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Health and social care workforce

Consultation by the Welsh Senedd Health and Social Care Committee

Response from BMA Cymru Wales

8 October 2021

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation being undertaken by the Welsh Senedd Health and Social Care Committee to inform its forthcoming oral evidence session with Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW) on its joint strategy entitled *A healthier Wales: our workforce strategy for health and social care* as published in October 2020

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.

RESPONSE

General overview

BMA Cymru Wales is grateful for the opportunity to respond to this consultation. We note that its purpose is to inform an oral evidence session with HEIW and SCW rather than a more comprehensive study into health and social care workforce planning. We previously provided a more in-depth response into the draft of the strategy when it was being produced, and we consider that much of what we said at that time still has much relevance. We attach a copy of our earlier response as **APPENDIX 1**. For this response, we have confined our comments to points that we feel may be more pertinent to the context of this short enquiry by the committee.

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We note that the Health and Social Care Committee is wishing to consider the progress made to date in implementing HEIW and SCW's workforce strategy and whether delivery is on track for 2030.

It is the view of BMA Cymru Wales, however, that the Committee might first wish to consider how appropriate this is in the context of the ongoing Covid-19 pandemic. Given that the strategy was largely drawn up and consulted on prior to the pandemic, we believe a key question may therefore need to be posed as to what extent it is both appropriate and realistic for the strategy to be pursued as written, or whether it needs to be reconsidered in the context of the significant impact on both workload and workforce that the pandemic has created.

Health and social care services are clearly in a different place from when the strategy was initially being drawn up, with considerable and sustained pressures that were unforeseen in 2019 when the initial draft of the strategy was published for consultation.

The impact these pressures have had on recruitment and retention of medical and other NHS staff may therefore be significant. Many staff have suffered burnout as a result of the pressures of working through the pandemic, prompting many to consider leaving the profession earlier than they might otherwise have planned or reduce the extent of their working week. And given the extent of the backlog in non-Covid related care which has built up throughout the pandemic, the overall level of the workforce required undoubtedly also needs to be revised as the service seeks to catch-up in the next few years.

By way of an example, we recently surveyed our consultant members in Wales, and many told us they have been working more hours than they are contracted for in their current job plans, and in some cases significantly so. This demonstrates the extent to which they have been working additional hours unremunerated as a result of service pressures and the impact of workforce gaps – something which has been made more acute by the pandemic.

This is clearly not a sustainable situation, and it is therefore unsurprising that more than a quarter of those who responded to our survey said that within the next twelve months they were planning to either reduce their working hours or leave the Welsh NHS altogether.

To add further to this, our April 2021 survey of members in Wales found that almost a third of respondents are now more likely to take early retirement, a quarter are more likely to take a career break, and 21% are more likely to leave the NHS for another career.

Although some of these findings relate specifically to consultants, we have every reason to believe they are typical of doctors working in other branches of medical practice as well. As such, the need to enhance efforts placed on recruitment and retention has become substantially more acute and this clearly underpins the need to determine if the plan as it stands would now need to be significantly revised. A failure to react to this appropriately could lead to further significant pressures on the NHS and frontline healthcare staff in the future which would ultimately impact adversely on patient wellbeing and health.

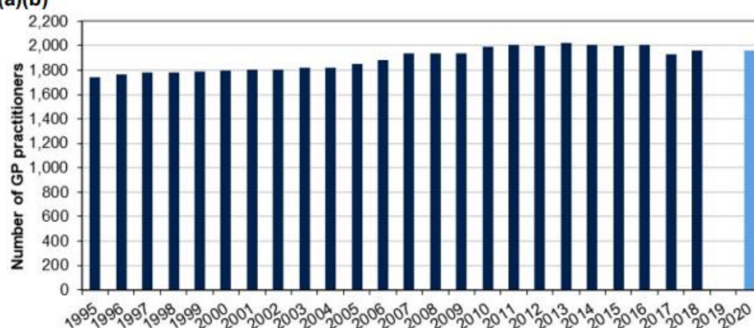
Primary care

GP Workforce Profile

Since the 2019 GMS contract agreement between Welsh Government and GPC Wales, GP practices in Wales are encouraged to input data into the National Workforce Reporting Service (NWRS), a system operated by NHS Digital. It was reported in March 2020[1] that 402 practices had inputted verified data into the system (99.5% of Welsh practices). Data is available to GP practices, Clusters and Health Boards of NHS Wales; it is anticipated this will inform local and regional workforce planning moving forward. Headline data from this system is reported periodically via Welsh Government's data release process; however, there has been no detailed trend analysis in the public domain since the Statistical release of July 2020.[2] Prior to this, statistical data was gathered via the GMS census and OpenExeter payment systems, which did not result in the most accurate returns.

As of March 2021, there are 1,963 GP practitioners working in Wales – which includes GP partners and salaried GPs. Based purely on headcount alone, it appears on the surface that the GP workforce in Wales is relatively stable in terms of 'practitioners', as illustrated in Figure 1. However, there are 47 (or 2.3%) fewer GP practitioners at 31 March 2020 than at 30 September 2011.

The number of GPs working as sessional locums has also steadily increased over the last several years, with 635 GPs that declared their primary work as a locum in 2015, and 828 locums registered on the All Wales Locum Register at end September 2020.



Source: WNWRS, GMS census

(a) Snapshots taken at 31 March for 2020, 1 October for 2009 and prior to 2000, and 30 September for every other year. No data available for 2019.
(b) Comparisons across years should be treated with caution due to changes in methodology. Data in light blue refers to WNWRS, data in dark blue refers to GMS Census. See data quality statement and key quality information.

Figure 1 - Headcount GP practitioners extracted from GP Practice Workforce Release 31 March 2020

However, this headcount data fails to take into account the changing working patterns amongst GPs. The WNWRS report from July 2020 notes that data on GP work patterns has not been

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[1] p.2, *GP practice workforce in Wales, as at 31 March 2020 (experimental statistics)*, Welsh Government, 2 July 2020, gov.wales/sites/default/files/statistics-and-research/2020-07/general-medical-practitioners-31-march-2020-716.pdf

[2] *GP practice Workforce in Wales as at 31 March 2020*

reported, even though information on GP Whole Time Equivalent (WTE) is gathered, due to the need for data validation. It is anticipated that this data will feature in future reports.

We suggest that this data will further evidence the increasing trend toward portfolio working amongst GP practitioners of all ages, with many GPs opting to lessen their number of sessions in their practice in favour of other roles. For example, a census of over two thousand GPs in the South West of England in 2017[3] revealed that seven out of ten GPs reported a career intention which, if implemented, would adversely impact the GP workforce capacity in the region, either through reducing hours spent in direct patient care or by taking a career break within the next five years. Another study of early-career GPs in 2017[4] demonstrated that while entering GP partnership was a popular career choice five years after completing training (33%), a significant proportion (19.2%) anticipated working in roles outside of GP practice in that timescale, citing workload pressures and desire for a work-life balance.

This trend needs to be considered alongside the fact that Wales has the oldest GP workforce compared to other UK nations. According to data from the General Medical Council register[5] and outlined in Table 1, 23.9% of GPs resident in Wales are 60 years old and over, compared to an average of 19.5% elsewhere. This presents a clear sustainability challenge for independent contractor practices in Wales and emphasises the need for a sustained increase in GP trainee numbers, as well as contractual measures to reduce workload pressures in order to retain the most experienced.

Country of residence	Total number of resident GPs	Number of GPs aged over 60	% of total
Wales	3,107	742	23.9%
England	61,851	12,100	19.6%
Scotland	7,119	1,384	19.4%
NI	2,093	403	19.3%

Table 1 - Age profile of GPs across UK nations (extract from GMC data explorer)

Impact of the Pandemic

The impact of the past 18 months upon GPs and their staff will inevitably have in impact on both retention and recruitment. A snapshot survey of Welsh GPs[6] taken in Sept-Oct 2020 revealed that 84% of respondents felt workload levels were higher than pre-pandemic levels, and 90% of respondents were being asked to provide services which would usually be provided in secondary care. Respondents unanimously felt that these pressures were having a

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[3] Fletcher, E. et al., 2017. *Quitting patient care and career break intentions among general practitioners in South West England: findings of a census survey of general practitioners*. BMJ Open, p. 7(4):e0125853.

[4] Dale, J., Russell, R., Scott, E. & Owen, K., 2017. *Factors influencing career intentions on completion of general practice vocational training in England: a cross-sectional study.* BMJ Open, p. 7(8)e01714

[5] Data extracted from the GMC Data Explorer on 30 September 2021 www.gmc-uk.org/about/what-we-do-and-why/data-and-research/gmc-data-explorer

[6] https://www.bma.org.uk/bma-media-centre/leading-welsh-doctor-pays-tribute-to-role-gps-playing-in-pandemic

detrimental effect on staff wellbeing and morale. The longer term consequences of this on the workforce are evident when looking at the data for Welsh GPs who responded to the BMA's tracker survey (n = 108) during February 2021: with 30% of respondents citing they were more likely to take early retirement in the next year, and 44% more likely to work fewer hours in that timescale.

GP training

BMA Cymru Wales has consistently advocated for the need to increase GP trainee numbers in Wales[7] through targeted activity and incentivisation, as a means to address the long-term challenges facing the workforce. We welcomed the Welsh Government's *Train Work Live* recruitment campaign, launched in 2017, which brought in a £20,000 'golden hello' payment for GP trainees who chose to train in hard-to-recruit areas, alongside a one-off contribution towards Royal College of GP exam costs for all Welsh GP trainees. Through our representation on the Ministerial Taskforce for Primary Care we also called for the need for further innovative solutions, including a 'single point of contact' system for prospective newcomers to Wales; spousal/family support measures, and above all else an increase in the number of training places available. This has been imperative for a number of years; in 2015 one Health Board estimated[8] a need for between 1.5-2 new GPs to replace each retiring GP.

