Y Gymdeithas Feddygol Brydeinig
Pumed Llawr
2 Pentir Caspian
Ffordd Caspian
Bae Caerdydd
Caerdydd
CF10 4DQ

British Medical Association
Fifth Floor
2 Caspian Point
Caspian Way
Cardiff Bay
Cardiff
CF10 4DQ

BMA

Cymru Wales

Health and social care workforce enquiry – follow-up questions

Consultation by the Welsh Senedd Health and Social Care Committee

Response from BMA Cymru Wales

13 January 2022

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the follow-up questions put to us following the Welsh Senedd Health and Social Care Committee's oral evidence session with Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW) on their joint strategy, *A healthier Wales: our workforce strategy for health and social care.*

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

Following the submission of our written evidence in October ahead of the Health and Social Care Committee's recent oral evidence session with HEIW and SCW, BMA Cymru Wales is happy to consider the follow-up questions put to us in a letter from the chair, Russell George MS, dated 29 November 2021.

Our response is as follows:

Q1. How effectively does 'A healthier Wales: our workforce strategy for health and social care' *address staff wellbeing?*

We note the clear intentions within the strategy to address staff wellbeing and, from our dealings with HEIW, we would certainly consider that the organisation pays significant attention

Cyfarwyddwr Cenedlaethol (Cymru)/National director (Wales):
Rachel Podolak

Cofrestrwyd yn Gwmni Cyfyngedig trwy Warant. Rhif Cofrestredig: 8848 Lloegr
Swyddfa gofrestredig: BMA House, Tavistock Square, Llundain, WC1H 9JP.
Rhestrwyd yn Undeb Llafur o dan Ddeddf Undebau Llafur a Chysylltiadau Llafur 1974.
Registered as a Company limited by Guarantee. Registered No. 8848 England.
Registered office: BMA House, Tavistock Square, London, WC1H 9JP.
Listed as a Trade Union under the Trade Union and Labour Relations Act 1974.

to promoting staff wellbeing. This is particularly the case in relation to doctors in training for whom it has specific responsibility in its role as the medical deanery for Wales.

In our members' experience, however, the problems they face with regard to wellbeing lie much more at the level of the health boards and trusts they work for due to the realities of the pressures of working at the frontline. Frequently, they find that consideration of their wellbeing is overlooked in the wake of the relentless pressures which health board and trusts face in ensuring that services are delivered by a level of staffing resource that is often insufficient. Many doctors often don't therefore find that the actions of health boards and trusts always lead to them, and other NHS staff, feeling sufficiently valued.

From a primary care perspective, the impression of many of our GP members is that insufficient consideration is given to those staff who work on a contactor basis, or those who are employed by GP-practices rather than directly by health boards. They feel that many of the decisions made by health boards don't sufficiently take into account the impact they might have on the wellbeing of such staff, and access to health board provided wellbeing services can prove difficult for contractors and their staff.

On top of this, a huge concern at present is the impact of Covid (particularly the Omicron variant) on staff sickness. This serves to expose the lack of resilience that currently exists amongst both staff and estates capacity within the NHS in Wales. We are currently hearing increasing reports of acute shortages due to Covid-related staff sickness and requirements to self-isolate, and this is clearly having a negative impact on the wellbeing of other staff who are having to plug the gaps as a result.

Staffing levels were already a concern prior to the onset of the pandemic, but clearly this has worsened as a result of Covid. We are now dealing with a workforce that is exhausted from the impact of a pandemic which has been with us for just short of two years. They have suffered from the trauma of the acute pressures the pandemic has brought over this time period. As we have previously stated, this may be having a significant impact on both recruitment and retention, with many staff suffering from burnout as a result of these pressures which is prompting them to consider leaving the profession early.

For more information on how this is impacting, please refer to our earlier response to this enquiry in which we outlined some of the relevant findings of a survey we conducted last year amongst our consultant members in Wales.

Q2. What are your views on current approaches to assessing staff well-being? Are surveys as a standalone tool sufficient to provide an accurate picture of the wellbeing of the health and social care workforce? Are there other measures that you believe should be adopted?

Whilst surveys can provide a snapshot of opinion, they cannot always offer the depth that may be required to fully understand the issues impacting on staff.

Participation rates are not always as great as might be hoped, something that is regularly the case for the NHS Wales Staff Survey, but this partly reflects a workforce that may simply be too busy to engage.

Surveys should only be seen as one part of engagement work, and the approach to assessing staff-wellbeing needs to be multi-faceted. Where surveys are used, and concerns identified, the value of following this up by asking the same questions again to track any improvement or worsening performance over time needs to be recognised. There is often a desire from NHS management to reinvent the NHS staff survey each time it is run, but that can then impact on the ability to demonstrate if different indicators are improving or deteriorating.

It is also important that surveys aren't just seen as a tick box exercise and that follow-up action is taken to address any concerning findings. The survey is just a means of gathering information; it's what is then done with that information that is the important thing. So, having a clear mechanism in place to respond to a survey's finding is vital; and it's also equally important that whatever is done to address those findings is communicated back to the workforce.

If little is done between different sets of surveys then the fact is that little is likely to change, and improvement won't then be observed.

A clear example of this would be to consider the findings of the Medical Engagement Scale surveys which were undertaken across Welsh health boards and trusts in 2016, and again in 2021.

