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Ymchwiliad i gynaliadwyedd y gweithlu iechyd a gofal cymdeithasol
Inquiry into the sustainability of the health and social care workforce

Ymateb gan: Y Gymdeithas Feddygol Brydeinig Cymru

Response from: British Medical Association Cymru Wales

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SUSTAINABILITY OF HEALTH AND SOCIAL CARE WORKFORCE

Inquiry by the National Assembly for Wales Health, Social Care and Sport Committee

Response from BMA Cymru Wales

9 September 2016

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the Health, Social Care and Sport Committee on the sustainability of the health and social care workforce in Wales.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 160,000, which continues to grow every year. BMA Cymru Wales represents over 7,500 members in Wales from every branch of the medical profession.

RESPONSE

In October last year, BMA Cymru Wales provided a comprehensive evidence submission to the *NHS Wales Workforce Review*¹ that was commissioned by the previous Welsh Government and chaired by David Jenkins. That review clearly has a significant cross-over in terms of its remit with this current committee inquiry. Given that there has been little change in the issues in hand in the intervening period, we would therefore ask the committee to accept our earlier submission – attached as [Appendix 1](#) – as a key part of our response to this inquiry.

Similarly, the committee will be aware that its predecessor committee in the Fourth Assembly also undertook an inquiry last year into the GP workforce. Our comprehensive responses to that inquiry which was submitted in January 2015 should also be accepted as part of our response to this new inquiry. It is attached at [Appendix 2](#).

In undertaking this current inquiry, we feel that committee could benefit from looking at the findings of the *NHS Wales Workforce Review*, including by looking at what is now being proposed should be done to address its recommendations. Given that such a major, and comparatively recent, piece of work has been undertaken, such an approach could prove more beneficial than starting to look again at many of the same issues in isolation. We would similarly suggest that the committee should look at what progress is being made in implementing the Welsh Government's workforce strategy for primary care, *A Planned Primary Care Workforce for Wales*², which was also published last year.

The timescale and timing of the call for evidence for this inquiry has presented us with a number of challenges. For member-based organisations like us, we need sufficient time, for instance, to effectively gather evidence from amongst our members. This is understandably difficult when undertaken at a time of year when many of our members are on annual leave, when a time-period of just over a month is offered for evidence to be submitted and when three inquiries of interest are launched by the committee concurrently. This has therefore limited our ability to respond to this call for evidence as effectively and as comprehensively as we might have wished, but we hope this contribution is helpful nonetheless.

¹ Jenkins D, Phillips C, Cole S & Mansfield M (2016) *NHS Wales Workforce Review*. Available at: <http://gov.wales/topics/health/publications/health/reports/workforce/?lang=en>

² Welsh Government (2015) *A Planned Primary Care Workforce for Wales*. Available at: <http://gov.wales/topics/health/nhswales/plans/care/?lang=en>

In relation to the specific questions posed as part of the terms of reference for this inquiry, we would wish make the following additional points for the committee's consideration:

Do we have an accurate picture of the current health and care workforce? Are there any data gaps?

This issue is already touched upon within our response to the Jenkins Review. There are a number of factors, in our view, which prevent us from seeing an accurate picture. For instance, headcount numbers which are often quoted can mask a reduction in the workforce resulting from an increasing prevalence of less than full-time working. At the same time, it is not always possible to easily provide accurate whole time equivalent (WTE) figures. For instance, in the case of GPs, particularly those who are independent contractors, there can be much variety in the number of hours a full-time partner might actually work in a given week, with many working hours in excess of those that would otherwise be regarded as constituting full-time working. We know that the Welsh Government has been looking to identify a suitable methodology for arriving at an acceptable definition for a WTE GP but we are not aware that this work has yet reached a satisfactory conclusion due to the difficulties involved.

Another issue that we believe needs to be addressed to assist in effective workforce planning is the current lack of collection and publication of meaningful data on vacancies. We understand that such data has not been routinely published since 2011. As such, we have had to resort in more recent times to the use of Freedom of Information Act requests in order to obtain such data. Even then, the responses we received would appear to be highly inaccurate – largely due to the use of a fundamentally flawed definition which means a vacancy is only counted as such when an active process is underway to fill it. In addition, there is a lack of consistency in the definitions used for vacancies between different health boards and trusts making comparisons difficult. We fail to understand how health boards and trusts can undertake effective workforce planning when those in charge don't appear to be effectively monitoring the extent to which vacancies are impacting on workforce provision. Not only do we feel that this needs to be addressed by returning to a system whereby data on vacancies is routinely and regularly published, but steps also need to be taken to ensure that workforce data is meaningful and therefore able to be used for effective comparison.

In relation to secondary care, the committee might also wish to look at the extent to which effective job planning is often not properly undertaken by health boards and trusts. With reference to consultants, this issue has previously been the subject of investigations undertaken by the Wales Audit Office. We are also aware that this issue is a concern amongst staff and associate specialist grades.

We regularly hear from members that stress-related illnesses are becoming increasingly common. Burnout is a very serious threat to the sustainability of services, not to mention to individual doctors' health. We believe that an all-Wales comprehensive occupational health service for all NHS staff is required, and that action is needed to recruit more consultants in this specialty (some health board areas have less than one). Data collection is needed in this area beyond sickness absence recording, and should include capturing workloads and the impact of vacancies. Conducting exit interviews for employees leaving health boards (including GPs handing back their contracts) should also be formally collected and routinely analysed.

Is there a clear understanding of the Welsh Government's vision for health and care services and the workforce needed to deliver this?

Whilst we have previously expressed a number of concerns regarding the findings contained within the 2015 report of the Welsh Government-commissioned *Health Professional Education Investment Review*, carried out by a review panel chaired by Mel Evans, one of the report's key findings with which we did certainly agree is that there is a need for '*a refreshed strategic vision for NHS Wales which provides the longer term context for shaping the workforce of the future*'.

Given that there is already broad acceptance of that view amongst stakeholders across the sector, there may therefore be little need for the committee to pursue this particular question in further depth. Instead we would welcome a concentration on how this current lack of a strategic vision for the service, and its impact on effective and sustainable workforce planning, might now be addressed.

Regarding physician associates, there has been no detail or strategy about what role they are intended to play – i.e how they would contribute to the more effective delivery of care, or to alleviating the workload of existing staff, in addition to that which existing professions already provide. We would therefore welcome details of the training, regulation and career development options for such roles. We remain concerned that physician associates may be sold as the ‘holy grail’ of workforce planning, but will not have been adequately thought through for the longer-term, and that there is a danger that such roles would be filled by staff who would have otherwise entered existing shortage professions (such as healthcare assistants). That said, we are not opposed to such roles, and believe that the teams of professionals needed to meet local population health is best identified and determined locally (we hold hopes for GP clusters networks in this regard).

How well-equipped is the workforce to meet future health and care needs?

This is a very broad question which could be interpreted in a number of different ways. It is clear to us that, in many regards, the capacity of the workforce is failing to keep pace with increasing demand and is already therefore under strain in relation to current demand. This is particularly the case within primary care where there is an increasingly recognised recruitment and retention crisis amongst GPs against a backdrop where demand is continually increasing as a result of an ageing population and an increasing prevalence of chronic disease. There are also increasing recruitment and retention challenges amongst certain specialties within secondary care which have been the driver for various service reconfiguration proposals in recent years across different health board areas. Increasing use of locum doctors, and increasing overtime costs being reported by health boards amongst medical staff, are also signs that the current workforce provision is under severe strain. Taken in the round, these indicators suggest that the workforce is struggling in many regards to provide for current health and care needs, and these challenges will no doubt become greater in the medium- to long-term.

What are the factors that influence recruitment and retention of staff across Wales? This might include for example:

- *the opportunities for young people to find out about/experience the range of NHS and social care careers;*
- *education and training (commissioning and/or delivery);*
- *pay and terms of employment/contract.*

This question covers a number of issues already touched upon in the previous responses we have attached in the appendices to this response. We would therefore refer the committee to these earlier responses, but we also wish to make a few additional points which are outlined below.

In terms of opportunities for young people to find out about and/or experience the range of NHS and social care careers, we previously touched upon this issue in our response last year³ to the report of the Welsh Government-commissioned *Health Professional Education Investment Review*.⁴ Our responses to the following two questions posed in the Welsh Government’s subsequent request for feedback are of relevance, and we have therefore reproduced them here:

³ <https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-walesreportheireview-01-06-2015.pdf?la=en>

⁴ Evans M, Phillips CJ, Roberts RN & Salter D (2015) *Health Professional Education Investment Review*. Available at: <http://gov.wales/topics/health/publications/health/reports/education-investment-review/?lang=en>

What are the barriers to providing wider work experience and apprenticeship opportunities and how can they be addressed?

In more deprived areas, local children may be more likely to lack personal links to health professionals. Another barrier that needs to be considered is how to identify the time for students to take up any work experience opportunities. We would suggest that consideration could be given to developing local NHS careers services with local NHS careers champions. Departments could also be established in each health board and university with a remit to promote NHS careers.

These suggestions could enable Wales to build upon the work that is currently undertaken by many hospitals and GP practices that already offer work experience opportunities through both formal schemes and informal arrangements, thereby providing scope to formalise and extend the links which already exist between the NHS and local schools in order to ensure wider access to such opportunities. They could also enable the NHS to go into schools at a stage much earlier than that at which pupils might be allowed into clinical areas, but early enough for them to consider aspiring to work in healthcare before their career choices have been narrowed by subject choices and exam results.

We would also suggest that work needs to be undertaken with schools to ensure opportunities can be provided for students to take up work experience opportunities in ways that will not disrupt teaching schedules. Some students may be willing to take time out of their holidays to undertake placements, but for others there may be a requirement to work with schools and colleges to ensure such opportunities can be taken up within term-time.

How can experience in the health care system be made more attractive to young people?

We would support greater opportunities for young people to gain work experience in all NHS settings, improved career information and guidance to be provided in schools from local NHS staff and organisations, and the development of stronger links between schools/colleges and local NHS establishments. Career days for students could be provided through which the benefits of working in healthcare can be advocated.

Consideration should also be given to the benefit of using role models to promote the merits of a career within the NHS. Health boards and universities should identify staff who can facilitate work experience, as well as visiting local schools to talk about their roles in healthcare.

We note the suggestion in paragraph 84 for a targeted approach to increase the quota of Welsh-domiciled students. This is something we would support but we also note the concerns raised in paragraph 80 regarding legal constraints which might preclude certain financial incentives being offered. This may similarly be the case in relation to the suggestion in paragraph 107 of the need to incentivise children from Welsh medium education to consider careers within NHS Wales. The suggestion of increasing the quota of students from lower socio-economic groups referred to in paragraph 84 is also something we would certainly support.

Attention clearly needs to be given, in our view, to both recruitment and retention of the medical workforce. It needs to be recognised that medicine is very much a global workforce and Wales is therefore competing within a global marketplace. Consideration must therefore be given to what can be done both to attract doctors to Wales and encourage them to remain here at subsequent stages throughout their careers.

As well as looking at how we might train more doctors here in Wales, we should also consider how we can attract more doctors who have been educated and/or trained elsewhere, including overseas. It should be noted that attracting more doctors who have been already trained elsewhere could be a

cheaper solution to plugging recruitment gaps than increasing the number of doctors trained here (who might then go on to work elsewhere), although both elements clearly have a role to play.

It should indeed be recognised that Wales has long-since depended on recruiting doctors from overseas. However, we would also point out that current immigration rules in the UK act as a barrier to such recruitment. For instance, we have previously argued that GPs should be added to the Home Office's occupation shortage list – but, much to our frustration, this suggestion has not been agreed by the Migration Advisory Committee which considers such matters on the Home Office's behalf. We have also argued that Wales should have its own shortage occupation list, as Scotland has.

In seeking to attract doctors at different stages in their careers, we should also be aware of the many and wide-ranging factors that will influence where they may choose to locate. These include: high quality training; access to funded study leave; evidence of exam success; research opportunities; access to a good social life and quality of living; availability of good career opportunities for their spouses or partners; and access to good schools for their children.

In many ways retaining existing staff may be seen as more of a concern than recruiting new staff. Recruitment initiatives can only contribute so far to addressing existing challenges if too many doctors are subsequently choosing to leave Wales, reduce their working hours, leave the profession or retire. We therefore need to consider the impact of the various factors which impact on retention. Amongst other factors, these include: workload pressures; working conditions; the extent to which doctors feel valued and empowered to influence decisions or be listened to and able to raise concerns without fear of recrimination; the bureaucracy around processes such as revalidation; pension changes, including the impact on pensions of those doctors continuing to work beyond a certain stage in their careers; and worsening sustainability challenges for many GP practices.

A clear strategy is also needed to support older workers in general within the NHS in Wales, particularly as the state pension age continues to rise towards 68.

In terms of the impact of issues such as pay, terms and conditions, and contracts, you would expect this is an area in which we would have much to contribute as a trade union. Although we have touched on some relevant issues – such as the impact of operating within a global marketplace – it has been difficult to provide a comprehensive and evidence-based response on the impact of all these factors within the timeframe offered. We would therefore suggest that this topic might warrant a more-focussed inquiry of its own. These issues clearly impact on recruitment and retention as well as upon the wider morale of the workforce. This includes the impact of an ongoing erosion of salaries in real terms for a number of years and there is clearly an impact with pay rises across the public sector no longer keeping pace with those in the private sector at present.

Pay erosion has had a particular impact amongst independent contractor GPs as it has been accepted by the pay review body for doctors and dentists that many recent funding increases for GP practices have failed to keep pace with the rising costs of GP practice expenses due to the failure of the formula previously employed to accurately calculate the costs incurred over a number of successive years.⁵ This has led to GP earnings falling significantly in actual cash terms, and not just in real terms when adjusted for inflation. Indeed, figures show that there was a drop of over £11,000 a year in average GP earnings in Wales between 2005-06 and 2012-13.⁶

⁵ Review Body on Doctors' and Dentists' Remuneration *43rd Report* (2015). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412151/DDRB_47332_Accessible.pdf

⁶ NHS Digital *GP Earnings and Expenses - 2013-14*. Available at: <http://digital.nhs.uk/article/2021/Website-Search?productid=18736&q=GP+earnings+and+expenses&sort=Relevance&size=10&page=1&area=both#top>

Whether there are there particular issues in some geographic areas, rural or urban areas, or areas of deprivation for example.

There is clear evidence that recruitment and retention challenges are being felt more acutely in more rural parts of Wales as well as in some of our more deprived communities. Many of the factors we have referred to above – such as access to the availability of good career opportunities for doctor’s spouses or partners – may be more of an issue in some rural parts of Wales. Perceptions, whether right or wrong, that a suitable command of the Welsh language may be required to work in certain parts of Wales can also hamper recruitment to certain geographic areas. We have previously raised concerns that training rotations that cover both north and south Wales can also deter junior doctors from undertaking their training in Wales, particularly if they have partners or children they may have to be located four or five hours’ travel distance away from for long periods of time during their training. Greater use of training rotas which are more geographically concentrated, including those which operate across the border to nearby areas of England, can help to address this concern.

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CALL FOR EVIDENCE BY THE NHS WALES WORKFORCE REVIEW

Response from BMA Cymru Wales

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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 panel 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.

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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 longterm 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 pressures 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 surveys¹ 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 than 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 required 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.

¹ BMA Membership Surveys, HPERU, August and October 2011

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 integration². 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 medical profession is so important can be found in the Audit Scotland report³ into CHPs (Community Health Partnerships)⁴. 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)⁵. 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 successful⁶.

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 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'

² John Crompton (December 2011) *Transforming Your Care* <http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf>

³ Audit Scotland (June 2011) *Review of Community Health Partnerships* Audit Scotland: Edinburgh http://www.audit-scotland.gov.uk/docs/health/2011/nr_110602_chp.pdf

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>

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 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. Whilst 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 retiring early¹¹. 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 period¹². When an aging workforce is considered alongside the difficulty of recruiting trainees to posts it points to a very real a 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 year¹³ 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

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.

¹⁰ Health & Social Care England (May 2015) *NHS Workforce Statistics March 2015, Provisional statistics* <http://www.hscic.gov.uk/searchcatalogue?productid=18106&topics=2%2fWorkforce%2fStaff+numbers%2fMedical+and+dental+staff&sort=Relevance&size=10&page=1#top>

¹¹ BMA (April 2015) *BMA quarterly tracker survey, current views across the medical profession* <http://bma.org.uk/working-for-change/policy-and-lobbying/training-and-workforce/tracker-survey/omnibus-survey-april-2015>

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>

¹³ NHS Working Longer Group. Preliminary findings and recommendations report for the health departments. 2014. Available at: <http://www.nhsemployers.org/your-workforce/need-to-know/working-longer-group/preliminary-findings-and-recommendations-report-for-the-health-departments>

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 unsustainable¹⁴. Over 70 per cent of GPs who responded stated increasing workloads and rising pressures were becoming unmanageable or unsustainable all of the time¹⁵. 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 service¹⁶ 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.

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*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

¹⁴ BMA (April 2015) *BMA quarterly tracker survey, current views across the medical profession* <http://bma.org.uk/working-for-change/policy-and-lobbying/training-and-workforce/tracker-survey/omnibus-survey-april-2015>

¹⁵ BMA (April 2015) *BMA quarterly tracker survey, current views across the medical profession* <http://bma.org.uk/working-for-change/policy-and-lobbying/training-and-workforce/tracker-survey/omnibus-survey-april-2015>

¹⁶ BMA Cymru Wales. Occupational Health Service in NHS Wales. 2015. Available at: <http://bma.org.uk/working-for-change/policy-and-lobbying/welsh-assembly/policy-documents>

¹⁷ BMA (March 2015) *Every doctor a scientist and a scholar* London: BMA

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 Health 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 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 prudent 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:

- Chapter 2 of the GPCW's document 'Prescription for a Healthy Future' available here: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-members/gpc-wales>
- BMA Cymru Wales response to the National Assembly for Wales Health and Social Care Committees Inquiry into the GP workforce in January 2015, available here: <http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-walesgpworkforceresponse-19-01-2015.pdf>
- BMA Cymru Wales response to the Welsh Government Consultation 'A planned primary care workforce for Wales', available here: <http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-primarycareworkforce-01-09-2015.pdf>

Further information – wider workforce planning and training:

- BMA Cymru Wales response to the call for feedback by the Welsh Government on the Report of the Health Professional Education Investment Review, available here: <http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-walesreportheireview-01-06-2015.pdf>

Y Gymdeithas Feddygol Brydeinig
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INQUIRY INTO THE GP WORKFORCE

National Assembly for Wales, Health and Social Care Committee

Response from BMA Cymru Wales

16 January 2015

INTRODUCTION

BMA Cymru Wales welcomes the opportunity to contribute to the Health and Social Care Committee's inquiry into the GP workforce in Wales.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents over 7,000 members in Wales from every branch of the medical profession.

OVERVIEW

In an ever-evolving healthcare environment the independent contractor model has been at the heart of general practice's flexibility and innovation, which has been vital for affordable NHS care. It is well

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documented that high-quality primary care provides excellent value for money,^{1,2,3,4,5} at around £23 per consultation.

Accessible and well-resourced general practices are essential if NHS Wales is to deliver good health outcomes to patients in all parts of Wales. Yet, general practice is facing unprecedented challenges; we recognise that there needs to be fundamental change to make the provision of general practice in Wales sustainable.

Last year, the BMA's General Practice Committee Wales published a strategy⁶ intended to chart a way forward to a more certain future. Many of the recommendations in that document are replicated here.

MODERN GENERAL PRACTICE

There is a clear and increasing requirement for the GP workforce to be able to respond effectively to the growing demand for primary care services. This demand has been driven by a range of factors,⁷ including:

- population growth, higher birth rates and an ageing population;
- increased prevalence of chronic conditions (e.g. diabetes, obesity, dementia) and multi-morbidity;
- patients with higher expectations;
- increasing non-clinical duties (for example, multiple inspections from QOF, CHC, HIW visits, post payment verification visits; adapting funding changes; engaging in GP clusters and with health board initiatives e.g. prescribing leads); and
- policy initiatives for better-quality care, delivered closer to home.

GPs have increasingly reported they have never known a time when the workload was so intense; many say that services are under immense strain. We regularly hear from members that stress related illnesses are becoming increasingly common. Burnout is a very serious threat to the sustainability of general practice, not to mention to individual doctor health.

In attempting to respond to rising demand, the role of the GP has evolved and individual GPs are more accustomed than ever to innovating in order to improve practice operations and be more effective – for example: reviewing skill-mix; reducing the number of missed appointments; taking a prudent approach to prescribing; increasing the use of new technology; and engaging in cluster networks.

Working pattern preferences have also changed. The younger generation of GPs have different expectations and lifestyle desires than their predecessors. Partnerships are no longer seen as the end point of a career for some in general practice, as they increasingly resemble an overburdened path due to increased workload, bureaucracy and financial responsibility. This needs to be urgently addressed; and the

¹ A Survey of Primary Care Physicians in 11 Countries, 2009. Perspectives on Care, Cost and Experiences. Schoen, Obsorn, Doty, Squires, Peugh, Applebaum: Commonwealth Fund 2009. Available at: <http://www.commonwealthfund.org/Surveys/2009/Nov/2009-Commonwealth-Fund-International-Health-Policy-Survey.aspx>

² Barbara Starfield, LeiYu Shi, and James Macinko, 2005. Contribution of Primary Care to Health Systems and Health.

³ Pierard E. 2009. The effect of physician supply on health status as measured in the National Population Health Survey. Waterloo [Canada]: University of Waterloo. Available at: http://economics.uwaterloo.ca/documents/TheEffectPaperPierard_000.pdf

⁴ Oldham, et al. 2012. Primary Care – the central function and main focus: Report of the Primary care Working Group. The Global Health Policy Summit.

⁵ Kringos et al. 2013. Europe's strong primary care systems are linked to better population health but also higher health spending. Health Affairs:32(4),686-694 Available at: <http://nvl002.nivel.nl/postprint/PPpp5128.pdf>

⁶ BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales>

⁷ CFWI GP in-depth review: Preliminary findings 2013. Available at: <http://www.cfw.org.uk/publications/gp-in-depth-review-preliminary-findings/@@publication-detail>

impossible pressures of GP partnership need to be removed to make it an attractive option – for new and existing GPs alike. The partnership model needs to be maintained, supported by flexible career options for both men and women. We feel this is essential for being able to attract and retain new doctors to the profession, but note that few such flexible opportunities exist.

In terms of the size of the existing workforce, Wales has 2,617 GPs. This represents 85 GPs per 100,000 patients – the lowest ratio of GPs to patients in the UK.⁸ The number of GPs in Wales has risen in absolute terms by 11.2% over the last ten years, but this figure may be misleading because an increasing number of GPs are working less than full-time. When the number of GPs is expressed in terms of whole time equivalents, it has in fact remained broadly static over this time period, whilst the overall number of health board staff has increased by 19.7% (with some staff groups up by 120%).⁹

A report by the Kings Fund¹⁰ highlighted that the looming shortage of GPs, and the oversupply of hospital specialists, will undermine the drive to safeguard the NHS in the future. The think-tank said the workforce needs to be rebalanced to drive down future costs and prepare for the future needs of the NHS. The projected imbalances between different specialties will have serious implications for patient care and come on top of reports showing wider staff shortages in key areas such as emergency care.

Between 2003 and 2013, the proportion of GPs aged over 55 in Wales increased by 42.1%. While the number of practitioners below 45-years-old also increased, the rate of increase was significantly slower at just 1.2% throughout the same period^{11,12}. At the same time, the number of GPs under 50 planning to leave the profession has reached an all-time high.¹³ In 2014, 23.4% of all GPs were aged 55 and over – the figures are likely to be much higher in rural and more deprived areas.

The retirement bulge will occur over the next few years; but in combination with both poor recruitment, and concerns over a ‘brain drain’ with doctors choosing to leave the profession in the UK, the result will be a significant shortfall of GPs. This is a scenario that the BMA has previously warned about as a ‘perfect storm’.

Vitality, the GP workforce in Wales needs to increase to more sustainable levels. We estimate that, in addition to other measures, Wales needs at least 200 GP specialty trainee places each year, a rise from the current number of 136. Welsh Government will need to take action to attract trainees to these posts. Since it will take a minimum of three years to train these individuals, it will not significantly mitigate any supply shortfall that exists currently, or could emerge in the next few years.

Other measures, alongside trainee expansion, are therefore required; these are discussed in the sections that follow. These other measures also recognise the fact that an increase in capacity alone may not provide a long term solution – i.e. more GPs working equally as hard while demand continues to rise.

The Welsh Government is planning for more work to be done in primary care and for care planning to be managed through GP cluster networks. Primary care needs the workforce, infrastructure and resources to do the job. Despite strong evidence to support further investment, the share of total NHS expenditure allocated to Welsh GMS has fallen from 10.3% in 2007 to 7.9 %.¹⁴

⁸ GMC State of Medical Education and Practice in the UK 2014

⁹ BMA Cymru Wales ‘General Practice – a prescription for a healthy future’ 2014. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales>

¹⁰ King’s Fund report on NHS workforce development, 24 July 2013

¹¹ <http://www.walesonline.co.uk/news/wales-news/fresh-concerns-raised-gp-recruitment-6882121>

¹² <https://stats.wales.gov.uk/Catalogue/Health-and-Social-Care/General-Medical-Services>

¹³ Centre for Health Economics, University of Manchester Seventh National GP Worklife Survey

¹⁴ Figures supplied to GPC Wales by Welsh Government

The Shape of Training Review,¹⁵ and the implementation of its recommendations, are likely to have a considerable impact on the GP training curriculum – the review correctly identifies the huge challenges faced by the NHS in delivering a high-quality health service to a changing patient population in the decades ahead. These challenges are real and serious but the remedies suggested by Shape of Training do not offer the right solutions for patients and could risk all that currently works well in high quality medical education; for that reason the BMA has called for a pause in the review.

As health and social care needs grow in both volume and complexity, and health budgets remain constrained, pressure on the current fragmented system will continue to build. The downward pressure on GP income and working conditions has reached a nadir where the very infrastructure of practices is under threat. When practices fail to recruit, they are often forced into reducing the services that they offer to their patients. This is in no one's best interests.

There needs to be a recognition that with improved resources, enhanced GP training, and a significant expansion of the workforce, general practice can help to address the pressures posed by changing demographics and rising co-morbidity.

In the sections that follow, we provide commentary and offer recommendations on each of the three terms of reference areas of the inquiry, namely:

1. barriers to GP recruitment and retention;
2. whether the commissioning and delivery of medical training currently supports a sustainable GP workforce; and
3. the actions needed to ensure the sustainability of the GP workforce.

Cutting across all of this is the need for a comprehensive workforce strategy for primary care in Wales; one which includes the whole practice team.

RESPONSE (TO TERMS OF REFERENCE)

1 - BARRIERS TO GP RECRUITMENT AND RETENTION

As noted in the preceding section there are a multitude of factors that are combining to negatively affect both the retention of existing GPs in Wales and the attractiveness of entering a career in general practice. These factors include:

Workload

Almost half of the GPs who responded to the recent General Practitioners' Committee UK (GPC UK) survey revealed that increasing workloads and rising pressures were becoming unmanageable or unsustainable all of the time,¹⁶ with 89.4% of GPs indicating 'very high/high levels' of pressure at work.¹⁷ This is the single biggest issue reported to us by general practitioners.

Stress and burnout

Many GPs report that they feel an unsustainable level of pressure in their work, and many are choosing to leave the profession altogether¹⁸ or to move abroad.¹⁹ The Lack of occupational health provision for primary care is a serious problem.

¹⁵ <http://www.shapeoftraining.co.uk/home.asp>

¹⁶ BMA GPC online workforce survey, 26 March 2014

¹⁷ BMA UK 2013 Omnibus Survey

¹⁸ CFWI, July 2014. In-depth review of the general practitioner workforce; and HEE Securing the Future GP Workforce, Delivering the Mandate on GP Expansion - GP Taskforce Report 2014

¹⁹ GMC p57 State of medical education and practice in the UK 2014

Potential applicants to GP training are put off by well-documented reports of the stressful nature of working in general practice. In the most recent National Survey of GPs the level of overall job satisfaction reported was lower than in all surveys undertaken since 2001.²⁰ Of all BMA membership grades, GPs report the lowest average satisfaction with their work-life balance,²¹ and GPs, by far, use ‘Doctors for Doctors’ (the BMA’s 24/7 counselling and personal support service) the most.

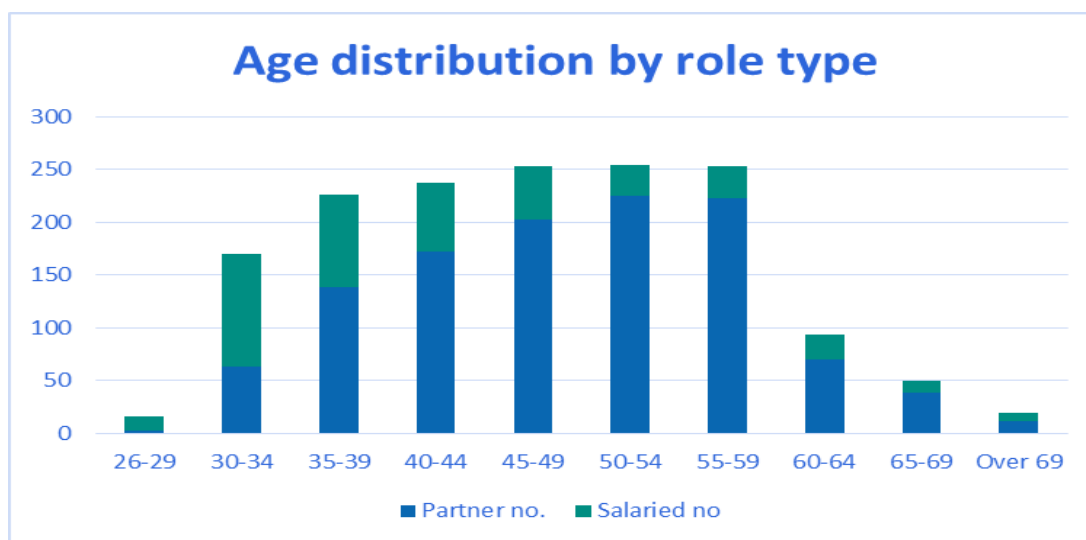
GP training arrangements

Against the background of recruitment problems and an ageing workforce, it is imperative that adequate numbers of new GPs are trained – despite longstanding commitments to expand primary care, the overall number of training places in Wales has remained static. It is also imperative that they are trained appropriately to deal with the modern day pressures of general practice. 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.

Partnerships and GP Principles

GP partnerships are increasingly being seen as unattractive, and therefore not sought after, due to the workload, bureaucracy and financial responsibility they involve – all for very little gain. In other circumstances, if such pressures are addressed, then many of the new generation of GPs have indicated that they would want to enter GP partnerships.

The graph below details the age profile of BMA GP members in Wales and their salaried/partnership split:



BMA GP members in Wales who work part-time comprise a quarter of those who are salaried GPs, compared to just 7% of those who are partners.

Lack of career flexibility

Flexible career schemes, for example posts that combine general practice partnership with an ability to undertake other roles within NHS Wales, are highly popular but very rarely supported.

Retainer and return-to-practice schemes

There is a lack of sufficient investment in making GP retainer and returner schemes accessible. The returner programmes are relatively inflexible in duration and content, regardless of the individual situation. They are costly, and the exit criteria often act as a deterrent for some individuals.

²⁰ <http://www.population-health.manchester.ac.uk/healthconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf>

²¹ BMA Quarterly tracker survey, September 2014

Out-of-Hours (OOH)

There has been under investment in OOH services since 2004. This is irreconcilable with Welsh Government commitments to improve unscheduled care. Without adequate investment, it is impossible to attract and retain capacity – particularly at weekends and over public holiday periods.

We note that there is no mention of OOH services in the Welsh Government’s proposed primary care plan, despite the fact they operate for more hours of the day than in-hours services.

Barriers to recruitment and retention in specific areas

In more deprived areas poor local amenities, smaller practices and a higher workload generated by a disadvantaged population act as disincentives for GPs to work in such areas.²² Current core GP funding arrangements do not properly recognise deprivation.²³

Rurality causes similar recruitment difficulties. Issues in rural areas – such as limited choice of local schools, lack of career options for spouse or wider family members, lack of local amenities – act as disincentives, especially for younger GPs. Rural practices are also threatened by issues over their financial stability related to inadequate resourcing, threats to funding for dispensing practices and the forthcoming phasing out of Minimum Practice Income Guarantee (MPIG) funding.²⁴

Hospital Waiting Times

The shift of work from secondary care to general practice has not been accompanied by resources moving in the same direction. This adversely affects the ability of GPs to do the job, puts services under immense strain, and further damages the morale of GPs.

This is further exacerbated by frustration over long secondary care waiting times, difficulties accessing some diagnostics, inadequate administrative systems within hospitals adding to GP workload (e.g. delayed clinic letters, poor discharge letters, chasing appointments), acute intakes regularly closing and the cancellation of routine surgery meaning that the patient’s condition worsens in the interim and more GP appointments are required – often consuming more health resources, particularly around prescribing.

Successive adverse policies

Pension changes, a series of below-inflation pay increases, wide underinvestment (e.g. in premises) and the transfer of more work into primary care have added to the stresses on an already demoralised workforce, and pushed more and more GPs to consider leaving the profession. Government policies on extending GP access are unrealistic and irresponsible; there are not enough GPs to cover even core weekday hours let alone evenings and weekends.

Lack of incentives to work in Wales

There are no ‘made in Wales’ policies that act to attract GPs to Wales and which make Wales stand out as a positive place to work. We have put forward a number of suggested incentive options to Welsh Government to help address shortages across the medical profession – none of the ideas have, so far, been taken forward.

²² Sibbald, B. (2005) Putting General Practitioners where they are needed: an overview of strategies to correct maldistribution. National Primary Care Research and Development Centre, University of Manchester. Available at: <http://www.medicine.manchester.ac.uk/primarycare/npcrdc-archive/archive/PublicationDetail.cfm/ID/139.htm>

²³ <http://www.gponline.com/why-gp-funding-linked-deprivation/article/1328431>

²⁴ BMA General Practitioners Committee Wales. 2014. GPCW Chair’s speech to the national LMC Conference. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales/lmc-conference-speech>

For Welsh GPs, this is compounded by that fact that they earn less than English counterparts²⁵ which impacts on a GP's decision as to where to work – whilst this is not the only factor affecting recruitment, in light of the higher workload and the other factors noted, it does need to be acknowledged.

Separate medical performers lists

The existence of separate performers lists for England and Wales has a number of detrimental impacts. For instance GPs on the English performers list may not be immediately able to take up vacancies that may exist within practices in Wales. In border areas, having separate lists can prevent GP colleagues in nearby practices, on either side, from simply being able to cover for each other in the way that might often happen between practices on the same side of the border. In the same way, the separate lists also limit the availability of locums for border practices.

Lack of data

Assessment of the true performance of NHS Wales, and its workforce numbers or requirements, is difficult due to the inadequate availability and reliability of data.

2 - WHETHER THE COMMISSIONING AND DELIVERY OF MEDICAL TRAINING CURRENTLY SUPPORTS A SUSTAINABLE GP WORKFORCE

Improve the attractiveness of training in general practice

In 2014, across the UK only 5559 GP trainee applications were received during the first round of the selection process – the lowest number of applications since 2009.²⁶ General practice has become the least popular specialty, second only to psychiatry.

Unfilled training places are a problem across the UK – in Wales this is exacerbated by the fact that we have the lowest number of Foundation Level 2 (FY2) posts in general practice (24%²⁷ compared to a UK average of 55%). The Department of Health has committed to a 30% increase in training places in England.²⁸

Whilst working to improve the image of general practice in medical schools, GP placements need to attract more doctors into general practice. 670 applicants who applied to general practice last year eventually chose other specialties.²⁹ Improving the attractiveness of training in general practice could include financial incentives, for example, and the provision of high quality accommodation for trainees and their families alongside adequate relocation expenses – this is especially needed in areas that are currently less popular.

The profession, the Welsh Deanery, medical schools and the Welsh Government need to work together to inspire and incentivise these applicants to choose a career in general practice. This will require new investment.

Increase exposure to general practice through foundation year placements

Consideration should be given to making foundation year GP placements mandatory for all doctors in training.

Increase the number of GP specialty trainee places

There needs to be a substantial increase in the commissioning of GP training numbers in Wales, phased in over several years. Based on an extrapolation of the data for England, which is not available in Wales, we estimate that Wales needs at least 200 GP specialty trainees each year, there are currently 136

²⁵ HSCIC GP Earnings and Expenses, 2012/13, p6

²⁶ General Practice National Recruitment Office & HEE MWAG Specialty Recruitment Update, Feb 2014

²⁷ note current 1 year increase to 34% in Wales

²⁸ DoH HEE Mandate 2013

²⁹ General Practice Recruitment Data, HEE, 2014

places. The numbers need to be reviewed regularly and against sound evidence/data (currently lacking). If demand on GPs increases at a faster pace than projected, additional measures should be considered. As we have noted, an increase in numbers alone will not solve the recruitment problem.

Ensure lead employer for GP trainees is implemented

This would ensure stability and, for example, would enable access to such things as childcare vouchers and mortgages – as the individual would not be moving employer every six months. It would also enable consistent human resources advice to be given.

Support training practices

Consideration should be given to an enhanced trainers' grant to recognise the impact that training has on the delivery of routine practice work. It is widely acknowledged that the workload involved, particularly the e-portfolio, is cumbersome and is becoming more onerous. The foundation placement fee and GP trainer's grant no longer reflect the current workload associated with training foundation and general practice trainees. An uplift proportionate to the workload is essential. The premises strategy also needs to ensure adequate space for GP training.

Extend GP Training

The RCGP makes a compelling case for extending GP training to four years³⁰ to prepare young doctors for the rigours of modern general practice. We recognise that this proposal would create a 'fallow' year where fewer GPs would exit training, temporarily compounding the already bleak environment of recruitment.

However, the GP specialty training programme needs to be planned to suit the challenges facing a 21st century GP, who is only part clinician, but also manager, commissioner, employer, negotiator, educator and book keeper. Many young GPs cite a lack of readiness as a reason they wish to defer joining partnerships following the completion of their training.

3 - THE ACTIONS NEEDED TO ENSURE THE SUSTAINABILITY OF THE GP WORKFORCE.

Increasing the GP workforce and training numbers should be a priority. However, as noted in the overview section above, we recognise that an increase in workforce numbers in isolation may not deliver better services to patients in the long-run.

In addition to supporting partnership working, we must also embrace new measures and ways of working to ensure the delivery of high quality, personalised and integrated care and to attract and retain GPs.

For instance we believe that a salaried service is valuable for supporting flexible careers and may help to retain doctors at the beginning and end of their careers, and thus plays an important role supporting the mainstream partnership model.

There are a number of measures that can be taken to support the partnership model and to help ensure the sustainability of general practice in Wales. It is important to realise that unless the attractiveness of general practice in Wales improves, and the working conditions for permanent staff are addressed, then the situation is only likely to worsen.

All of these have previously been put to Welsh Government, they include:

- ***Look at new models of care and practice viability, for example:***
 - i. Support flexible career and training schemes:

³⁰ RCGP, 2012 'Preparing the Future GP: the case for enhanced GP training'

Wales needs to create environments where the new generations of both male and female GPs seeking different ways of working can flourish. Sessions spent in portfolio roles, for example, offers both variety and ways of preventing burnout.

More opportunities for flexibility are needed that combine general practice partnership with an ability to undertake other roles in NHS Wales. For example, where a GP works a certain amount of time in practice and then the rest of their contract time in a mix of out-of-hours work, or work on health board priorities (e.g. audit, network pathways, using or acquiring specialist skills).

The increase in the proportion of the medical school intake who are women has led to a more equal gender balance in GP training and has changed the composition of the profession – we celebrate the fact that there are more female doctors now than ever before; 48% of doctors on the GP Register in Wales are now female.³¹ However, a dedicated piece of work needs to be commissioned to explore the multifactorial complexities behind why 40% of female GPs in the UK have left the profession by the age of 40.

Doctors in less than full-time training are expected to take at least five years to train, compared to three or four years for the majority of GPs in full-time training. This should be considered in workforce planning since it will reduce the rate of production of trained GPs.

ii. A salaried service

A salaried GP service is the most commonly promoted alternative to the independent contractor model and it remains attractive to some GPs. According to the King's Fund,³² salaried GPs give flexibility, as they often have short-term contracts and do not have the financial commitment of GP partners.

Whilst having an important place in primary care provision, there is little reliable evidence to support the case for wholesale change. Evidence from health boards suggests that a salaried service is more expensive and requires a lot of management involvement.

iii. Encourage federations of practices where appropriate:

This could involve practices making informal arrangements to share staff or work collaboratively on the provision of services to patients, either in individual premises or in jointly-shared premises. It could, of course, also include practices formally merging or joining together.

The GPC UK paper 'Developing General Practice – providing health care solutions for the future' expands on the value and importance of the primary care health team working in collaboration with other health care providers, and the value of collaborative alliances and federations tailored to local population needs.³³

iv. Develop opportunities for collaboration and innovation in primary care:

The expansion of the primary care team with pharmacists, health visitors, district nurses etc. can address some of the workload issues. There is currently a shortage of practice and district nurses, which has a knock on effect on GP workload. The King's Fund report on the future of general practice goes further by

³¹ GMC State of Medical Education and Practice in the UK, 2014

³² The King's Fund, 2011. Improving the quality of care in general practice: report of an independent enquiry commissioned by the King's Fund. Available at: <http://www.kingsfund.org.uk/publications/improving-quality-care-general-practice>

³³ GPC UK Vision Document. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision/improving-urgent-and-oooh-care>

suggesting GPs, dentists and optometrists collaborate to create a much larger primary care team.³⁴ However, this is likely to be an option in the medium to long term rather than an immediate one.

GPs are part of a wider primary care workforce – we must ensure that each element is complimentary and presents an effective use of skill mix and, in line with the principles of prudent healthcare,³⁵ does not duplicate or complicate other parts of care pathways or delivery.

The GP Cluster Network also, if properly supported and operational, holds some potential to assist in the area of collaboration, the sharing of innovation and best practice.

- v. Introduce an expanding practice allowance:

Currently practices have to see a significant rise in population numbers in order to have enough funding to take on additional partners. An expanding practice allowance would enable the development of staff and succession planning. It could for instance be paid for 24 months, after which the rising list would self-fund the practice expansion.

- **Measures to retain existing GPs:**

- i. Develop and invest in returner schemes:

Improving return-to-practice schemes should be a key area of consideration with regards to ways in which retention rates in Wales could be improved. It costs around £500K to train a GP³⁶ and around £30K to enable them to return. In addition, returners tend to be committed to the area in which they retrain. No matter how many individuals apply to the returner scheme, there should be sufficient funding available to enable them to return, and they should be supported to do so – in a flexible way if required.

We believe that for individuals who have been working in a country with a similar NHS system and doing general practice work, the ‘returner scheme’ should be of much shorter duration. We support the recent paper developed by the Welsh Government, the Royal College of General Practitioners (RCGP) Wales, the Wales Deanery and GPC Wales which proposes amendments to the current scheme and is currently with the Health Minister for consideration.

- ii. Develop and invest in retainer schemes

Incentives and flexible working opportunities should be offered to retain older GPs, including perhaps to those approaching retirement age.

This would be designed to avoid performers in exceptional circumstances becoming returners and having to go through the associated formal processes. For example, there is a need to retain and develop GPs who are unable to work full-time for specified and short term reasons.

The Welsh Government must change its funding priorities and provide fully-funded retainer schemes. Work needs to be undertaken to discover why doctors choose to take early retirement or to leave the profession, and at the same time to ascertain if these doctors have any interest in alternative ways of remaining in practice – for example becoming mentors, or moving to part time working or flexible contracts/portfolio roles.

- iii. Provide a full occupational health service

³⁴ Securing the future of general practice: new models of primary care, The King’s Fund, July 2013

³⁵ <http://wales.gov.uk/topics/health/nhswales/prudent-healthcare/?lang=en>

³⁶ <http://hee.nhs.uk/2013/05/28/new-education-and-training-measures-to-improve-patient-care/>

GPs in Wales have access to Health 4 Health Professionals, but there is no complete occupational health and well-being service. It is widely acknowledged that burnout, stress, low morale and risks of mental health illness are becoming increasingly prevalent.³⁷

BMA Cymru Wales has previously called for a comprehensive all-Wales occupational health service to be developed for all NHS employees. Given the significant cost of training a GP it makes complete economic sense to preserve and protect that investment – a comprehensive service is long overdue. It has been over five years since the recommendations of Sir Mansel Aylward's One Wales report into Occupational Health were accepted by the Welsh Government, and yet we are still only in the 'pilot' stages of projects.

- **Additional enhancements**

Incentives, such as 'golden handcuffs', can be very effective in recruiting GPs to certain areas. For example, in exchange for working in an area for a set amount of time, contributions could be made towards student loan repayments, or to training and examination fees. Incentives should especially be considered for rural and more deprived areas. Such schemes also would help efforts towards widening access to medical education.

Wider incentive schemes also need to be considered to increase the number of applicants to GP training places. For example medical schools could be incentivised to increase the proportion of their graduates selecting General Practice (and other shortage specialties) as first choice careers.

- **Review of Out-of-Hours (OOH) services**

Out of Hours (OOH) services have been underfunded since health boards took over in 2004; this has a serious knock on effect on the whole of unscheduled care. There is an urgent need to review the way in which OOH services are provided – while considering the introduction of the 111 service and ensuring its appropriate use – as in many areas there simply are not enough GPs to fill rosters.

GPs should be more involved in the planning and development of OOH services through strengthened GP clusters working arrangements. Competitive remuneration rates should be set to create attractive OOH GP salaried careers and to encourage the participation of local GPs.

Dedicated funding for continuous professional development (CPD) within OOH work should also be considered.

- **Capitalise on local commissioning expertise**

GPs need greater involvement (and a stronger voice) in local NHS management and commissioning, but they have limited capacity to engage in this currently given other pressures on workload.

We are very supportive of GP Cluster Networks, but in many areas they are no more than irregular meetings organised by the health board to administer the Quality and Outcomes Framework (QOF). They will only work if they are given adequate resources and real decision-making power.

- **Leadership**

The management of primary care requires a very different skill set from running hospitals. The specialist nature of this work may not be well suited to delivery by seven small primary care teams based in each health board. We believe that primary care management expertise should be consolidated into a Primary Care Authority for Wales.

Wales would also benefit from the reinstatement of a Primary Care Directorate within Welsh Government. Given the emphasis on primary care in Welsh health policy, the lack of a dedicated director level post in Welsh Government is, in our view, a major oversight.

³⁷ <http://www.pulsetoday.co.uk/your-practice/battling-burnout/one-in-eight-gps-have-sought-help-for-stress-in-past-year/20003871.article>

- **GP Premises**

There is no obvious funding stream for premises development; responsibility was handed to health boards in 2013 without a budget. A review of the condition of premises is required in order to identify a more affordable way of implementing the 2004 programme of development; it would need to take into account sufficient teaching and learning space. The requirement to sign leases with onerous terms and conditions is also a barrier to young GPs taking on partnerships.

This situation in Wales contrasts greatly with that in England, where £1.25 billion has been identified for investment in premises (£250 million a year for each of five years), meaning that Wales is now significantly lagging behind.

- **Data availability**

There is a worrying lack of data available on service performance and on workforce numbers and workload – starkly portrayed by the fact that neither Welsh Government, nor Health Boards in Wales, hold data on vacancies.

Chapter seven of the General Practitioners' Committee Wales (GPCW) strategy³⁸ deals with data availability and continuous service improvement. It makes a series of recommendations as to how the paucity of data and evidence gathering can be turned around.

- **Add General Practice to the Migration Advisory Committee (MAC) Shortage Occupation List**

The BMA has submitted evidence to the Migration Advisory Committee (MAC) in support of GPs being included on the shortage occupation list.

The MAC gives considerations to occupations within the UK suffering from workforce shortages on an annual basis. For shortage occupations on the list, individuals from outside of the European Economic Area (EEA) are then able to obtain a short term visa, i.e. two years, to enable them to apply for those vacancies in the UK.

The advantages of inviting non-EEA doctors to fill vacancies are twofold. First, it should alleviate some of the pressure on the overstretched workforce and, secondly, that will enable sufficient numbers of UK/EU GPs to train and qualify in the intervening period.

It is of note that there is a separate shortage occupation list for Scotland; while shortages in Wales and England are contained within the same list (which has the potential to skew specific shortage variations between the two).

- **Retired GPs**

We need to look at avenues to enable retired GPs to return in the event of a major outbreak/emergency situation without having to go through the hurdles of the medical performers' list, GP returner scheme, revalidation etc.

- **Patient Expectations**

Patient's expectations have changed over the last decade, as have the lifestyle factors affecting population health. As individuals we all need to take better responsibility for our health and well-being, and use health services appropriately.

Patients need to be able to access advice as to whether they need to see a health care professional or not; and where the most appropriate place to do so is. There are many advertising campaigns warning patients not to miss symptoms of illness and diseases. These campaigns have been introduced without taking into consideration the need to educate patients on the use of online and other resources to

³⁸ BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales>

signpost them to relevant services, in line the Welsh Government-backed principles of prudent healthcare.³⁹ Although many patients are beginning to do this, it is poorly advertised at present.

Education (for example on first aid, CPR, and the role of healthy and active lifestyles in warning off a number of illnesses and diseases) should be a compulsory part of the curriculum. The lack of implementation in an effective self-help agenda encourages the inappropriate use of healthcare resources.

CONCLUSION/SUMMARY

We hope the recommendations in this paper, and those contained in our strategy document, will inform the committee's work in this area.

The BMA is currently undertaking a national survey of GP members, covering many of the areas touched upon in this paper – models of working, premises, opening hours, workload, morale, consultation times with patients, and career motivators. We would be happy to share the results for Wales when the survey has concluded.

In representing GPs in Wales, we are wholly committed to working with the Welsh Government, the Wales Deanery, RCGP and others to bring forward lasting change for primary care in Wales.

It is clear that the solution is not a simple turning on of a switch, but a complex, multifactorial change in culture and strategy within the NHS and government, to recognise the clear problem facing us all and to implement action with both immediate and longer-term effects.

A recent BMA survey found that a staggering six in ten GPs in the UK were 'actively considering' leaving the profession.⁴⁰ We are at a watershed moment, and the time to act really is now.

Thank you for the opportunity to respond to this inquiry.

³⁹ <http://wales.gov.uk/topics/health/nhswales/prudent-healthcare/?lang=en>

⁴⁰ BMA quarterly tracker survey, Quarter 4, 2014