Through the actions of HEIW and the Welsh Government, and making use of Wales' well-established GP trainer network, there has been a significant increase in training places since 2018 onwards. This is referenced in the Workforce Strategy as *Action 7.* In November 2020, 200 new GP trainees were recruited[9], which was an increase of 7% on the previous year's number of 186. We understand that this year's intake may be lower in order to accommodate pressures on the training system caused by the pandemic with trainees opting for deferred starts and extended periods of training, but have received assurances that this does not represent a reduction in the long-term.

In recent years Wales has seen a shift toward a new model of GP training under the 1+2 Model[10], with 24 months of training spent in GP practice and 12 months in hospital settings. Previously training time had been split equally between both settings. We supported this move, as a means of ensuring that GP trainees can maximise the opportunity to acquire the skills and experience of working in general practice over an extended period of time. In addition to this increase, many other allied health professional and nursing training schemes are planning to increase the periods of time spent in GP surgeries, in line with *Action 9* of the Workforce Strategy. Whilst this is to be welcomed in ensuring these much-valued staff groups are best equipped for primary care working, capacity in the current primary care estate overall may be insufficient to meet this increasing demand for space. This, coupled with the extreme workload

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[7] p8. BMA Cymru Wales. '*GPC Wales: A prescription for a healthy future*'. October 2014.

[8] P16. Workforce Education Development Services, 2015. *NHS Wales Workforce: Key themes and trends,* Cardiff: NHS Wales WEDS. heiw.nhs.wales/files/weds-education-contracting-links/nhs-wales-key-themes-january-2015/

[9] Welsh Government. '*A record number of GPs training in Wales in 2020*'. 15 Nov 2020 .https://media.service.gov.wales/news/a-record-number-of-gps-training-in-wales-in-2020

[10] The 1+2 Model of GP training https://www.cardiff.ac.uk/curemede/research/wales-model-of-gp-training

pressures upon the GP trainers themselves, highlights the need for further investment in premises as well as workforce.

Secondary care

From a secondary care perspective, we would highlight some current issues that the committee might wish to consider, as follows:

Publication of vacancy data

For a number of years, we have repeatedly called on the Welsh Government to return to routinely publishing vacancy data across secondary care. We see the creation of a reliable and standardised workforce data set is a necessary priority and remain deeply disappointed this has still not been addressed. The Welsh Government should build on the workforce reporting system for primary care, by making secondary care workforce vacancy data available in the public domain.

Currently, we find that we are only able to acquire vacancy data within secondary care by submitting Freedom of Information requests to Welsh health boards and trusts. But often the data we received in response is incomplete, notwithstanding the fact that different organisations use different definitions to determine what counts as a vacancy making comparisons between different NHS employers across Wales practically meaningless.

Where we have managed to acquire data on vacancies, we have found significant variation across Wales. Our analysis of recent information requests on consultant vacancies found that in one health board as many as 48% of consultant posts were not filled by a permanent consultant.

As we have previously said in a number of similar responses to earlier enquiries, we fail to understand how workforce planning can effectively be undertaken when we don’t know how many vacancies exist amongst medical staff across different specialties and across different parts of Wales. In our view, this therefore needs to be addressed by the Welsh Government as a priority.

Impact of pension tax charges/retire and return

Due to perversities in the way taxation is applied to those within NHS pension schemes, many senior doctors have found themselves facing significant tax charges in recent years from breaching annual allowance or lifetime allowance limits imposed by the UK Treasury. Whilst changes made to annual allowance limits in 2020-21 have reduced the impact to a certain extent, these problems have not altogether gone away and continue to impact on many of the more senior and more experienced doctors we would wish to retain within the NHS in Wales, leading in many cases to them considering retiring earlier or reducing their willingness to undertake additional work such as taking part in much-needed activity under waiting list initiatives.

In October 2019, NHS Wales Employers issued guidance[11] for the 2019-20 tax year on flexibilities that could be accessed by health boards and trusts to help minimise these problems. Many affected doctors may choose to opt out of the pension scheme for all or part of the financial year to avoid punitive tax charges, but this means they can miss out on receiving the contributions that their employer would have made towards their pension. This is clearly a concern given that these pension contributions are an integral part of a doctor's overall remuneration package. For 2019-20, an option was introduced with support from the Welsh Government for employers to offer to make an additional pay offer to staff using any unused employer contributions. This helps to ensure doctors don't lose out on part of their remuneration by opting out of the pension scheme. It therefore acts as an incentive for these senior doctors to remain working within the Welsh NHS when they might otherwise simply choose to leave or retire.