The initial surveys conducted in 2016 painted a very patchy picture of medical engagement across NHS organisations in Wales. Whilst they identified some examples of good practice, there were too many instances where scores for medical engagement were poor, with much variance being found between different NHS organisations, different departments within NHS organisations and different groups of doctors. Despite a commitment that health boards and trusts would take action to improve medical engagement with the surveys then being re-run after a three-year interval, the follow-up surveys were in fact delayed until last year. (In fairness this delay was in part due to the pandemic.) Regrettably the 2021 surveys did not illustrate anything like sufficient change in the overall picture, and some poorly performing organisations in 2016 somewhat concerningly demonstrated worse results in 2021.

This suggests that insufficient action was taken between those two sets of surveys to address the underlying issues. This backs up our assertion that surveys on their own are not enough to bring about change. They can only achieve that if they are seen as triggers for follow-up action to address the findings they highlight. Culture change may also be necessary within NHS organisations to bring about meaningful and positive change.

Q3. In your view, are the partnership forums referred to above by HEIW operating effectively?

For a number of years, BMA Cymru Wales did not participate in the Wales Partnership Forum which now covers all employed staff across the NHS in Wales. Instead, we participated in a number of standalone forums with Welsh Government and NHS Wales Employers for different groups of doctors. This, in part, reflected the fact that employed medical and dental staff are engaged under a distinct set of contracts compared to other NHS staff who are employed under *Agenda for Change* contracts.

In 2019, we took the decision to re-join the Wales Partnership Forum on behalf of employed doctors within the NHS in Wales after it was agreed that a sub-group of the Partnership Forum would be created known as the Medical and Dental Business Group (MDBG). This sub-group separately considers terms and conditions of service issues for NHS-employed medical and dental staff, with appropriate autonomy to reach agreement on issues which are specific to those staff. MDBG has now been meeting on a regular basis since early 2020.

Our experience of being part of these partnership arrangements through 2020 and 2021 has in the most part been positive, and particularly so when compared to the arrangements they replaced. MDBG provides us with a regular forum to discuss issues of concern to different groups of employed doctors directly with appropriately high-level representatives from Welsh Government and NHS Wales Employers. It also provides a framework to ensure issues raised are followed up between meetings. Amongst other issues, it has helped facilitate our participation in contract discussions (e.g. for junior doctors); consider the implementation of new contracts (e.g. for specialty doctors and the new specialist role); agree measures to help mitigate against the punitive impacts of the taxation system as it impacts on the pensions scheme for senior doctors; and enabled us to establish sub-groups to look at specific issues of particular concerns (such as a sub-group focusing on recruitment and retention of medical staff).

Whilst not every issue may always be addressed as quickly as we might like, we have nonetheless seen good progress on a number of issues as a result of being part of these partnership arrangements.

Q4. To what extent is there sufficient staff capacity to ensure that workloads are manageable and that staff are able to take breaks, annual leave, access wellbeing support and undertake training and professional development? Is the picture improving or deteriorating, and do staff feel they are sufficiently supported in this respect by their organisations' leadership and management?

Insufficient staff capacity has long been a concern, but the situation has undoubtedly worsened as a result of the pandemic. And as we touched upon earlier in this response, the level of staff sickness resulting from Omicron is very much an immediate concern.

Owing to the pandemic, many specialties within secondary care have not sufficiently recruited to fill vacancies and have relied increasingly on internal locum cover, with pressure falling upon many junior and SAS-grade doctors to cover service gaps. Doctors are therefore being called upon more and more to provide cover and this most certainly impacts negatively on their ability to take breaks, access annual leave, access wellbeing support and undertake training and professional development.

Many of our secondary care members report particular ongoing difficulties with staff recruitment and retention within their departments, including within theatres as well as for staff providing general medical and dental care. As the GMC have reported, 7% of all doctors said they had taken 'hard steps' towards leaving the profession in 2021, up from 4% in 2020 and 3% in 2019,[i] so the impact of dealing with the pandemic is clearly having a serious effect on retention.

General practice has rapidly, and rightly, changed its working patterns in order to cope with the national emergency caused by the COVID-19 pandemic whilst ensuring that face to face appointments were available for those in most clinical need. Following the relaxation of the initial Spring 2020 lockdowns, demand on general practice for routine care has increased, with most practices experiencing significantly higher demand than the same point in previous years. 82% of respondents to our recent survey of GP members in Wales said that remote consultations have increased their overall number of daily contacts, with over half (54%) saying that remote consultations have enabled longer lengths of patient contact. In this context of unprecedented and ongoing demand, it is unlikely that GPs and their staff have the adequate time to access training, adequate breaks and wellbeing support.

We would also note that it is very difficult to dissociate wellbeing from other work-related factors that impact negatively on the working lives of all doctors, and indeed other NHS staff, including the particular pressures that have been brought by the pandemic.

As we have pointed out on a number of previous occasions, the fact that health board vacancy data is not routinely published is a huge concern that needs to be addressed. Unless we know the extent of the vacancy problem then how can we know what action needs to be taken to address it? We are only able to get hold of vacancy data by undertaking Freedom of Information requests but often the date we obtain is incomplete, and different heath boards and trusts use different definitions of what constitutes a vacancy making comparisons extremely difficult.

Please refer to our initial response to this enquiry for more information regarding our concerns about this. The need to address this issue is something we would once again wish to stress.

Q5. What are your views on the pilot approach to assessing staff's digital skills, capabilities and training needs? Is a self-assessment tool sufficient to identify where there are skills gaps across health and social care, and what further action is needed to ensure the health and social care workforce have the digital skills required?

We would consider this to be a reasonable approach, but clearly it will need to be backed up with suitable follow-up action and appropriate training where required.

[i] GMC (2021). *The state of medical education and practice in the UK*. Available at: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk