professional groupings and roles will be required? e.g physician assistants, advanced practitioners.
- What is the evidence for the effectiveness of such groups and roles in meeting supply deficits?

Over the last 10 years, the demographic and epidemiology changes combined with the difficult public spending environment has put increasing pressures on the NHS in Wales. Delivering high quality and flexible healthcare is heavily reliant on a well-resourced and high performing workforce.
Doctors are at the heart of healthcare delivery, but to date, the medical workforce has not been adequately resourced to adapt to these changes and is now facing a recruitment and retention crisis, to the inevitable detriment of patient care.

Evidence around the number of doctors in Wales can be misleading. The number of doctors, by headcount and WTE (whole time equivalent) has increased, yet to clearly different extents. Workforce figures are often expressed in headcount terms which not does give a wholly accurate picture since it does not take account of the increases in preferences for less than full-time working. For instance, there has been an increase in GPs in absolute terms by 11% over the last ten years, yet when expressed in WTE terms this has in fact remained broadly static. In 2014 Wales had the lowest number of GPs per 1,000 population in the UK at 0.6 GPs per 1,000 patients7. Whist the number of directly employed doctors may have increased to a greater extent, this does not counteract the significant and increasing recruitment and retention problems, including a high number of unfilled vacancies, facing Wales.

Indeed, BMA Cymru Wales members have increasingly reported high vacancy rates. However, there is no official national data on vacancy rates in Wales8 in order to verify this. In March 2015 BMA Cymru Wales undertook a FOI (freedom of information) request to obtain information on consultant vacancies in Wales. Responses from health boards and trusts demonstrated a high vacancy rate across Wales of 6.8 per cent. Some local health boards and trusts reported significantly higher rates, for example Hywel Dda University Local Health Board had a 15.9 per cent vacancy rate and Public Health Wales 15.6 per cent. Vacancy rates are likely to be higher still, due to the definition of what constitutes a vacancy being starkly geared towards under-reporting9. The FOI request also showed a high use of locum consultants. The results estimated 10.5 per cent of consultants in Wales, by headcount, were locums – with significantly higher reliance on locum and temporary staff in some areas. This is significantly higher than the number of consultant locums in England during the same period, which was reported to be around 4 per cent10.

Furthermore, BMA members have reported increasing numbers of doctors planning for early retirement. A recent UK BMA survey recorded that 41 per cent of doctors have considered

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7 BMA (May 2015) 2014 UK Medical Workforce Briefing London: BMA
8 The Welsh Government stopped collecting and publishing data on consultant vacancies in 2011 following a consultation. Local health boards and trusts continue to collect this information but it is not published.
9 Local health boards and trusts across Wales use different definitions of a vacancy. This makes the data collected inconsistent. The majority use the definition agreed by the Welsh Government and Medical Workforce Managers in 2013, “an established post which is currently unoccupied and despite actively taking steps to recruit to this post, no appointment has been made’. There is however no agreed interpretation of this definition. For example how to record a role that is empty but is not under current active recruitment, or, a role that is vacant but temporarily occupied such as by a locum.
Between 2003 and 2013, the proportion of GPs aged 55 years and over in Wales increased by 42 per cent. While the number of GPs aged below 45 years also increased, the rate of increase was significantly slower at just 1.2 per cent throughout the same period. When an aging workforce is considered alongside the difficulty of recruiting trainees to posts it points to a very real recruitment crisis to which NHS Wales is currently ill-equipped to respond.

The Panel may also wish to consider the work of the NHS Working Longer Group; its preliminary findings were published last year and included the need to gather more data from those retiring before normal retirement age in order to better explore the reasons for this.

Another area of concern is that moves to provide more care closer to home has not been made with a corresponding move of resources to primary care – in fact the share of NHS expenditure allocated to General Medical Services in Wales has fallen from 10.3% in 2007 to 7.9% in 2014. Coupled with this, out-of-hours services are facing huge challenges and continue to be astonishingly under-resourced; to the obvious detriment of unscheduled care and the workload of practices during core daytime hours.