We are currently in discussion with the Welsh Government and NHS Employers Wales for this flexibility to be reintroduced, and for it to be offered as a right rather than at the discretion of individual employers. At time of writing, we would therefore be keen to see progress on this.

Another option for some doctors who face highly punitive pension tax charges if they remain in work is to retire and then return to work, and this is one way by which senior doctors may choose to remain in the workforce for longer. We would like to see clear principles adopted which could give doctors more consistent access to this option. We are currently aware there is much variability across Wales in whether or not this option may be offered and, if it is, how it is then applied.

Inductions and mentoring for international medical graduates

Doctors who are international medical graduates (IMGs) form a sizeable and increasing proportion of the medical workforce. In 2017, 37% of UK doctors on the General Medical Council (GMC) list of registered medical practitioners had gained their primary medical qualification outside the UK[12]; and according to the GMC,[13] over 10,000 IMGs joined the UK medical workforce in 2020 – more than UK and EEA graduates combined.

Ensuring IMGs have a good experience when coming to work here in Wales is vital, in our view, to maximising the extent to which they will want to remain working in Wales where their contribution to addressing recruitment and retention challenges is clearly much needed. Starting a post in Wales, or elsewhere in the UK, can be challenging for IMGs who may be unfamiliar with many aspects of life and culture here. They may face many difficulties that can hinder their performance and career progression—they have to learn new medicolegal frameworks, training systems, duties and skills, guidelines, and negotiate working relationships

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[11] NHS Wales Employers. '*Pension tax guidance for employers: Local measures to support staff and service delivery during the 2019/20 financial year*'. October 2019. https://www.nhsconfed.org/sites/default/files/2021-06/Pension-tax-guidance.pdf

[12] Bourne S. '*What are the biggest challenges international medical graduates face when starting work in the NHS?*'. British Medical Journal (2018). *BMJ* 2018;360:j5618

[13] General Medical Council. *'The state of medical education and practice in the UK 2020'*. November 2020. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

with other professionals.[14] They may also experience differences in the role of a doctor from their country or origin.

We are aware of the successful collaboration between the NHS in Wales and BAPIO (British Association of Physicians of Indian Origin) which has been bringing medical graduates from India to Wales to undertake training and development programmes under the Medical Training Initiative (MTI). As part of this programme, considerable effort is made to ensure that participants receive a suitably comprehensive induction both before they come to the UK and after they arrive.

We feel it is important that such enhanced induction is offered to all IMGs coming to work in Wales, as well as access to appropriate mentoring schemes to ensure they continue to receive support. We are keen to see this offered to IMGs regardless of their country of origin, and not just to those coming here via the BAPIO scheme. We know this is an area of work that HEIW is currently looking to develop, and we would therefore be keen to see further progress made.

New specialist grade

We were pleased to successfully endorse the adoption of new contracts earlier this year for the staff, associate specialist and specialty doctor (SAS) group of doctors. We particularly welcome the creation of the new specialist grade which provides an opportunity for career progression for more experienced specialty doctors.

We know that a few posts under the new specialist grade have recently started to be advertised. We feel this provides a great opportunity to retain more experienced specialty doctors within the workforce in Wales, and we are therefore keen to see more such roles created across Welsh health boards and trusts.

NHS Wales fatigue and facilities charter

Prior to the onset of the pandemic, we developed a fatigue and facilities charter[15] in partnership with the Welsh Government and NHS Wales. Aimed at combating the problem of fatigue amongst junior doctors in Wales and improving facilities in a service that operates 24 hours a day, 365 days of the year, the charter was officially launched in early 2020.

We are keen to see progress made on the implementation of this charter, which to an extent has been hindered by the Covid-19 pandemic. It is important, however, that we now secure a clear framework for monitoring the charter's implementation so we can establish what progress has been made and set clear timeframes for further progress to be achieved.

Fair work principle and medical engagement

Action 3 in '[A healthier Wales: our workforce strategy for health and social care](#)'seeks to deliver progress towards fair reward and recognition across the health and social care workforce. We

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[14] Valero-Sanchez I, McKimm J and Green R. '*A helping hand for international medical graduates*'. British Medical Journal (2017). *BMJ* 2017;359:j5230
[15] NHS Wales Fatigue and Facilities Charter. 2019. https://www.bma.org.uk/media/2147/wales-fatigue-and-facilities-charter-march-2020.pdf

note the Welsh Government's consultation on its Social Partnership and Public Procurement (Wales) Bill and recognise its role in supporting this action.

We agree with the principles of fair work as outlined in the Fair Work Framework,[16] namely "*effective voice, opportunity, security, fulfilment and respect*". These values reflect the core ethos of the BMA as a professional body and trade union, as attested to by our long-standing advocacy and support for medical engagement.[17]

However, we are concerned that a lack of effective medical engagement is having a detrimental impact on both the medical workforce and wider efforts to address the significant service challenges the NHS faces.

Aside from the wider socio-economic benefits of having an engaged, secure workforce, there is also clear evidence of the direct relationship between engagement and clinical performance within the NHS.[18]

Yet, engagement with medical, clinical and wider staff within the NHS is generally poor. In 2016 the NHS in Wales undertook a Medical Engagement Scale survey to gain an understanding of the situation and to develop a baseline of data for future work. The survey found wide variation of engagement across organisations and branches of practice, but overall poor levels of medical engagement within the NHS in Wales.[19]

It is crucial that action to improve medical engagement is progressed if the aims of the workforce strategy are to be realised.

We are aware that the Medical Engagement Scale surveys have been re-run this year across Welsh health boards and trusts. A time of writing, however, we are waiting for the full results to be shared with us.

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[16] Fair Work Convention (2016) *Fair Work Framework* www.fairworkconvention.scot/wp-content/uploads/2018/12/Fair-Work-Convention-Framework-PDF-Full-Version.pdf
[17] BMA (2017) *Medical Engagement: Doctors Contributions to Change* https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/integration/medical-engagement-doctors-contributions-to-change
[18] Clark J and Nath V (2014*) Medical Engagement, a journey not an event*. King's Fund
[19] Engage to Perform Ltd (2016) Medical Engagement Scale, Patterns of Medical Engagement in the Welsh Health Boards

APPENDIX 1

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A Workforce Strategy for Health and Social Care

Consultation by Healthcare Education and Improvement Wales and Social Care Wales

Response from BMA Cymru Wales

18 September 2019

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation by Healthcare Education and Improvement Wales and Social Care Wales regarding their joint workforce strategy which follows the publication of *A Healthier Wales*. Representatives of HEIW have previously attended meetings of the BMA Welsh Council to outline initial thoughts in this area, and this response hopes to build on these initial discussions, for which we are grateful. BMA Members were also able to attend several of the engagement workshops which have taken place during 2019.

Whilst we appreciate and support that the strategy is for health and social care in Wales, our response will primarily focus on the medical profession and the NHS Wales, although where appropriate we will make links to the social care system. Likewise, our engagement sits primarily with Healthcare Education and Improvement Wales and this document should be read with that in mind.

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.

RESPONSE

To begin, we strongly support the fact that the strategy builds on the ambitions set out in *A Healthier Wales* and is guided by the Quadruple Aim. We welcome the positioning of the health and wellbeing of the workforce at the very heart of the strategy. This focus aligns with the core mission of the association, which is "*to look after doctors so they can look after you*". We hope to continue our positive relationship with HEIW to ensure this is borne out in reality to the benefit of our members, patients and the wider health and social care system.

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We have consistently advocated for an all-Wales workforce strategy to tackle the long-term sustainability challenges facing NHS Wales and social care services. As per our representations to the National Assembly's health, social care and sport committee to their inquiries on recruitment[i] and workforce sustainability[ii], the capacity of the medical workforce is failing to keep pace with increasing demand and is already therefore under immense strain. This is true across primary and secondary care, and this situation is only likely to intensify given our aging population, particular socio-economic challenges, and the continued uncertainties posed by Brexit.

In addition, the traditional medical career model is changing. Studies have demonstrated the increasing popularity of portfolio-based careers (King's Fund[iii],[iv]) and less than full time working and career breaks (BMA[v]). This highlights the increased importance of the wider multidisciplinary team and collaboration between professionals to ensure service provision can be balanced alongside these preferences. Training programmes will require adaption to prepare for this increased multidisciplinary approach at an earlier stage. We therefore support the laudable aspiration to develop a whole system strategy.

However, whilst we agree with the case for change, we have some overall high-level concerns with some of the ambitions and commitments outlined in the document.

- We would agree with the aspirations outlined in the draft strategy, however throughout we feel that it lacks detail on the mechanisms to achieve them and how future success would be measured. The strategy should include reference to evaluation methods and measures near the outset of the document to emphasise the importance of this element.
- The timescale for change is insufficiently ambitious, given the current workforce pressures across the health and care sectors. For instance, the ambition of making health and social care the sector of choice must be realised far earlier than 2025, should we wish to attract and retain professionals to roles in Wales.

  Data from the General Medical Council[vi] (GMC)r suggests that Wales had almost no increase in doctors aged under 50 years from 2012 to 2017, suggesting a difficulty in retaining or attracting this cohort. Applicant numbers from Wales for Cardiff University's 5-year medical degree is lower per capita compared to the rest of the UK, which is concerning as it is recognised by the GMC and others that students who study in their own region are more likely to work in the same area[vii]. These issues specific to Wales are compounded by the fact that, on a UK-wide basis, the percentage of doctors going into specialty training directly after completing the second year of the Foundation Programme has declined to 37.7% in 2018, from a high of 71.3% in 2011[viii]. Whilst 55.6% do enter clinical roles of some sort in the NHS, many are preferring to opt for career breaks or choose to work overseas (around 8.6%). The reasons behind this increase in breaks from training are no doubt multifactorial (as recognised by the GMC in their *Training Pathways 2* working paper[ix]), but it does suggest that there is something about UK training programmes that deters doctors from entering them. This helps to illustrate the challenge facing the medical workforce

BMA

- The strategy suggests that multidisciplinary education and training will be the default. As we mentioned previously, the changing landscape of the health and care system means that training programmes must adapt to the realities of increasing multi-professional and multi-agency working in order to best prepare professionals to work in these settings. However, there is a clear and defined need to retain the important structures, networks and standards of current professional training programmes. For medicine, this is necessary to meet the training outcomes set across the UK by the GMC[x] and the requirements outlined in specialty curricula by Royal Colleges. Divergence from these in favour of MDT training as the default mode could risk trainee doctors having to undertake training in their own time to ensure requirements were met, or ultimately to create an under skilled, underprepared medical workforce.

  Additionally, medical training in Wales benefits from strong well-established training networks that should be maintained, with general practice training being a particular example. We would be concerned that training quality across these networks could be compromised should the current defined budgets be reallocated to MDT training.

We will now continue to comment on the emerging themes outlined in the strategy. Please note that we will only provide comment on questions we consider relevant.

Valuing and retaining our workforce

1. *Does this theme support the workforce transformation needed to deliver A Healthier Wales?*
2. *If not – what is missing?*

We welcome the priority given to retention and valuing the workforce, which we agree is the most valuable asset within the health and social care sectors. We are pleased to see the strong commitment to work in partnership with trades union colleagues for the benefit of our members.

We are pleased that the harmonisation of practices across employers has been recognised as something that requires streamlining and harmonisation. Our members report substantial variance in working practices, policies and procedures across different health boards.

We suggest that there needs to be recognition of the immense pressures within the health service at the moment, which is one of the primary factors affecting staff morale and wellbeing.

3. *Are the emerging priorities and potential actions sufficient?*
4. *If not what else would you like to see?*

We welcome the proposal to introduce staff charters provided this does not cut across or compromise the individual needs of each staff group. This work should build on existing work going forward, such as the BMA's Fatigue and Facilities Charter, which we are working with employers to roll out across Wales for the benefit of junior doctors.

Likewise, we would support the intention to improve and standardise inductions provided individual requirements are maintained and promoted.

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The introduction of robust evaluation tools alongside a greater focus on understanding staff concerns and reasons for wanting to leave aligns with some of our long-term aspirations such as the universal roll-out of exit interviews. We would therefore support this good practice being prioritised.

The prominence given to ensuring sustainability and effectiveness of occupational health services as a proposed action is laudable, given its vital importance to staff wellbeing. However, we know that this service is significantly under-staffed and resourced at present, meaning that appointments are not available to those that need it. This requires immediate attention and investment to ensure a viable service exists in the present, let alone in the near future.

We note at enhancing the flexibility of training is considered a longer-term action for 2028-30. This should be featured with greater immediacy given ongoing work by the Academy of Medical Royal Colleges and GMC[xi].

Effective communication with staff is vital to ensure that staff are engaged. This has been a long-term BMA priority through our work on medical engagement[xii], which is defined as '*the active and positive contribution of doctors…to maintain and enhance the performance of the organisation…in supporting and encouraging high-quality care*' (Spurgeon, 2008). Enhancing communication should be a continuous and immediate priority rather than being considered a medium-term aspiration.

Seamless Working

1. *Does this theme support the workforce transformation needed to deliver A Healthier Wales?*
2. *If not – what is missing?*

As previously described, we acknowledge that increased collaboration across sectors and professions is a necessity given current pressures in many parts of the health and care service. The Frailty service is a particularly positive example of an integrated program delivered with multidisciplinary input, preventing unnecessary secondary care admissions.

A Healthier Wales gave some prominence to regional partnership boards as a means of co-ordinating priorities across several agencies. However, we continue to question representation on these boards by front line staff or their representatives, in order to ensure the staff voice is heard within this new and increasingly influential arena.

3. *Are the emerging priorities and potential actions sufficient?*
4. *If not what else would you like to see?*

We would question the feasibility of several of the priorities. For example, the co-location of multi-disciplinary teams will not be possible in many parts of the health service, without significant investment in the estate. This is particularly true of primary care. Services dispersed across rural areas will also find this aspiration difficult.

The increased focus on multi-agency primary care cluster working over the last 5 or so years, now enshrined in the Primary Care Model for Wales, is something that BMA Cymru Wales has long supported as a means of relieving the pressure within general practice. Continually, we

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hear from our members that while the rhetoric is sound, true multidisciplinary working is hampered by bureaucracy and red tape which can delay progress or prevent successful initiatives from continuing into the next budgetary year.

We support the intention to deliver a quality improvement and positive risk approach.

Harmonisation of governance is again a laudable aim, but in practice has already proven difficult, with primary care cluster working as an example. Additionally, we would not wish to see a one-size fits all approach that could lose focus on the individual needs of particular professions or sectors, or to eliminate good practice and innovation in some areas.

Digital

1. *Does this theme support the workforce transformation needed to deliver A Healthier Wales?*
2. *If not – what is missing?*

This theme adequately captures the high-level aspirations and goals necessary to bring about change within an evolving digital landscape.

3. *Are the emerging priorities and potential actions sufficient?*
4. If not what else would you like to see?

We have major concerns that the priorities and actions, whilst positive and laudable, are simply unachievable in the short to medium term given the perilous state of the IT estate within NHS Wales. To realise the priorities, firstly we must address the basics: ensuring all grades of doctor have access to appropriate devices; enabling cloud working as standard; and having true integration between primary, secondary and tertiary systems.

We support enhancing digital literacy of the workforce, but this would be to no end if we do not urgently upgrade the current system architecture and digitalise working processes.

Additionally, this increased focus on digital as a means of delivering education should not be to the detriment of other more resource or people-focused forms of educational delivery, which remain vital to the learning process.

Attraction & recruitment

1. *Does this theme support the workforce transformation needed to deliver A Healthier Wales?*
2. *If not – what is missing?*

Establishing Wales as an attractive place to work and train is fundamentally important, particularly given the aforementioned recruitment and retention challenges. BMA Cymru Wales has launched initiatives to widen access to medicine amongst Welsh schools[xiii] and has consistently supported other nationwide activities through membership of the Ministerial Taskforce for Primary Care and the All Wales Medical Workforce Strategy Group.

Regarding values-based recruitment, we would question how the recruitment system could be transformed from the standardised UK selection system which is based on meritocracy. This

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would create a differential in Wales and possibly discourage applicants from applying within a system with which they are unfamiliar. Recruitment must also adhere to UK-wide professional regulatory systems, with their associated safeguards; variance from this could be detrimental to the service and public safety, should a different system be implemented in Wales.

3. *Are the emerging priorities and potential actions sufficient?*
4. *If not what else would you like to see?*

The impact of Train.Work.Live has been felt within primary care through the incentive scheme, and we would support measures to continue this work. However, the campaign will only be truly effective if the training and working conditions within NHS Wales are comparable, if not better than, the rest of the UK.

We would welcome explicit recognition of the importance of promoting the development of the healthcare workforce from within Wales, which would be supplemented by the overseas recruitment activities that are referenced.

Incentives and bursaries need to be considered more widely than in financial terms. This should include reference to career opportunities, staff engagement, opportunities for partners/spouses, and other practical support.

Education & Learning

1. *Does this theme support the workforce transformation needed to deliver A Healthier Wales?*
2. *If not – what is missing?*

In general, we are supportive of the vision and ambitions stated within this theme. We would suggest that the word ‘competent’ is not used in light of the GMC move toward professional ‘*capabilities’*[xiv].

As stated earlier, BMA Cymru Wales is very supportive of widening access initiatives [xii] and would welcome continued efforts in this area to reverse the trend of fewer Welsh domiciled students applying to study medicine in Welsh universities. The commitment toward greater flexibility within education, making best use of digital technologies, is to be particularly welcomed as this in itself is a measure that can make education and training more accessible.

‘Grow your own schemes’ should be encouraged and continued, but with appropriate quality management and assurance in place to ensure UK-wide requirements and outcomes are met.

We are concerned at the assertion that ‘*Undergraduate programmes must align to the needs of the service’*. We accept that undergraduate education must prepare graduates of any professional group for the working world and ensure preparedness for practice. It would be preferable were this to be framed as ‘*Undergraduate programmes must align to the needs of the patient*’ as this follows the aspirations of A Healthier Wales to reshape the paradigm towards health, wellbeing and prevention. Undergraduate education should also focus on innovation, for instance to bring forward clinical leadership earlier on in doctors’ careers.

The vision of promoting multi-display education at every opportunity may prove impossible to attain for medical education and training, given GMC and Royal College requirements for

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curricula. As previously mentioned, we agree with the rationale that professionals must be trained to work in an increasingly MDT-focused environment which should be shaped around the best clinical outcomes for patients, but this cannot be at the expense of the individual specific needs of medical training.

3. *Are the emerging priorities and potential actions sufficient?*
4. *If not what else would you like to see?*

We support the priorities relating to enhancing strategic educational partnerships and mapping common educational requirements, which is a proportionate step toward identifying multidisciplinary training opportunities. The prioritisation of ensuring flexibility and promoting innovation is also welcome, as is the embedding of quality improvement throughout curricula.

We cautiously welcome the priority given to reviewing the funding of professional education and training. At the outset, we would emphasise the importance of maintaining profession specific education and training budgets to ensure that outcomes for individual professional groups can continue to be met in accordance with UK-wide standards, and in recognition of the competitive global market. There could be scope as part of this review to consider improving the study budget system to provide another tangible benefit of choosing to train in Wales.

We would be very interested in hearing more about the intention to align CPD across professions and agencies by 2030, which would presumably follow the extensive mapping exercise. Many postgraduate specialty curricula in medicine, and no doubt other professions, have very specific and detailed outcomes that would fail to easily map across to other staff groups. Expansion of aligned MDT training therefore cannot come with the consequence of requiring doctors to undertake more training in their own time in order to meet these specific requirements.

We feel that this emerging theme would benefit from reference to enhanced, expanded or advanced practice roles for different staff groups. It is widely recognised, in primary care in particular, that these advanced roles do have a place in daily practice as a means of lessening the burden on already stretched GPs, and thereby increasing public access.

A common issue raised by members is over-scrutiny, by education/training supervisors, of their choice of educational course, should it sit outside of their current scope of practice. This can hamper their development and expansion of their capabilities, leading to disengagement. Whilst we agree that education opportunities have to be relevant, the current system could be reviewed, and we would like to see this considered.

Leadership

1. *Does this theme support the workforce transformation needed to deliver A Healthier Wales?*
2. *If not – what is missing?*

We agree with the high-level goal of producing quality-focused, compassionate leaders. The vision of a safe and open environment whereby individuals can suggest improvements and raise concerns without fear of recrimination is something BMA Cymru Wales would wholeheartedly support. Rather than a long-term aspiration, this should be reality in the present day, but it is

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apparent from our members that this currently is not the case in many parts of the health service.

The aspirations to develop the leadership competence of all staff with a focus on the wellbeing of the workforce is particularly welcome. This shared leadership approach was identified during the BMA's work on medical engagement[xv], as a means of creating a learning culture.

3. *Are the emerging priorities and potential actions sufficient?*
4. *If not what else would you like to see?*

We feel that this section could benefit from a clearer demarcation between leadership and management, as there is some conflation. This potentially cuts across the wider vision to develop leadership from amongst all staff groups.

Innovation and dynamic leadership should feature within the emerging priorities list, and we feel this section could be further improved by reference to values-based recruitment for leaders.

Undergraduate leadership development is referenced; postgraduate leadership development should likewise be acknowledged explicitly.

The intention to develop multi-disciplinary graduate learning programmes is a laudable aim, but one that needs to be thoroughly worked through prior to launch. There are nuances inherent within different professions, and a one-size fits all approach could lose some of the benefits that the current system can provide. Additionally, there are existing medical leadership development programmes, such as the Clinical Fellow schemes offered by the Faculty of Medical Leadership and Management, which are well-recognised, well-evidenced and well-used.

Workforce Supply & Shape

1. *Does this theme support the workforce transformation needed to deliver A Healthier Wales?*
2. *If not – what is missing?*

The emerging theme reiterates the rhetoric and direction of travel expressed within *A Healthier Wales* and taken forward in other plans such as the Strategic Programme for Primary Care. It recognises the deficiencies in workforce data. In primary care, this will partly be resolved by the launch of the Wales National Workforce Reporting System (WNWRS). It also acknowledges the current issues in workforce planning, which we believe would be aided by the publication of reliable secondary care vacancy data.

The theme does not however, in our opinion, tangibly describe how the service can move forward to make the whole system transformation a reality.

3. *Are the emerging priorities and potential actions sufficient?*
4. *If not what else would you like to see?*

The reference to improved investment in the workforce as a means to reduce locum and agency dependence is welcome. However, it does not propose any solutions for how this can be achieved: for instance, by making substantive roles more attractive, widening the pool of individuals to whom shifts are offered on a pan-health board basis, and offering internal locums

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swifter pay. It should also acknowledge that greater locum working in primary care is often due to the greater desire across the board for a more varied portfolio career.

The creation of a reliable and standardised workforce data set is a necessary priority. This should build on the recently launched workforce reporting system for primary care, by making secondary care workforce vacancy data available in the public domain.

Investment in workforce planning capacity is vital to create the necessary in-house expertise within the health and social care system, to enable the delivery of integrated workforce plans. This will need clinical input to ensure the plans are focused on the best clinical outcomes, and not purely service throughput.

Social partnership working with workforce representatives will be of fundamental importance to realise the ambitions of this theme: in order to have an informed understanding of day-to-day issues; to encourage evaluation; and to ensure roles are made more attractive through improved working conditions.

Finally, this section could benefit from acknowledging the current existence of the All Wales Primary Secondary Care Communication Standards, issued as a Welsh Health Circular in 2018[xvi]. Embedding the principles of this document within workforce development will help to realise the goal of an integrated, flexible and sustainable workforce.

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