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Private & Confidential

Mr Stephen George
Clerk - Health, Wellbeing and Local Government Committee
National Assembly for Wales
Cardiff Bay
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31st October 2007

Dear Mr George

Inquiry into Health and Social Care Workforce Planning

Thank you for your letter of the 24th September, addressed to Dr Tony Calland Chairman, BMA Welsh Council, requesting written evidence to assist your inquiry into health and social care workforce planning.

I am responding on behalf of the British Medical Association in Wales. I understand that Dr Calland has agreed to provide oral evidence on the 14th November.

1. Summary of main points:

- The demand for doctors is affected by short term changes in NHS delivery systems than has been recognised by planners. As a consequence governments should avoid making the sorts of change which exacerbate the position without first evaluating the impact.
- More account needs to be taken of medical advance and technological change in workforce planning than is currently the case.
- The training needs of doctors should be included in workforce planning. There is a need for planners to put in place measures that encourage, reward and recognise the contribution of medical trainers.
- Skill mix change is not a universal panacea and should be carefully evaluated for cost, effectiveness and evidence base before being introduced.
- Workforce planners should concern themselves with recommending change as much as with predicting it.
- More attention should be paid to designing incentives for encouraging recruitment, retention and changes in working practices, this maybe particularly important in respect to providing services in rural areas.
- The need for a strong and effective regulatory environment should be tempered by recognition of its impact on the resources available for patient care.

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- The way in which doctors make career choices is an important issue affecting recruitment into both the profession itself and individual sectors and specialties and should be taken into account in workforce planning.
- Whilst the service needs of NHS providers are a major variable in the process, overall resource constraints also impact on providers' capacity to employ or contract with NHS staff.

2. Introduction – BMA Cymru Wales

BMA Cymru Wales is a professional association of doctors established to look after the professional and personal needs of our members. The BMA represents doctors in all branches of medicine all over Wales and the rest of the UK.

We are a voluntary association of practising UK doctors in membership and an independent trade union dedicated to protecting individual members and the collective interests of doctors.

We promote the medical and allied sciences, seek to maintain the honour and interests of our profession and promote the achievement of high quality healthcare. Our policies cover public health issues, medical ethics, science, the state of the NHS, medical education and doctors' contracts. Policies are decided by elected members, mainly practising doctors and supported by a professional staff who work with other bodies to meet its objectives.

3. Evidence

BMA Cymru Wales is pleased to contribute to the Committee's inquiry into health and social care workforce planning. Our evidence concentrates on workforce planning as it relates to the medical workforce but it also attempts to place the demand for and supply of doctors in a wider context, in discussing the role of skill mix change.

Medical workforce planning operates on two levels. At the macro level it deals in aggregate supply and demand whilst at a micro level it seeks to allocate (insufficient) numbers amongst competing sectors and specialties largely, though not exclusively, on the basis of staffing norms.

The history of overall medical workforce planning in the UK - the macro approach - is a well known one and we do not intend to deal with it in any great detail.

The format of such reviews has, with increasing levels of sophistication in modelling, been to assess the likely supply of doctors under certain assumptions and to compare it with measures of prospective NHS demand.

The third report of the Medical Workforce Standing Advisory Committee in 1997, for example, recommended:

- An increase of about 1,000 in the annual intake of medical students.
- The development of clinical courses with graduate entry.
- Holding constant the number of undergraduate medical students from overseas.

The distinction between self-reliance and self-sufficiency is an important one and has implications for future medical workforce planning, implying as it does a significant though stable role for international medical graduates. We should perhaps not overlook the potential contribution of International Medical Graduates already present in the UK. It must also be noted that NHS Wales would still find it difficult to maintain the service without those doctors from outside the EEA.

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It is also important to ensure that Wales' workforce is not seen in complete isolation to the rest of the UK. It is important that the workforce needs of Wales are considered in the overall context of training numbers and the number of medical school places available throughout the UK. However, it is essential that we plan correctly for the numbers of International Medical Graduates that we need and ensure that our own graduates here in Wales are able to access appropriate training to get them to the level of Certificate of Completion of Training in either speciality or general practice.

Furthermore, the stepping off point for medical workforce planning has always been the existing position and no needs-based evaluation of that position has been undertaken. The starting position has always been a shortfall of doctors relative to demand and a very low stock relative to population by international standards – masked to some extent by long working hours and a remuneration system that did not encourage substitution of labour. Progressive changes to junior hospital doctor contracts and the threat of the European Working Time Directive have been major factors in altering this perverse incentive.

Notwithstanding this, the present approach to workforce planning means that the effect of any changes to the way in which the current workforce works will be felt long before the impact of future recruitment. Getting the numbers of doctors wrong has, furthermore, potentially serious consequences.

The ratios of doctors to head of population served, both in hospital and in general practice, seem, for example, to be critical determinants of standardised hospital death rates; the higher these ratios, the lower the death rates in both cases. However, substantial changes to working arrangements have taken or will shortly take place which will severely impact on the ability of the workforce to meet existing let alone prospective demand.

These include:

- The European Working time Directive.
- The full impact of consultant job planning under the 2003 contract.
- The impact of clinical governance on available clinical time.
- The increasing feminisation of the workforce and its implications for flexible working.
- Increasing preferences for part-time working amongst the workforce as a whole.
- Transferring activity from a hospital to a community setting.

The Wanless Review had, however, high hopes for the roles of skill mix change and new reward mechanisms in helping to ameliorate the position.

3.1 Skill mix and service redesign

The Wanless Review explored the potential contribution that skill mix changes could make to the potential mismatch between the demand for and supply of doctors.

Its interim report highlighted evidence suggesting that Nurse Practitioners could undertake at least 20 per cent of the work of doctors while maintaining the safety and quality of care. If, Wanless concluded, 20 per cent of GP and junior doctors' work were shifted to Nurse Practitioners, this would eliminate any potential capacity constraint in doctor numbers.

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However, it is important that this is fully considered and evaluated. Whilst we fully accept the potential of skill mix we maintain that the future of the NHS remains a service that is doctor-led. We need to maintain the position of a doctor focused service that can be cost effective and efficient while recognising where it can be supplemented by the need and potential of skill mix. There is otherwise a risk in substitution of skills to the lowest common denominator which we believe can lead to a false economy, is unacceptable to patients and the public and introduce increased risks to patient safety.

3.2 Training needs

Central to any consideration of workforce planning is the recognition of training needs and requirements.

A major criticism of the current arrangement is that training numbers are decided on a year-to-year basis and fail to take account of the specialists required in the future, both in Wales and the rest of the UK.

In this context, there appears to be little objective assessment of the 'real cost' of training doctors which has major implications for the service and ultimately, patient safety. In this context it is often considered that training is not fully factored into Consultants' time.

This is also a major concern in relation to academic training opportunities for doctors in Wales. There is currently no transparent organised academic programme within Wales to deliver those doctors who will contribute to health research in the future. This needs urgent consideration.

In addition, whilst the Deanery is looking to ascertain the number of doctors in training and ultimately the needs of Trusts and Local Health Boards in Wales to accommodate our training numbers, this does need a greater lead from both the National Leadership and Innovation Agency for Healthcare (NLIAH) and the Welsh Assembly Government to take this forward.

3.3 The role of incentive

Although skill mix change could make a major contribution to eliminating any potential skills mismatch over the 20 years, there will clearly also need to be an increase in the number of doctors and nurses over that already planned. Wanless argued that this should be achievable if pay modernisation resulted in improved recruitment and retention. The role of incentive has been insufficiently explored by workforce planners in the past.

Higher rewards for doctors have undeniably contributed to the increased popularity of medicine as a career. The rise in applicants in 2004 represented an increase in home applicants per place from 1.71 to 1.97, only just below the 1997 level (2.04), when the current expansion in places began.

However spiralling student debt may be the next major disincentive and workforce planners should be aware of this. In this context, the BMA's 2004 survey of medical student finances showed average 5th year debt of £19,248, an increase of 16% over its 2003 level.

The role of incentive in retention should not be ignored. Research commissioned jointly by the BMA and the NHS Confederation during the new GP contract negotiations found, for example, that:

- Over one third of GPs (36%) reported that 'having insufficient financial incentive to stay in general practice was an important factor influencing their retirement decisions.
- Almost half of GPs (47%) felt that financial considerations were an important influence on their planned retirement age. The scenario most likely to postpone retirement was a retention bonus lump sum payment of £15,000 for each year retirement was deferred beyond the age of 60.

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3.4 The outputs from workforce planning

To date, the major output from overall medical workforce planning has been a recommendation to change (usually increase) the UK medical school intake. This has been because the methodology implicitly assumes increased derived demand for doctors arising from increased NHS activity. As we have seen, there might be scope for deflecting some of this demand to other staff groups although this does not affect the underlying premise that more activity equates with a need for more staff.

Ideally, workforce planning should be at least equally concerned with recommending mechanisms for meeting demand by implementing best practice not only in redesigning services but also in the effective deployment and rewarding of NHS staff to maximise their contribution to direct patient care. It will often, given lead times for adjusting the numbers of professional staff, be more effective to change working patterns at least in the interim. Such changes as do occur do so in isolation from workforce planning.

For example, the new GP contract is practice-based and it provides resources to deliver primary care rather than linking payments to doctors. This leaves practices free to make better use of the available workforce – not only satisfying the requirements of a new generation of doctors wishing to work part-time or as salaried doctors but also making better use of other professionally trained staff. The workforce implications of this have yet to be evaluated. Allied to system reform are the issues of changes to medical training (Modernising Medical Careers) and the service needs of NHS providers.

3.5 Governance

For the medical workforce as a whole there has been a dramatic increase in non-clinical workload with management and administrative duties, teaching and training taking up an increasing share of available time.

Time spent on management by whole time consultants increased by over 4 hours per week between 1989 and 1998, helping to increase average total hours of work (excluding emergency recalls) from 48.3 to 51.3 hours per week. In consequence the time available for clinical work has declined by around 2 hours (6%) per week.

The Wanless review identified two competing trends in workforce growth - information and communication technology (ICT) investment which might significantly reduce the amount of time medical and nursing staff had to spend on administration, freeing up more time for patient care and the amount of time spent on clinical governance which would have the opposite effect. For its financial projections, the review assumed that 10 per cent of professional staff time would be devoted to clinical governance.

3.6 How doctors make career choices

The way in which doctors make career choices is an important issue affecting recruitment into both the profession itself and individual sectors and specialties. The BMA has studied the career progression of a cohort of over 500 doctors who graduated in 1995.

These suggest that a medical career no longer follows a traditional pattern for a significant proportion of doctors. Workforce planning will need to take greater account of this in future. This will be particularly true of planning at the micro level.

Findings from 10th (2005) report of BMA cohort study. While three-quarters of cohort doctors are currently satisfied with practising medicine, a fifth report a lukewarm desire to practise medicine and the remainder have little or no desire to practise medicine. A key factor in the morale and motivation of cohort doctors is achieving an acceptable work-life balance.

The proportion of cohort doctors working in general practice continues to increase, with a third of cohort doctors working as general practitioners (GPs) in the past year. Around a quarter of cohort GPs worked as full-time principals, with the remainder working in part-time principal or non-principal posts.

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One in five cohort GPs worked as a locum. Flexibility is one of the key reasons given for cohort doctors working as locums in both general practice and hospital medicine.

The numbers of cohort doctors choosing to specialise in radiology, anaesthetics and pathology or pursue a career in academic medicine have increased over the nine-year period. In contrast, the proportions planning a career in general medicine or surgery have more than halved since graduation in 1995.

In the past year, 15 per cent of cohort doctors had changed their choice of career and one of the key factors influencing this change is 'hours of work and working conditions'.

A third of the cohort plan to practise medicine overseas in the future, either on a temporary or permanent basis. The main reasons centre on increased experience and improved standards of living.

Many cohort doctors suggest that the real impact of the European Working Time Directive (EWTD) has not made the working lives of junior doctors any easier. Many doctors complain that although the number of hours worked may have been reduced, other important aspects of their job have suffered, including training and patient care.

Three-quarters of the cohort are either currently working less than fulltime or would like to do so in the future. Since 2001, the proportion of cohort doctors working part-time has more than doubled, from 13 per cent in 2001 to 30 per cent in 2004. Despite the increase in the number of flexible trainees over the past four years, a third report difficulties in working less than fulltime.

For two in every five cohort doctors, the reality of a career in medicine is very different from that envisaged at graduation in 1995. Many cohort doctors admit that they were unprepared for the reality of life as a doctor.

The career choices of cohort doctors vary somewhat according to gender. Females are more likely to choose a career in general practice, while males are more likely to choose a career in hospital medicine or research/academic medicine. Female cohort doctors are more likely to be undecided about their future career options.

4. Recommendations

- Medical workforce planning needs to be an ongoing process and whilst this is theoretically the position, changes in demand are affected more radically by short term changes in NHS delivery systems than has hitherto been recognised by planners. One solution is clearly to avoid making the sorts of change which exacerbate the position without first evaluating the impact.
- This is not however, an option where such changes are prompted by technological or medical advance and more account needs to be taken of these forces in workforce planning than is currently the case.
- Skill mix change offers a potential solution to some of the problems likely to be faced by workforce planners in the future. It is not, however, a universal panacea and should be carefully evaluated for both its cost and effectiveness before being introduced.
- Additional work must be undertaken to ascertain the real cost of training doctors. Workforce planning must assess the needs of trainers and future training needs.
- Workforce planners should concern themselves with recommending change as much as with predicting it and this is especially true of designing incentives for encouraging recruitment, retention and changes in working practices.

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- The need for a strong and effective regulatory environment should be tempered by recognition of its impact on the resources available for patient care.
- The way in which doctors make career choices is an important issue affecting recruitment into both the profession itself and individual sectors and specialties and should be taken into account in workforce planning. It is particularly important in the context of training requirements, where any mismatch has costly unemployment consequences.

I hope you find this information useful. Please do not hesitate to contact me should you require any additional information.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Richard Lewis', with a horizontal line underneath.

Dr Richard Lewis
Welsh Secretary

Copy to: Dr Tony Calland, Chair BMA Welsh Council