Doctors, in both primary and secondary care, are reporting increasing and unmanageable workloads. In a recent UK BMA survey, 30 per cent of junior doctors reported that their workload was unmanageable or unsustainable. Over 70 per cent of GPs who responded stated increasing workloads and rising pressures were becoming unmanageable or unsustainable all of the time. This is the biggest issue reported to us by GPs. In addition, BMA members report that stress related illnesses are becoming increasingly commonplace amongst doctors. Burnout is a very serious threat to the sustainability of the NHS, not to mention the individual health of doctors. Along with other healthcare professionals we have called for a comprehensive occupational health service to be established, run for and by the NHS in Wales – occupational health provision is an area that the panel should consider in its deliberations. Progress to date, where any can be identified, has been unacceptably slow, with obvious consequences.

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11. BMA (April 2015) BMA quarterly tracker survey, current views across the medical profession
12. Julia McWatt (March 2014) Fresh concerns raised about GP recruitment after figures showed more than a 40% rise in number of GPs over age of 55 in past decade http://www.walesonline.co.uk/news/wales-news/fresh-concerns-raised-gp-recruitment-6882121
14. BMA (April 2015) BMA quarterly tracker survey, current views across the medical profession
15. BMA (April 2015) BMA quarterly tracker survey, current views across the medical profession
BMA Cymru Wales recommends that NHS employers and the Welsh Government develop incentives to promote the retention of doctors in the NHS. For example, a national financial resettlement programme to incentivise and support doctors to return to work in Wales. For GPs, the existence of a separate performer lists for England and Wales has had a detrimental impact. GPs on the English performer list may not immediately be able to take up vacancies that may exist within practices in Wales. In the same way, the separate lists also limit the availability of locums for border practices. We understand that the Welsh Government is looking at ways to address this.

Work also needs to be undertaken to dispel a number of negative perceptions about training and working in Wales – this includes myths around mandatory use of the Welsh language. BMA Cymru Wales has put forward a number of suggested incentives options to the Welsh Government to help address shortages across the medical profession; we enclose relevant details. Only when the attractiveness of a career (or training) in Wales is addressed will we see long-term and sustainable improvements to the current and worsening problems.

Adequate numbers of new doctors in primary and secondary care need to be trained in Wales. For example, despite longstanding commitments to expand primary care, the overall number of training places for GPs in Wales remains static. The Welsh Government needs to urgently address this deficit so that existing NHS services can be maintained. In addition priority must also be given to providing high quality undergraduate education, postgraduate training and continuing professional development. The recent BMA paper, *Every Doctor a Scientist and a Scholar*\(^\text{17}\), puts forward the case that every doctor needs to be engaged as a scholar and scientist. It is important that undergraduates and post graduate education should equip doctors not only with clinical skills but the scientific skills to enable lifelong learning and enquiry. This will enable doctors to provide their patients with excellent standards of care throughout their careers. Our members consider that the WCAT scheme has been successful in attracting high quality doctors to Wales, although the numbers benefiting from it have been steadily eroded, which needs to be reversed. Retaining those who complete their medical academic training here would place Wales in a unique position through attracting those who bring high quality scientific work, research and innovation.

We have set out just some of the considerable evidence of the medical workforce crisis which is currently facing the NHS in Wales, and have enclosed copies of recent papers we have drafted on workforce issues (our responses to Welsh Government’s Heath Professional Education Investment Review and the Health and Social Care Committee’s inquiry into the GP workforce will both be of particular relevance and outline further recommendations). Ultimately, the NHS in Wales needs to create an attractive environment in which to work or train; fundamental to that is addressing the current workload pressures. We cannot fully comment on what a future workforce should look like until it is clear what services will be delivered and where. Therefore

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\(^{17}\) BMA (March 2015) *Every doctor a scientists and a scholar* London: BMA
our recommendations regarding the future shape of the workforce are limited; instead we have focused on two overarching issues which should be a ‘foundational’ part of future workforce planning.

Firstly, BMA Cymru Wales calls for a whole-system approach to workforce planning across primary, community, secondary, public health and social care. Workforce planning needs to take account of the changing demands, current and projected future demands – and therefore needs to also look at training requirements as well as measures to support greater retention such as portfolio careers and mentorships. We welcome this review, as we hope it will help take a comprehensive approach to ensure the workforce plan is aligned to a strategic vision for the NHS in Wales; and in line with prudent healthcare will avoid duplication and deliver multi-professional teams working to the benefit of the clinical needs of patients and their experience of using healthcare services. It needs to move forward with the engagement of all healthcare professionals.

Secondly, the association recommends that NHS data collection is significantly improved. Adequate data on the medical workforce is necessary, not only for the effective delivery of current care, but also for sustainable planning, and in understanding the requirements for medical training provision. BMA Cymru Wales calls for improved availability, quality and accuracy of NHS data collection, particularly around workforce numbers and vacancies which are currently not collected. BMA Cymru Wales would welcome the opportunity to work with the Welsh Government so that accurate data is routinely collected and reported.

Efficiency and prudent principles

Questions:
- How can the ‘only do what only you can do’ principle be translated into an estimate of workforce configuration in the future?
- How can the ‘only do what only you can do’ principle be factored into workforce planning mechanisms?
- What is the scope for professional substitution?
- What are the financial implications of professional substitution?
- What is the role of technology in compensating for time and distance?
- What are the financial implications of technological developments in this area?

BMA Cymru Wales supports the philosophy and principles of prudent healthcare. We must ensure that each element of the workforce is complementary, working across the range of their professional competence and presenting an effective use of skill mix and, in line with the principles of prudential healthcare, does not duplicate or complicate other parts of care pathways or delivery.

We are not clear on what ‘professional substitution’ is in practice or why it is needed if every professional is working at the top of their clinical competence. There has been much talk of
Physicians Assistants but again we are unclear as to what role they will play and how they would contribute to the more effective delivery of services or to alleviating the workload of existing staff. We would welcome details of training and regulation requirements for such roles. We remain concerned that this may be sold as the ‘holy grail’ of workforce planning, but will not have been adequately thought through for the longer-term.

Certainly there is a discrete range of activities being undertaken by some doctors, particularly GPs, which could be more appropriately delivered by other professionals and this would hopefully help to address a little of the medical capacity issue. However a one-size-fits-all approach should not be developed; we feel that the teams of professionals needed to meet local population health is best identified and determined locally.

We believe that there is a need to invest in those already working for NHS Wales to extend their skills, work flexibly, remain in work, or to work in different ways in order to deliver clinically appropriate care or treatment which is decided upon on the basis of clinical need. There is, for instance, potential to extend the professionals who can play a role in admission, discharge and putting in place care plans. Such moves would need to be supported by sound and responsive communication systems, that are clinically appropriate, between all partners and which provides all necessary safeguards in relation to data confidentiality. Secondary care IT systems certainly have a long way to go in this regard.

Pay and reward

Questions:

- What are your expectations for the long term strategic direction for pay and rewards within the NHS and in relation to pay and rewards within the wider economy?
- What are your expectations with regard to the continuation of, or changes to, current pay and reward differentials?
- What are the existing arrangements for A4C staff, executives and senior posts and how have these operated in each of the past five years?
- To what extent does Wales have autonomy, authority and powers to be able to determine pay and reward mechanisms and to what extent does this vary as between A4C staff, executives and senior posts?
- To what extent can the long-term strategic direction for pay and reward for people currently covered by the UK Agenda for Change contract terms and conditions be considered separately from a similar consideration of pay and reward for staff covered by the Doctors and Dentists Review Body?
- To what extent can pay and rewards be considered in isolation from all the other terms and conditions of employment?
We have not answered questions in this section on the UK Agenda for Change contract terms and conditions as they do not apply to doctors. The BMA will submit evidence to the Review Body on Doctor and Dentist Remuneration at the end of September 2015.

It is important to note that the BMA believes that the determination of pay should be conducted separately for doctors and dentists and those members of NHS staff subject to the Agenda for Change agreement. The market for medical and dental staff is different in being more significantly international, the qualifications and skills expected of them more demanding and the range of work undertaken, including academic as well as clinical activities, significantly more extensive and at a greater level of responsibility. Consequently, the pay comparators used by the Review Body on Doctor and Dentist Remuneration differ from those for other NHS staff.

Further information – Primary Care

For detailed information in relation to the workforce challenges, and solutions, in primary care specifically please refer to:


Further information – wider workforce planning and training: