Dogfennau Ategol - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:

Ystafell Bwyllgora 2 - y Senedd

Dyddiad: Dydd Iau, 1 Rhagfyr 2016

Amser: 09.15

I gael rhagor o wybodaeth cysylltwch a:

Sarah Beasley

Committee Clerk

0300 200 6565

SeneddIechyd@cynulliad.cymru

Noder bod y dogfennau a ganlyn yn ychwanegol i'r dogfennau a gyhoeddwyd yn y prif becyn Agenda ac Adroddiadau ar gyfer y cyfarfod hwn

Ymchwiliad i recriwtio meddygol: Ymatebion i'r Ymgynghoriad

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Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad i recriwtio meddygol

Tachwedd 2016

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Y Pwyllgor Plant, Pobl Ifanc ac Addysg

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Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Cynulliad Cenedlaethol Cymru
Bae Caerdydd
CF99 1NA

Ffôn: **0300 200 6565**
E-bost: **Seneddlechyd@cynulliad.cymru**
Twitter: **@SeneddPPIA**

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MR 01
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Phil Jones
Response from: Phil Jones

Thank you for seeking opinions/views on this issue.

I offer my thoughts as a consultant physician born in Cardiff, qualified in Cardiff and working in Aberystwyth for 21 years. I am a geriatrician with an interest in stroke.

To get a qualified consultant or GP working in Wales requires the recruitment to start in secondary schools. We need to enthuse our Welsh pupils about a career in health care (recruitment challenges extend into nursing and therapies). We need to attract students into our Welsh medical schools and we need to expose them in their undergraduate training (or within their postgraduate medical training in Swansea) to working in rural areas. We need training posts to offer placements in rural areas.

At a conference about rural surgery we heard that the Scottish government require 20% of students and 20% of trainees to experience a rural placement.

Rural posts (in Scotland) account for about 10% of all posts so we don't need many but we do need some.

Our training programmes in medicine are directing doctors into more and more sub-specialisation. In Wales there are only a few (of the some 14 acute DGH sites) who have sufficient mass to need such sub-specialisation skills. Many sites need a cardiologist (for example) who can also cover general medicine – we don't all need a cardiologist who can provide PCI. This example is generalisable to many other areas.

We need to ensure that the Welsh consultant contract is as attractive as the English version – when people have a choice this might be a deciding factor.

We need to look at our reputation for training and act decisively where we need to so that we ensure we meet the statutory requirements and the trainees experience is good.

We may attract poor feedback/experience through the quality of our accommodation for students and junior doctors – again a remediable issue.

I understand that Cardiff has very few Welsh students – why? What can we do to improve this? Can we offer scholarships from HB/hospital areas to encourage local applications from the community – there is a better chance that they will return.

The Brexit issue is one that I don't think we can predict with any accuracy. I do think that we should be absolutely clear that NHS Wales welcomes the best applicants for posts from anywhere in the world and it may be that we can look globally to recruit and that may be better than EU only. To my surprise when Greece and Portugal ran into problems we didn't get an influx of doctors from those countries (at least not in mid Wales). Can we recruit from the commonwealth better than we did from Europe for doctors? We always used to. It would be important to ensure that our valued colleagues in NHS Wales from outside the UK are appreciated and that there is no threat to their continued employment – if we can do that then we would provide a lot of reassurance and prevent loss of staff on top of failure to recruit.

From a local perspective a bigger problem at present is retention of staff. Before the merger into Hywel Dda the hospital at Aberystwyth was well staffed, we recruited and retained well. Whilst I understand the need to reduce from 22 trusts the experience of "merging" has been awful and I believe that poor leadership in the past has left mid Wales in a very precarious position. We cannot undo that which has been done but we must learn from that and in any future organisational change there must be some fixed points that new structures must observe to prevent the erosion of smaller units.

The alternative however unpleasant is to consider whether Wales has too many hospitals and needs a radical rethink of organisation of services to meet current and future healthcare needs.

I haven't touched on primary care – I don't feel qualified to do so but I do believe that that is on the brink of a collapse that will cause enormous upset to the safe, effective delivery of healthcare in Wales.

I hope my comments are useful.

Phil Jones

MR 02
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Dr Adam Dallmann
Response from: Dr Adam Dallmann

Dear Sir/Madam,

I am writing in response to the "Inquiry into medical recruitment" consultation, wishing to highlight a significant issue affecting Histopathology trainees in Wales following the introduction of the new junior doctor contract in England.

Histopathology is the only specialty training programme which is unbanded (salary is solely made up of basic pay, with no banding supplement due to no out-of-hours work) during its entire length (5.5 years). With the introduction of the new contract in England, Histopathology trainees there will see a significant rise in their salary owing to the increased basic pay. Below is the gross annual income of unbanded trainees in Wales and England following the introduction of the contract:

	Wales	**England**
ST1	30,302	36100
ST2	32,156	36100
ST3	34,746	45750
ST4	36,312	45750
ST5	38,200	45750
ST6	40,090	45750
Total	**211806**	**255200**

It is clearly visible that an ST4 in Wales (with greater responsibilities and having already passed two exams out of the three required by the College) would be earning the same as a fresh-starting ST1 in England, and those in

England at ST3 level or higher would earn significantly more than any Welsh trainee could ever do. During the entire duration of the training (5.5 years), trainees in England will earn a full year`s worth of salary more than their counterparts in Wales, for working the same hours and having the same level of responsibility.

I cannot stress enough the devastating effect such a significant level of cross-country pay gap will have on the morale of the current workforce, the potential retention problems that would go with it and on the recruitment of new trainees, as seeing these figures it is not difficult to deduce that no trainee would want to come and train in Wales. This in turn would inevitably manifest as low consultant recruitment figures in the specialty, directly influencing patient care and waiting times for diagnoses.

I urge the Committee to address this inequality affecting one of the smallest medical specialties before it manifests as a recruitment and retention crisis, to maintain the status of Wales as an attractive Deanery to train in Histopathology.

Yours sincerely,

Dr Adam Dallmann

ST2 in Histopathology

MR 03
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Dr Geraint Morris
Response from: Dr Geraint Morris

Dear Senedd Committee

Please may I draw your attention to a situation that is not helping the current recruitment of doctors into Wales and for which there is a simple solution?

I am a Consultant and Clinical Lead in the Neonatal Unit at Singleton hospital in Swansea and have been involved in both undergraduate and postgraduate teaching since my medical career began 27 years ago.

For many of those years I have been offering potential medical student (current 6th form/college/university students) workplace experience. In each case the students have shown interest and ability to be doctors in the future. As I work in Swansea, all of the work experience students will have come from around the vicinity of Swansea, and most of these have applied for Medical School places in Cardiff.

Unfortunately, all too often, students are unsuccessful in applying to Cardiff Medical School but are then successful in getting places in London/Birmingham/Bristol Medical Schools – even Edinburgh. It then strikes me that not only is a complete waste of resources sending these Welsh students to England to train, but also *as they will become doctors anyway*, why not train them in Cardiff? Many students who train in London stay in London, but likewise many students who train in Wales stay in Wales. There is no better way of retaining doctors in Wales, and of ensuring that places like Pembrokeshire, Ceredigion and Gwynedd are adequately able to recruit doctors than by recruiting medical students from Wales in the first place.

Our Medical Schools in Swansea and Cardiff really need to start encouraging students who are from Wales to apply for medicine, and ensure that those who are successfully recruited reflect the proportion who have applied.

I came to know yesterday (informally) that a huge proportion of current medical students in Swansea Medical School are from England. Many of them, in fact perhaps most of them, will apply outside Wales for Foundation training after qualifying and will never come back. What a shame, as it takes a huge amount of investment and effort to train them.

The medical profession has seen a huge amount of feminisation over recent years – Over 70% of paediatric trainees are female. I suspect that there is also a much higher proportion of female medical students than male. Whilst I welcome this to a certain extent, it does provide added challenges in regard to staffing, and should cause us to ask why are boys not applying or being successful at interviews?

Solutions:

1. Advertise the medical schools in Wales, targeting potential Welsh medical students
2. Target young men in Wales in particular who might choose medicine as a career
3. Ensure the school curriculum does not favour girls – this is a serious point as we know that there have been swings toward better grades among girls than boys
4. Ensure that medical schools in Wales are not favouring students from outside Wales by checking that the proportion of successful applicants from Wales matches the overall proportion of applicants from Wales, with a similar comparison for English students
5. Why not have a system that allows students who are unsuccessful in getting into medical school in Wales but who are successful in getting into a non-Welsh medical school to have a place in Wales – a number of Welsh medical school places can be reserved for such students.

Thanks for your consideration

Dr Geraint Morris

Clinical Lead
Neonatal Unit, Singleton Hospital
Swansea SA2 8QA

MR 04
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Andrew Davies
Response from: Andrew Davies

Medical recruitment is the biggest problem I face in my capacity as Orthopaedic consultant in Morriston. More than anything else it is limiting our ability to improve services. There simply aren't enough staff to provide any more than a basic safe level of cover and sometimes we struggle to provide even that.
The greatest problems are at consultant and core training level
We have failed to appoint to consultant posts in Orthopaedics in Morriston this year and last. We have adverts live continuously for junior doctors but we find it extremely hard to get appointable applicants.

Core trainees (SHOs) continue to have an important role in service provision in Orthopaedics. Deanery training numbers have been reduced however and it is extremely hard to recruit and retain non-training grade juniors to work in the department. Of four such posts we have three unfilled and are forced to run the department on agency locums for extended periods which is hugely expensive and does not provide and continuity of patient care. Doctors who do come are usually first job in the UK and use the post to get a reference and move on.
Nationally Orthopaedics is over-subscribed but in Wales we have unfilled posts.

The controls on recruiting overseas doctors also severely affected recruitment
Wales has a particular problem recruiting doctors at all levels. Trainees do not want rotations which mean they may have to rotate between distant hospitals. Rotations between North and South Wales are particularly unpopular.
Having a Welsh connection is the factor most likely to encourage doctors to work in Wales. Thus doctors who have lived or trained in Wales at any stage are much more likely to want to work here.

Graduates of the Welsh medical schools are much more likely to stay in Wales for their training if they were previously domiciled in Wales.
Doing core training in Wales greatly increases the likelihood of applying for specialist training in Wales
Doing specialist training in Wales greatly increases the likelihood of applying for consultant posts in Wales
Any initiative in England to increase training grade posts adversely affects recruitment in Wales.
We need to increase the numbers of medical school places in Wales and increase the percentage of Welsh-domiciled students.
We need to examine to structure of the hospital service in Wales. It is more difficult to recruit trainees to smaller rural hospitals. Training needs to concentrated in larger hospitals.
We need to introduce innovative training posts to attract trainees. eg academic-linked posts, rural medicine posts etc
The Welsh-language names of our Health Boards do not encourage applicants. They are seen as opaque 'foreign' and offer no clue as to geographical location or workload.

Andrew Davies
Consultant Orthopaedic Surgeon. Morriston Hospital

MR 05
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Coleg Nyrsio Brenhinol Cymru
Response from: Royal College of Nursing Wales

Dai Lloyd AM
Chair of Health, Social Care & Sport Committee
National Assembly for Wales
Tŷ Hywel
Cardiff Bay
CF99 1NA

Dear Dr Dai Lloyd,

We are very grateful for the opportunity to contribute to the Health, Social Care & Sport Committee's current inquiry into medical recruitment.

As outlined in previous evidence submitted to the Committee, the Royal College of Nursing Wales believes that it is important to consider wider workforce issues, and not to focus solely on medical recruitment. Nevertheless, we fully recognise that medical recruitment is a key vulnerability in the healthcare system and one that needs addressing urgently in order to improve patient care. We are therefore very supportive of any measures being taken to find solutions for the benefit of patients.

The Committee has asked for comment on a variety of specific issues, not all of which we have chosen to address directly. We do however have some general comments, and these are outlined in our response attached.

Please do not hesitate to get in touch if you would like any further information.

Yours sincerely,

TINA DONNELLY
DIRECTOR, RCN WALES 1

Response from the Royal College of Nursing Wales to the Health, Social Care & Sport Committee's Inquiry into Medical Recruitment

I. As outlined in previous evidence submitted to the Committee, the Royal College of Nursing Wales believes that it is important to consider wider workforce issues, and not to focus solely on medical recruitment. Nevertheless, we fully recognise that medical recruitment is a key vulnerability in the healthcare system and one that needs addressing urgently in order to improve patient care. We are therefore very supportive of any measures being taken to find solutions for the benefit of patients.

II. The medical workforce in Wales operates as part of a multidisciplinary team which includes a full range of healthcare professionals. In this way, the medical workforce and medical recruitment cannot and should not be considered in isolation from the rest of the workforce. It is increasingly important to fully understand the way in which development within one healthcare profession impacts on others and the system overall. This will require a different approach regarding workforce planning and a shift towards a more holistic, multi-professional workforce planning system. It could be argued for instance that the Physician Associate role was introduced in Wales before an all Wales perspective from the wider workforce had been established, even though these roles will have an impact not only on physicians themselves but their colleagues and patients across the healthcare system.

III. The interdependence of the different healthcare professionals and sectors within the healthcare system means that any shortages or issues in recruitment have implications not only on the directly affected workforce, but on the workload of other professionals and across the whole healthcare system.

IV. The Royal College of Nursing Wales has expressed our concerns previously around workforce planning for nursing in Wales, with particular concerns regarding the number of district nurses, children's nurses and the recruitment crisis in nursing in the care home sector. This is of relevance to medical recruitment because, inevitably, a shortage of nurses within the community and independent sectors will cause hospital admission to rise, and increase the work demand on medical practitioners.

V. RCN members are reporting that nursing shortages within the care home sector are beginning to negatively affect patient care. Patient outcomes and safety will be adversely affected without adequate nursing care provided by registered nurses, and this will inevitably result in more patients being admitted into hospital, additional demand for GP visits to care homes, and additional pressure being put on the medical workforce and the system as a whole.

VI. Also of relevance to this inquiry is the issue of access to primary care and the primary care skill set. We know that it is important that people are able to be seen, treated and advised on minor illnesses within their own communities. Not only does this mean people being treated more quickly and efficiently, it also avoids unnecessarily impacting on the acute sector.

VII. The RCN in Wales has long been calling for more innovative ways of supplementing the system of primary care, using advanced nursing skills and extended nursing skills (for example prescribing) and using salaried medical practitioners. It is vital that healthcare professionals working within the primary care and community sectors are being adequately skilled up and are employed in sufficient numbers in order to prevent pressure on the A&E admission route and the wider healthcare system.

VIII. In relation to Brexit, depending on the settlement that the UK negotiates with the EU post-Brexit, it is likely to have an impact on international recruitment, both in the NHS and the independent sector. Brexit is also likely to have an impact on access to research funding. Pan European collaboration has contributed significantly to the success of UK science and research, and continued access to sustainable financial support for world-class infrastructure and facilities are essential for UK medical and health research.

About the Royal College of Nursing
The RCN is the world's largest professional union of nurses, representing over 430,000 nurses, midwives, health visitors and nursing students, including over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards

of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

MR 06
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Deoniaeth Cymru
Response from: Wales Deanery

Ymateb Deoniaeth Cymru i Ymchwiliad Recriwtio Meddygol Iechyd a Gofal Cymdeithasol

Y Cefndir

Mae Deoniaeth Cymru yn darparu hyfforddiant o'r ansawdd gorau ac addysg feddygol a deintyddol ôl-raddedig arloesol yng Nghymru. Mae'n darparu cyfleusterau ôl-raddedig a chymorth addysgol o ansawdd da i bron 3,000 o feddygon a deintyddion ar raddfa hyfforddi drwy Gymru er mwyn iddynt wireddu eu dyheadau o ran gyrfa, gan sicrhau ar yr un pryd bod cleifion yng Nghymru'n ddiogel ac yn cael gofal o ansawdd da. Mae Deoniaeth Cymru yn cynnig ystod eang o weithgareddau sy'n seiliedig ar fframwaith rheoli ansawdd cymeradwy'r Cyngor Meddygol Cyffredinol.

1. Capasiti'r gweithlu meddygol i ddiwallu anghenion y boblogaeth yn y dyfodol yng nghyd-destun y newidiadau ym maes darparu gwasanaethau a datblygu modelau gofal newydd

1.1 Cydnabyddir bod y GIG yn wynebu heriau o ran recriwtio a chadw meddygon dan hyfforddiant mewn rhai meysydd arbenigol penodol. Nid yw'r prinder hwn yn unigryw i Gymru ac mae'n adlewyrchu system gymhleth sy'n newid o hyd. Mae nifer sylweddol o swyddi gweigion mewn amrywiaeth o feysydd arbenigol drwy GIG Cymru, gan gynnwys Hyfforddiant Meddygol Craidd, Ymarfer Cyffredinol, Seiciatreg, Meddygaeth Aciwt, Meddygaeth Frys Uwch a Phaediatreg Uwch. Mae'r prinder yn y meysydd hyn yn arwain at fylchau yn y rotas sy'n gallu ac sydd yn amharu ar hyfforddeion ac yn peryglu ansawdd a chynaliadwyedd eu profiad a'u hyfforddiant. Yn sgil hyn, gwelwyd ysbryd y grŵp hwn yn cael ei lethu. Yn ogystal â hyn, mae'r pwysau i recriwtio i swyddi hyfforddi wedi arwain yn aml at ostwng y trothwyon penodi. Mae hyn yn golygu bod angen rhagor o amser hyfforddi ar hyfforddeion a benodir a rhagor o gyfraniad gan yr hyfforddwyr oherwydd nad yw pobl yn gallu camu ymlaen drwy'r rhaglenni mor gyflym ag y byddai rhywun yn ei ddisgwyl.

1.2 Ym maes Ymarfer Cyffredinol, mae'r galw am wasanaethau wedi cynyddu'n sylweddol yn y degawd diwethaf ond mae'r targed ar gyfer y nifer i'w derbyn i raglen hyfforddi ymarferwyr cyffredinol Cymru wedi aros yn 136 ers degawd. Mae'r nifer targed yn Lloegr ar y llaw arall wedi codi o 2,400 i 3,250. Mae cynnydd mawr yng nghanran y targedau recriwtio wedi bod yn yr Alban hefyd (cynyddu'r targed i 400 y flwyddyn) ac yng Ngogledd Iwerddon. Serch hynny, mae'n wir nad yw'r un o'r gwledydd yn llwyddo i benodi i'w capasiti llawn. Hefyd, er bod y targed yng Nghymru ar gyfer y nifer i'w derbyn yn gyfrannol is ac yn statig, ni lwyddwyd i lenwi'r swyddi hyn yma ychwaith yn y blynyddoedd diwethaf. Ond, er mwyn dangos bod gennym uchelgais cadarnhaol o ran recriwtio pobl i'w hyfforddi'n ymarferwyr cyffredinol yng Nghymru, credwn y dylai'r Ymchwiliad ystyried o ddifri'r ddadl o blaid gosod targedau (yn seiliedig ar y boblogaeth) sy'n dechrau edrych o leiaf yn debyg i'r rheini a bennwyd eisoes yn y tair cenedl ddatganoledig arall.

1.3 Mae angen modelau gofal arloesol eraill i sicrhau bod y gwasanaeth i gleifion yn ddiogel, yn gynaliadwy ac yn briodol. Dylid datblygu modelau gwasanaeth a'u profi'n drwyadl heb ddibynnu'n unig ar feddygon dan hyfforddiant i ddarparu'r gwasanaeth. Mae pob hyfforddai'n gweithio ar sail cwricwlwm sydd wedi'i ddiffinio gan y Coleg Brenhinol ac wedi'i gymeradwyo gan y Cyngor Meddygol Cyffredinol ac fe bennir amcanion dysgu penodol ar gyfer pob blwyddyn o'r hyfforddiant. Pan fydd y gwasanaeth o dan bwysau, bydd hyfforddeion yn rhoi'r flaenoriaeth i anghenion clinigol a hynny'n aml ar draul eu gofynion hyfforddi. Yn ei dro, bydd ansawdd metrics hyfforddi, megis cyfraddau pasio arholiadau'r Coleg Brenhinol ar gyfer arbenigeddau penodol mewn ysbytai penodol felly'n wael ac mae'r rhain i'w gweld ar wefannau pob Deoniaeth. Mae hyn wedyn yn arwain at sefyllfa lle bydd hyfforddeion yn gweld ysbytai/unedau penodol yn anneniadol.

1.4 Lle bynnag y bo modd, rhaid symud at fodelau nad ydynt yn canolbwyntio ar feddygon nac ar fodelau gwasanaethau dibynnol. Mae angen cyfleu hyn yn y cynllun strategol 10 mlynedd newydd ar gyfer y gweithlu. Ym maes Ymarfer Cyffredinol, bydd cyfleoedd i newid y gymysgedd sgiliau a modelau gofal newydd deniadol lle bydd gweithwyr medrus y GIG (h.y. nyrsys

arbenigol, fferyllwyr, cynorthwywyr meddygon) yn ymgymryd ag o leiaf rai o rolau traddodiadol yr ymarferydd cyffredinol.

1.5 Mae dwy ysgol feddygol yng Nghymru; Rhaglen Derbyn Graddedigion Prifysgol Abertawe a rhaglen Prifysgol Caerdydd sydd i'r rhai sy'n ymadael â'r ysgol yn bennaf. Cyfanswm nifer y graddedigion meddygol o'r rhaglenni hyn bob blwyddyn yw 376. Yng Nghymru, nid yw'r rhai a dderbynnir i ddilyn hyfforddiant Sylfaen yn cyfateb â'r nifer sy'n graddio o'r ysgolion meddygol. Ar hyn o bryd ariennir 339 o swyddi blwyddyn Sylfaen 1 (S1) sy'n cael eu cyfateb â 339 o swyddi S2. Mae Cymru yn gyffredinol wedi cadw dwy ran o dair o raddedigion ei hysgolion meddygol (sy'n uwch na chyfartaledd y Deyrnas Unedig). Opsiwn i'w ystyried, fel y cyhoeddwyd yn Lloegr yn ddiweddar, yw cynyddu'r nifer a dderbynnir i'r ysgolion meddygol, ac felly, petai'r gyfradd gadw'n aros yn ddwy ran o dair, byddai nifer y graddedigion sy'n aros yng Nghymru'n cynyddu. Serch hynny, oherwydd bod angen pum mlynedd o leiaf i gwblhau gradd feddygol, bydd yn bum mlynedd o leiaf cyn y gwelir effaith y lleoedd ychwanegol hyn ac wrth gwrs, nid oes dim i warantu y bydd rhywun sy'n graddio yng Nghymru'n parhau i hyfforddi yng Nghymru. Mae'n ymddangos y byddai hyn yn strategaeth ddrud o'i ystyried ar y pwynt buddsoddi, ond byddai'n medi ar ei ganfed yn y tymor hwy oherwydd mae'n bwysig sylweddol bod y bylchau yn y rota yn sgil recriwtio a chadw gwael yn cael eu llenwi gan feddygon locwm. Mae hyn yn ddrud, ac, ar brydiau, mae ansawdd y ddarpariaeth yn amheus. Mae angen cynnal dadansoddiad cost/budd er mwyn ystyried y newidiadau sydd eu hangen a chynyddu nifer y myfyrwyr o Gymru sy'n mynd i ysgolion meddygol yng Nghymru. Mae gwir gost uniongyrchol bylchau yn y rotas hefyd yn rhywbeth y bydd angen edrych arni.

1.6 Mae Deoniaeth Cymru yn dal i geisio datblygu atebion arloesol i'r heriau recriwtio. Rydym wrthi'n gobeithio datblygu rhaglen gymrodoriaeth Cwblhau Hyfforddiant Ôl-Dystysgrif i ymarferwyr cyffredinol sydd newydd gymhwyso weithio mewn rhai ardaloedd lle mae recriwtio'n broblem. Er mwyn cefnogi'r agenda wledig, rydym hefyd wedi hysbysebu rhaglen Hyfforddiant Eang ei Sylfaen ddwy flynedd (sy'n cynnwys meddygaeth graidd ac ymarfer cyffredinol) gyda lleoliadau ym Myrddau Iechyd Prifysgol Hywel Dda a Betsi Cadwaladr.

2. Goblygiadau Brexit ar gyfer y gweithlu meddygol

2.1 Nid yw'n sicr eto beth fydd goblygiadau Brexit ar gyfer meddygon yr Undeb Ewropeaidd ond mae'n anochel y bydd yn golygu nifer o heriau sylweddol i Gymru.

2.2 Mae'n destun pryder cyffredinol y bydd yn fwy anodd recriwtio meddygon sydd wedi'u hyfforddi dramor yn y dyfodol. Rydym yn sylweddoli bod llawer o feddygon yr Undeb Ewropeaidd eisoes yn gweithio yn y GIG yng Nghymru ar raddfeydd meddygon ymgynghorol, ymarferwyr cyffredinol a Staff ac ar raddfeydd Arbenigwyr Cysylltiol sydd ar fin ymddeol a bod nifer yn ymadael â'r GIG i weithio dramor.

2.3 Mae Llywodraeth y Deyrnas Unedig wedi addo y bydd y GIG yn Lloegr yn hunangynhaliol o ran meddygon ar ôl i Brydain ymadael â'r Undeb Ewropeaidd drwy gymryd cyfres o gamau i leihau ei dibyniaeth ar feddygon sydd wedi'u hyfforddi dramor. Serch hynny, ni fydd y cynllun hwn yn golygu na fydd angen i'r GIG recriwtio staff o dramor. Bydd cynyddu nifer y lleoedd hyfforddi fel hyn yn costio £100m rhwng 2018 a 2020, ond yn y tymor hir, mae'r Llywodraeth yn gobeithio adennill arian drwy godi mwy ar fyfyrwyr tramor nag y mae'n ei godi ar hyn o bryd. Disgwylir hefyd i fyfyrwyr meddygol weithio i'r GIG am bedair blynedd o leiaf neu wynebu cosbau. Nid yw Deoniaeth Cymru fodd bynnag yn credu bod hwn yn nod y gellir ei gyrraedd. Bydd hyn yn cyfateb i 1,500 o fyfyrwyr meddygol newydd bob blwyddyn yn Lloegr ac mae'n debygol o gael effaith niweidiol ar Gymru o ran lefel yr ariannu ar gyfer hyfforddiant sylfaen yma. Mae'r Adran Iechyd hefyd yn bwriadu gwneud iawn am ran o'r gost, rhyw £100m ohoni, drwy ei gwneud yn ofynnol i fyfyrwyr meddygol tramor dalu am eu lleoliadau clinigol eu hunain. Bydd hynny'n sicr o gynyddu'r ffioedd y bydd yn rhaid i fyfyrwyr tramor eu talu i fynd i ysgolion meddygol.

2.4 Gobeithir y bydd y Swyddfa Gartref yn llacio'r rheolau mewnfudo i feddygon er mwyn i frodorion yr Undeb Ewropeaidd allu gweithio yn y Deyrnas Unedig neu y bydd o leiaf yn caniatáu i frodorion yr Undeb Ewropeaidd sydd yma eisoes aros yma ar ôl Brexit.

2.5 Oni allwn recriwtio a chadw meddygon yr Undeb Ewropeaidd yng Nghymru, bydd angen inni edrych ar rannau eraill o'r byd neu hyfforddi rhagor o fyfyrwyr sy'n hanu o Gymru a'u hannog i wneud eu hyfforddiant ôl-raddedig

yma drwy gynnig pecynnau cymell cynhwysfawr (ariannol ac anariannol) iddynt barhau i weithio yng Nghymru am gyfnod penodol.

2.6 O ran demograffeg y gweithlu meddygol ehangach, prin yw'r wybodaeth sydd gan Ddeoniaeth Cymru am gyfran y meddygon o'r Undeb Ewropeaidd sy'n gweithio yng Nghymru ond gwyddom fod 3% o'r meddygon ar y raddfa hyfforddi yng Nghymru ar hyn o bryd wedi cymhwyso'n wreiddiol mewn Ysgolion Meddygol yn yr Undeb Ewropeaidd ac felly rydym yn ffyddiog mai effaith fach y mae Brexit yn debygol o'i chael ar y grŵp hwn yng Nghymru.

3. Y ffactorau sy'n dylanwadu ar recriwtio a chadw meddygon, gan gynnwys problemau penodol mewn arbenigeddau ac ardaloedd penodol.

3.1 Mae nifer o ffactorau'n dylanwadu ar recriwtio a chadw meddygon yn GIG Cymru. Mae'r cyfraddau llenwi swyddi mewn meysydd arbenigol yn amrywio drwy'r wlad a'r rhesymau dros hynny'n amrywio hefyd. Rhai o'r ffactorau hyn yw'r cynnydd mewn hyfforddiant sy'n llai nag amser llawn, mwy o gyfran o fyfyrwyr meddygol yn fenywod, pwysau cynyddol ar y rotas a'r baich gwaith, newidiadau i'r rheoliadau mewnfudo a mwy o hyfforddeion Sylfaen sy'n dewis peidio â gwneud cais am hyfforddiant arbenigol. Mae'n bwysig nodi nad dim ond yng Nghymru y mae'r heriau hyn i'w gweld.

3.2 Mae'r profiad addysgol a gaiff meddygon dan hyfforddiant a sut maent yn cael eu trin a'r gwerth a roddir arnynt yn cael dylanwad mawr ar eu penderfyniadau ynglŷn â'u gyrfa. Mae'r dystiolaeth yn dangos inni, os bydd meddygon wedi cael profiad hyfforddi ôl-raddedig cadarnhaol, y bydd hynny gan amlaf yn gwella'r cyfraddau cadw dros gyfnod hir. Serch hynny, os byddant wedi cael profiad negyddol oherwydd hyfforddiant gwael neu oherwydd problemau, bydd hyfforddeion yn defnyddio'r cyfryngau cymdeithasol i gyfathrebu â'u cymheiriaid gan greu darlun negyddol o Gymru.

3.3 Mae darparu'r amgylchedd hyfforddi gorau posibl wrth galon strategaeth recriwtio a chadw Deoniaeth Cymru ac mae tystiolaeth Arolwg Hyfforddiant Cenedlaethol y Cyngor Meddygol Cyffredinol eleni'n dangos mai yng Nghymru yr oedd y boddhad cyffredinol ar ei uchaf o blith pob un o bedair Gwlad y Deyrnas Unedig, er bod nifer llai o hyfforddeion yma o safbwynt cymharol. Mae'r sgôr boddhad cyffredinol hefyd yn adlewyrchu tuedd

barhaus yn lefel boddhad hyfforddeion yng Nghymru a dyma'r bumed flwyddyn yn olynol inni weld cynnydd (atodiad 1).

3.4 Er bod y gyfradd foddhad gyffredinol yn uchel, mae Uned Ansawdd Deoniaeth Cymru yn dal i weithio gyda'r Byrddau a'r Ymddiriedolaethau Iechyd i fynd i'r afael â heriau a gofnodwyd mewn meysydd penodol. Mae canlyniadau 2016 yn dangos gwelliannau amlwg mewn llawer o'r meysydd hyn. Un peth i'w nodi'n benodol yw'r cynnydd ym maes hyfforddiant Meddygaeth Achosion Brys drwy Gymru. Mae Cymru yn unigryw yn y Deyrnas unedig yn yr ystyr nad yw'r maes hwn yn destun pryder mawr ond yn hytrach fe welwyd tair enghraifft o ragoriaeth sef addysgu lleol, addysgu rhanbarthol a mynediad at adnoddau addysgol. Mae Deoniaeth Cymru wedi gweithio'n galed iawn er gwaethaf heriau recriwtio difrifol, i sicrhau bod y canlyniadau ar gyfer rhaglenni Hyfforddiant Meddygol Craidd yn dangos gwelliant amlwg o ran boddhad ar yr hyfforddiant mewn llawer ardal yng Nghymru. Mae'r llwyddiant hwn yn rhannol i'w briodoli i'r Fframwaith Rheoli Ansawdd cynhwysfawr y byddwn yn ei ddefnyddio i nodi pryderon ac i ddechrau cynllunio'n fuan ac yn rhagweithiol drwy gydweithio â darparwyr addysg lleol.

3.5 At hynny, cyflwynwyd nifer o gynlluniau addysg wedi'u cyflwyno i helpu hyfforddeion a gwella'u profiad hyfforddi. Un enghraifft yw'r Hyfforddiant Dwys ar gyfer hyfforddeion llawfeddygol sy'n rhoi sgiliau cynhwysfawr, clinigol ac anghlinigol i hyfforddeion yng Nghymru er mwyn sicrhau gwasanaethau diogel i gleifion.

3.6 Mae daearyddiaeth yn ffactor pwysig i hyfforddeion. Ar y cyfan, mae'n well ganddynt fyw a gweithio yng nghyffiniau dinasoedd yn hytrach nag mewn ardaloedd gwledig. Ffactor arall yw bod cyfran helaeth o boblogaeth Cymru yn byw mewn ardaloedd diarffordd a bod cenhedlaeth o feddygon yn awyddus i ganolbwyntio ar ffordd o fyw drefol. Un ateb posibl fyddai cynyddu nifer yr hyfforddeion sy'n gweithio o fewn cylch 60 milltir i'r ardaloedd trefol hynny yng Nghymru e.e. Wrecsam gyda golwg arnynt yn llifo'n raddol wedyn i ardaloedd mwy gwledig.

3.7 Mae lefelau isel o gystadleuaeth ynghyd â'r ffaith ei bod yn well gan fwy a mwy o bobl y ffordd o fyw a gynigir yn y ddinas neu mewn tref fawr, yn golygu bod swyddi mewn ardaloedd diarffordd yn llai poblogaidd ac yn

anos eu llenwi. Mae'r sefyllfa'n arbennig o anodd yn ardaloedd gwledig Cymru. Ym maes Ymarfer Cyffredinol, o ran y deuddeg cynllun sydd ar waith yng Nghymru, pellaf y bydd y cynllun oddi wrth ganolfan drefol fawr, lleiaf poblogaidd fydd y cynllun hwnnw. Marchnad prynwyr yw hi bellach, ac oherwydd bod llai o ymgeiswyr nag sydd o swyddi, mae hyfforddeion yn gallu dewis a blaenoriaethu'r mannau lle yr hoffent weithio a byw. Rydym hefyd yn gweld cohort o hyfforddeion sy'n barod i roi'r gorau i'w rhaglenni hyfforddi yn hytrach na chael eu rhoi mewn lleoliad nad ydynt yn ei ffafrio.

3.8 Er mwyn cyflawni'r gofynion hyfforddi fel y'u nodir yn y cwricwla hyfforddi mewn meysydd arbenigol sydd wedi'u cymeradwyo gan y Cyngor Meddygol Cyffredinol, bydd gofyn yn aml i hyfforddeion, yn enwedig ar y lefel uwch, dreulio cyfnod ar rota mewn canolfannau trydyddol neu arbenigol er mwyn cael profiad ac ennill cymwyseddau mewn maes neu is-faes arbenigol. Mae profiad ar lefel Drydyddol fel hyn yn aml yn brofiad nad yw ond ar gael mewn canolfannau arbenigol neu ysbytai addysgu. Drwy Gymru, mae hyn yn her oherwydd bod gofyn i hyfforddeion dreulio cyfnod ar rota yn y de ac wedyn yn y gogledd a'r gwrthwyneb er mwyn ennill profiad o'r fath. Mae hyn wedi effeithio ar recriwtio a chadw mewn rhai meysydd arbenigol ac mae Deoniaeth Cymru wedi mynd ati'n rhagweithiol gyda chydweithwyr mewn Deoniaethau eraill yn y Deyrnas Unedig i fynd i'r afael â rhai o'r problemau hyn. Er enghraifft, bydd Deoniaeth Cymru bellach yn lleoli hyfforddeion yn Ysbyty Arrowe Park er mwyn i bobl gael profiad ym maes babanod newydd-anedig Lefel 3 ac i Alderhey i gael hyfforddiant paediatreg mewn is-faes arbenigol.

3.9 Mae peryglon ynghlwm wrth unrhyw raglenni hyfforddi o'r fath sy'n dibynnu ar drefniant cylchdro / consortiwm gyda Lloegr oherwydd mai strategaeth Health Education England (HEE) yw dod yn hunangynhaliol ac yn sgil datganoli mae'r bwlch rhwng y ddwy wlad o ran parodrwydd i gydweithio yn lledu.

3.10 Mae angen cynyddu nifer yr israddedigion meddygol sy'n hanu o Gymru a byddai modd gwneud hyn pe bai Llywodraeth Cymru yn rhoi'r gorau i dalu i fyfyrwyr meddygol o Gymru am astudio yn Lloegr drwy gyfrwng ffioedd hyfforddi rhaglenni a addysgir. Gwyddom hefyd fod nifer y myfyrwyr o Gymru sy'n gwneud cais am astudio meddygaeth wedi gostwng 15% yn y pum mlynedd diwethaf oherwydd y gofynion mynediad, ansawdd yr addysg

mewn ysgolion a'r cyfyngu ar ddyheadau mewn rhai cymunedau. Mae'n amlwg, mewn rhai ysgolion, nad yw mynd i ysgol feddygol yn cael ei weld yn uchelgais y mae modd ei gyflawni. Mae angen troi'r duedd hon ar ei phen. Mae rhywfaint o waith ar y gweill gydag ysgolion meddygol a chymunedau lleol ond byddai'r gwaith hwn ar ei ennill petai gan Lywodraeth Cymru safbwynt polisi a phetai rhagor o adnoddau ar gael i sicrhau bod ysgolion meddygol yn agored i bawb sydd â'r gallu i fynd iddynt, ni waeth am eu cefndir.

3.11 Ystyriwyd cyflwyno cymhellion ariannol ac anariannol a'r rheini ynghlwm wrth gytundeb ffurfiol y byddai'r hyfforddai'n aros mewn ardal benodol am gyfnod penodol. Byddai angen ymdrin yn sensitif ag unrhyw gwlwm o'r fath ac nid yw ond yn debygol o lwyddo petai'r un dull yn cael ei ddilyn ym mhob rhan o'r Deyrnas Unedig, ac y byddai hawl i hyfforddeion lifo o Gymru i rannau eraill o'r Deyrnas Unedig a'r gwrthwyneb.

3.12 Mae Deoniaeth Cymru o blaid cynllunio'r gweithlu meddygol ar lefel Cymru gyfan, gan ystyried a chynllunio ar gyfer risgiau i'r gweithlu meddygol a chwilio am gyfleoedd a allai liniaru'r risg honno. Rydym wrthi'n ymwneud â'r broses interim i ystyried niferoedd ar gyfer hyfforddiant meddygol nes y sefydlir un sefydliad unigol fel y'i disgrifiwyd yn Adolygiad yr HPEl ac rydym yn cyfrannu at gynllun GIG Cymru i ystyried nifer y staff meddygol y bydd eu hangen ar gyfer gweithlu meddygol cynaliadwy yn y dyfodol.

4. Datblygu a chynnal ymgyrchoedd recriwtio meddygol, gan gynnwys i ba raddau y mae rhanddeiliaid perthnasol yn ymwneud â hwy ac yn dysgu yn sgil ymgyrchoedd blaenorol ac arferion da mewn mannau eraill.

4.1 Mae Deoniaeth Cymru wedi bod yn ymwneud llawer â'r ymgyrch farchnata fawr i recriwtio meddygon yn ddiweddar dan arweiniad Llywodraeth Cymru gyda chyfraniad a chymorth gan y Byrddau Iechyd a Chydwasanaethau'r GIG. Mae'r cydweithio hwn wedi golygu bod pob rhanddeiliaid yn gallu rhannu yn y lefel uchel o arbenigedd, adnoddau a gwybodaeth sy'n ategu'r ymgyrch gan sicrhau bod y wybodaeth yn gywir a bod yr iaith a'r derminoleg briodol yn cael eu defnyddio. Bydd Deoniaeth Cymru yn croesawu'r cyfle i adeiladu ar hyn yn y dyfodol.

4.2 Mae'r ymgyrch "Hyfforddi, Gweithio, Byw" bresennol yn canolbwyntio ar ansawdd yr hyfforddiant (i feddygon dan hyfforddiant - cyfrifoldeb

Deoniaeth Cymru); sut beth yw gweithio yng Nghymru (i hyfforddeion a meddygon profiadol – cyfrifoldeb y GIG); a sut beth yw byw yng Nghymru (i bawb – cyfrifoldeb Llywodraeth Cymru). Ni ddylid ystyried yr ymgyrch hon yn ymgyrch unwaith ac am byth na dim ond er mwyn ymateb i bwysau gwleidyddol. Mae angen cynllun marchnata strategol barhaus am rhwng pump a thair blynedd gyda'r nod o gynyddu proffil cadarnhaol Cymru fel cyrchfan o ddewis i fyfyrwyr, hyfforddeion, meddygon cymwysedig a gweithwyr proffesiynol eraill ym maes gofal iechyd. Dylai unrhyw raglen farchnata barhaus ddefnyddio nifer o linynnau ac amrywiaeth o ddulliau marchnata sy'n apelio at y farchnad darged.

4.3 Proses Cymru gyfan yw recriwtio, ond mae angen inni allu caniatáu i unigolion gael yr hyblygrwydd i ddewis eu cylchdro a'u lleoliadau o ran ardal. Dadleuon ffug yw'r rheini sy'n honni bod trefniadau'r cylchdro yn broblem o ran recriwtio a chadw. Mae yna grŵp o raglenni hyfforddi lle bydd gofyn o hyd i hyfforddeion dreulio cyfnod ar rota yn y gogledd ac yn y de. Yn y rhaglenni hyn, yn ystod y deuddeg mis diwethaf, roedd gofyn i 52 o hyfforddeion (tua 2% o hyfforddeion Cymru) symud yn eu cylchdro o'r gogledd i'r de neu o'r de i'r gogledd er mwyn cael y profiad angenrheidiol, fel y crybwyllwyd uchod yn Adran 2.9. Mae Deoniaeth Cymru wrthi'n archwilio opsiynau ar gyfer yr arbenigeddau hyn fel rhan o ail-ffurfweddu rhaglenni hyfforddi. Rhaglen o ffrydiau gwaith a gweithgareddau yw hon sy'n ceisio ail-ffurfweddu'r hyfforddiant meddygol a ddarperir ledled Cymru er mwyn sicrhau ei fod o ansawdd da, yn gynaliadwy, yn ddeniadol i ddarpar ymgeiswyr a'i bod yn briodol ar gyfer anghenion y GIG yng Nghymru yn y dyfodol. Mae nifer sylweddol o raglenni hyfforddi nad ydynt yn gofyn i hyfforddeion dreulio cyfnod yn eu cylchdro yn y gogledd neu'r de neu yn Lloegr. Y rheswm dros hyn yw oherwydd bod modd darparu'r cwricwlwm hyfforddi i gyd mewn un rhanbarth penodol, e.e. rhaglenni hyfforddi ar lefel graidd.

4.4. Mae'r problemau capasiti hyn sy'n berthnasol i'r gweithlu meddygol yn gymhleth a rhai ohonynt wedi bodoli ers tro. Bydd y cyfryngau'n sôn am lawer ohonynt yn rheolaidd, gan atgyfnerthu'r negeseuon negyddol am y proffesiwn. Mae'n debygol bod y penawdau diweddar yn y cyfryngau am recriwtio meddygon teulu, y straen ar y GIG a'r negodi ynglŷn â chontract meddygon iau yn Lloegr yn gweithio yn erbyn hyrwyddo GIG Cymru yn ddewis cadarnhaol o ran gyrfa i fyfyrwyr a meddygon sydd ar drywydd gyrfa

feddygol yn y Deyrnas Unedig. Mae gan straeon newyddion da yr un potensial a'r un grym i greu cynnig cadarnhaol a deniadol i feddygon sy'n ceisio swydd yma.

5. I ba raddau y mae prosesau/arferion recriwtio'n gydgysylltiedig, yn darparu gwerth am arian ac yn sicrhau gweithlu meddygol cynaliadwy.

5.1 Nid yw'n dilyn o reidrwydd y bydd cael prosesau/arferion recriwtio cydgysylltiedig yn sicrhau gweithlu meddygol cynaliadwy oherwydd bydd rhywfaint o staff meddygol o hyd na fydd modd eu recriwtio oherwydd na fyddant wedi cyflawni'r meini prawf neu'r safonau a bennwyd.

5.2 Mae rhai'n dadlau y dylai Cymru ymeithrio o'r broses recriwtio genedlaethol (y Deyrnas Unedig). Mae'r dystiolaeth yn dangos, er gwaethaf anecdotau, na fyddai dychwelyd at recriwtio lleol yn datrys nac yn gwella'r sefyllfa recriwtio, ac mai cryfder y prosesau cenedlaethol yw na fydd hyfforddeion yn cael eu penodi heblaw eu bod yn cyrraedd safon y cytunwyd arni. Pwrpas y safonau hyn yw sicrhau diogelwch cleifion. Mae prosesau recriwtio presennol y Deyrnas Unedig yn syml ac yn fwy cost effeithiol na'r modelau a oedd ar waith gynt lle byddai sefydliadau'n cystadlu am yr un gronfa o ymgeiswyr.

5.3 Fel rhan o strategaeth Deoniaeth Cymru i wella'r cyfraddau recriwtio a chadw ac i sicrhau rhaglenni hyfforddi o ansawdd da, rydym wedi datblygu'r Contract Addysg sy'n bwynt gwerthu unigryw i Gymru. Cytundeb rhwng yr Hyfforddai, y Darparwr Addysg Lleol (Byrddau ac Ymddiriedolaethau Iechyd yng Nghymru) a Deoniaeth Cymru yw hwn. Bydd y Contract Addysg yn cael ei fonitro drwy gyfrwng system ymgeisio ar-lein ar y we mewn amser real, sef System Bresenoli'r Contract Addysg (ECAS) y gall hyfforddeion ei defnyddio ar eu dyfeisiau symudol. Mae hyn yn golygu bod modd casglu data am brofiad yr hyfforddeion o ddydd i ddydd ac mae'n dangos a ydynt yn gweithio mewn amgylchedd sy'n caniatáu iddynt gyflawni'r cwricwlwm perthnasol. Mae system ECAS yn gweithio fel system rhybuddio cynnar sy'n golygu bod modd newid pethau'n ddi-oed a gwella profiad yr hyfforddeion. Mae'r Cyngor Meddygol Cyffredinol wedi dweud bod y Contract Addysg yn cynnig esiampl dda ac mae rhannau eraill o'r Deyrnas Unedig yn awyddus i fabwysiadu strategaethau tebyg.

5.4 Mae datganoli'n dylanwadu fwyfwy ar hyfforddiant meddygol a deintyddol. Mae'r berthynas gydweithio â Deoniaid ôl-raddedigion unigol yn Lloegr yn benodol wedi cael ei herydu i ryw raddau yn sgil penderfyniadau unochrog diweddar Health Education England. Mae risg sylweddol y bydd y bylchau'n lledu gan beryglu rhai rhaglenni hyfforddi.

5.5 Serch hynny, mae yna rai cyfleoedd a manteision posibl, er enghraifft gyda golwg ar y problemau diweddar a pharhaus gyda'r contract i feddygon iau yn Lloegr. Mae angen i Gymru fod yn ddigon hyblyg a sicrhau bod digon o arian a phrosesau addysgol ar waith er mwyn inni allu bod yn rhagweithiol ac yn arloesol gan wrthweithio a rheoli'r gystadleuaeth â Lloegr.

Atodiad 1

Tabl Un: Sgôr Boddhad Cyffredinol yn ôl Gwledydd y Deyrnas Unedig

	Boddhad Cyffredinol (Sgôr Cymedrig o uchafswm o 100)			
Blwyddyn	Cymru	Lloegr	Yr Alban	Gogledd Iwerddon
2016	83.33	81.39	82.50	83.22
2015	82.58	81.68	81.60	82.64
2014	81.9	81.1	81.50	82.5
2013	81.5	80.6	81.30	81.4
2012	81.0	80.2	81.10	81.6

Arolygon Hyfforddiant Cyffredinol y Cyngor Meddygol Cyffredinol -2016: Y Prif Negeseuon i Gymru. Deoniaeth Cymru, Uned Ansawdd (Awst 2016)

MR 07
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Coleg Brenhinol y Meddygon Caeredin
Response from: Royal College of Physicians Edinburgh

Royal College of Physicians of Edinburgh

National Assembly for Wales: Health, Social Care and Sport Committee
Inquiry into medical recruitment

The Royal College of Physicians of Edinburgh ("the College") was founded in 1681. We support and educate doctors in the hospital sector throughout the UK and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties. We welcome the opportunity to submit evidence to the Health, Social Care and Sport Committee on the *Inquiry into medical recruitment*.

1. The medical workforce faces a number of challenges and the College recognises the need for safe and sustainable staffing levels throughout the NHS. We need to ensure that we continue to recruit and retain a world class workforce to deliver the best possible patient care[i]. The College is committed to working with the Welsh Government and other allied organisations to address issues around recruitment and retention such as consultant vacancies, rota gaps and trainee attrition rates, as a matter of priority. We are also committed to working with partner organisations to promote innovative ways of working in the NHS. The roles of Physician Associates, Advanced Nurse Practitioners and other examples of physician extenders should be further examined to create a workforce fit for the future.

2. Wales, particularly in the North and the West, has significant recruitment issues in many specialties and at all levels of seniority. There are unfilled consultant and more junior posts in many hospitals, and competition for posts which do arise is often limited. General Practice is also under stress and the GP workforce is ageing. Some aspects of the problems relating to medical recruitment have themes common to other parts of the UK (e.g. shortage specialties, dependence on non-UK/EU medical graduates to fulfil rota requirements). However, there are other aspects specific to Wales that require consideration and appropriate planning.

3. In the experience of College Fellows, many posts are filled by non-UK/EU trained doctors and some by EU trained doctors. There is concern that if Brexit results in greater barriers for non-UK trained doctors moving to the UK, the NHS workforce in Wales will be at a disadvantage. The current NHS delivery of care includes provision of acute medical and surgical services by a number of smaller hospitals in Mid, West and North Wales. The training environment in some of these centres may not always be appropriate for junior recruitment and exposure to a multidisciplinary working culture may be suboptimal. This impacts on both consultant recruitment (being perceived as posts that are not properly supported or valued), as well as the support teams and trainees. This is only likely to be compounded by current rota gaps, the workforce uncertainties in relation to the EU and changes in training.

4. The attraction of living and working in major cities or teaching hospitals is strong for some potential recruits and the opportunities in Wales are limited in this regard. Given Welsh geography, most hospitals are 'genuine' DGHs, often with limited connections to larger medical institutions. There is a perception that, if a doctor does not train in Wales, it may be difficult to imagine moving to Wales to work.

5. Bearing in mind local population sensitivities in Wales with regard to access to urgent and timely healthcare, the Welsh Government is urged to consider a pro-active approach to address these issues. Some interventions that may help to partly address some of the specific problems might include:

a) A strong emphasis on regionalisation of specialised services beyond the perceived health board boundaries to help attract recruitment of high calibre staff to these services.
b) Consideration of greater flexibility in consultant job plans to incorporate rotation between sites and across health board boundaries, to help with the posts being "valued" as equivalent to those across some other parts of the UK.
c) Consideration of incentives for both consultant and junior recruitment that involve not just financial packages but also specific support towards CPD events; study leave; memberships of appropriate societies and organisations.
d) A bold and widely advertised initiative linking support for medical research, training and teaching and offering specific support for these along with HEI partners (Cardiff University, Swansea University and Bangor University), over and above general opportunities in the UK.
e) Exploring partnership opportunities with other world leading institutions and specific consultant and trainee developmental opportunities, in conjunction with the same organisations and with government support and advertising these in job descriptions for recruitment of consultant, nurse and junior staff.
f) Embedding a greater use of IT infrastructure and state of the art telemedicine and video conferencing networks for both patients and professionals, and looking at innovative methods of healthcare delivery in a local environment with access to world class expertise. Advertising this widely would also assist with recruitment and retention and have a positive impact on job satisfaction.

6. In summary, we urge the Health, Social Care and Sport Committee to consider a bold and innovative approach to ensure that Wales is perceived as an attractive place to work in the NHS. We also caution against any complacency regarding junior doctor contracts in England and its perceived impact on recruitment in Wales, as this reactive approach may not be an adequate or indeed optimal long term strategy.

Further copies of this response are available from Lesley Lockhart (tel: [redacted] ext [redacted] or email: [redacted])

15 November 2016

[i] Academy of Medical Royal Colleges and Faculties in Scotland (Scottish Academy). Learning from Serious Failings in Care. May 2015. http://www.scottishacademy.org.uk/documents/final-learning-from-serious-failings-in-care-exec-summary-290615.pdf

MR 08
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Coleg Brenhinol Pediatreg ac Iechyd Plant
Response from: Royal College of Paediatrics and Child Health

Royal College of Paediatrics and Child Health

Submission to the Health, Social Care and Sport Committee's Inquiry into Inquiry into medical recruitment, November 2016

1. Introduction

1.1 The Royal College of Paediatrics and Child Health (RCPCH) is pleased to contribute to the work of the Health, Social Care and Sport Committee and its aims to understand and explore the issues around medical recruitment in Wales.

1.2 The RCPCH works to transform child health through knowledge, innovation and expertise. We have over 550 members in Wales and over 17,000 worldwide. The RCPCH is responsible for training and examining paediatricians. We also advocate on behalf of our members, represent their views and draw upon their expertise to inform policy development and the maintenance of professional standards.

1.3 For further information please contact Gethin Jones, External Affairs Manager for Wales: [redacted] or [redacted].

2. The capacity of the medical workforce to meet future population needs, in the context of changes to the delivery of services and the development of new models of care.

2.1 While children's health has improved greatly in the UK over the last 30 years, the UK continues to lag behind much of Western Europe and performs poorly on several measures of child health and wellbeing, including mortality[1]. The RCPCH's Why Children Die[2] report highlights a need to better manage sick children and recommends that measures are taken to improve recognition and management of serious illness across the healthcare service.

2.2 Infants, children and young people (ICYP) aged 0 to 18 make up around 20% of the UK population[3] and they are high users of healthcare services; accounting for around a quarter of a typical GP's workload[4] and more than a quarter of emergency department attendances.

2.3 The vast majority of children's illnesses are minor, requiring little or no medical intervention and a significant number of these emergency attendances may be deemed unnecessary or inappropriate. Unnecessary attendances are distressing and disruptive to children and families and also a wasteful high-cost intervention in a resource-limited health service, putting additional pressure on the hospital.

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[1] Wolfe et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reform. *BMJ* 2011; 342: d1277

[2] RCPCH, National Children's Bureau and British Association for Child and Adolescent Public Health. *Why Children Die: death in infants, children and young people in the UK.* 2014 http://www.rcpch.ac.uk/sites/default/files/page/Death%20in%20infants,%20children%20and%20young%20people%20in%20the%20UK.pdf

[3] 2011 Census, Office of National Statistics

[4] Hippisley-Cox J et al. Trends in consultation rates in general practice 1995 to 2006: analysis of QRESEARCH database 2007. Cited in Wolfe et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms? *BMJ* 2011.

2.4 The RCPCH has also continued to express serious concerns about the sustainability of the paediatric workforce and services across the UK and the latest data show that gaps on paediatric rotas are increasing[5].

2.5 From the data we currently have from the RCPCH 2016 Rota Vacancies and Compliance Survey, we estimate that there is currently an 11.2% gap in the paediatric rota at tier 1, which is higher than England (10%) and Scotland (10%). There is also a 13.1% gap in tier 2 in Wales compared to 21.7% in England and 11.8% in Scotland. 42.9% of clinical directors said they were "very concerned" that the service would not be able to cope with demands placed on it during the next six months.

2.6 Responses to our most recent workforce census show that recruitment issues are the most often cited source of pressure on units. Pressures cited included difficulty in recruiting consultants, trainees, nurses and other allied health professionals.

2.7 The RCPCH's Facing the Future: Standards for Acute General Paediatric Services[6] and Facing the Future: Together for Child Health[7] make the case for whole system change in paediatrics to meet the needs of ICYP. The model recommends fewer, larger inpatient units which provide consultant delivered care and are better equipped to provide safe and sustainable care. These units need to be supported by networked services and more care delivered closer to home through community children's nursing teams and better paediatric provision in primary care.

2.8 Where children do need to be cared for in a hospital setting we need to ensure that all those delivering urgent care are following consistent guidelines and make sure that all emergency departments have the appropriate skill mix and workforce to deliver safe, effective and efficient

[5] RCPCH. *Rota Vacancies and Compliance Survey*. 2016

[6] RCPCH. *Facing the Future: Standards for Acute General Paediatric Services*. 2015 www.rcpch.ac.uk/facingthefuture

[7] RCPCH,RCN, RCGP. *Facing the Future: Together for Child Health.* 2015 www.rcpch.ac.uk/togetherforchildhealth

care. The RCPCH is currently revising the Intercollegiate Standards for Children and Young People in Emergency Care Settings[8] (last published in 2012) which provide healthcare professionals, providers and service planners with measurable and auditable standards of care applicable to all urgent and emergency care settings.

3. The implications of Brexit for the medical workforce.

3.1 5.6% of paediatric consultants in the UK in 2013 were graduates from the European Economic Area (EEA); and 5.1% of paediatric trainees are EEA graduates compared to 3.6% of trainees across all medical specialities[9]. However, 18.7% of paediatric trainees are international graduates compared to 11.7% of all trainees; hence any restrictions on immigration from outside the EU would have a larger impact on paediatrics.

3.2 The freedom of movement of people has meant that the NHS in Wales has been able to recruit healthcare professionals from across the EU without visa restrictions. On a UK level, we believe that the Westminster Government must reassure EU staff of their value and make clear that EU citizens currently employed in the NHS will have the right to remain after Brexit, to stop their significant departure and to maintain services.

3.3 Before the referendum, leading Brexit campaigners suggested that the UK could introduce an Australian style points system which would enable highly skilled professionals such as paediatricians from around the world to work in the UK. However, as the details of this potential new system are being discussed, we will continue to need EU and other overseas staff in clinical and non-clinical posts at all levels to maintain services. We do not want the availability of medical staff from the EU to be restricted.

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[8] *Intercollegiate Standards for Children and Young People in Emergency Care Settings*. 2012 http://www.rcpch.ac.uk/sites/default/files/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf

[9] GMC State of Training 2015 http://www.gmc-uk.org/publications/somep2015.asp

3.4 We welcome the announcement made by Jeremy Hunt in England earlier this year to introduce 1,500 new medical training places to make the NHS 'self-sufficient' by 2020. However, it is not clear what this means for Wales. We are not clear as to whether this action will be in partnership with the Welsh Government and that the NHS across the whole of the UK will be 'self-sufficient' . It should be noted that it takes at least seven years to train new students to enter practice so many will not be in place until 2023/24 at the earliest and 1,500 new places is unlikely to fill the current vacancy rates across the medical profession as a whole.

3.5 The RCPCH is concerned that recruitment figures will fall as the UK begins the process to leave the EU. Prospective trainees may be hesitant to join what is already a depleted and highly pressurised workforce and EU citizens residing in or planning to move to the UK will quite likely be putting career plans on hold until their future in this country is certain.

4. The factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas.

4.1 There are significant changes planned for the process of recruiting trainees. In the past, all Deaneries delivered their own interviews for trainees at levels ST1&2. In future, applicants will be able to apply regionally. This will give applicants greater choice of preferences where to go and more scope to receive offers without having to go through additional interviews or clearing. We hope this improves fill rates, as the applicant gets a better range of possible places having interviewed for only one. We also hope this delivers better value for money, requiring fewer interview centres for fewer days.

4.2 The Welsh Government has announced the creation of an arm's length organisation, provisionally called Health Education Wales (HEW) to oversee

strategic workforce planning, workforce design and education commissioning for NHS Wales. We hope that this will be accompanied by a clear strategic vision for the recruitment and retention of the medical workforce in Wales and a strategy to realise this.

4.3 We also hope that the Welsh Government will plan for the interim period between now and April 2018, when it is envisaged that HEW will become operational, given the possible disruption. We would welcome clarity as to how the Welsh Government will ensure that this transition does not negatively impact on recruitment.

4.4 We would also emphasise the need for HEW to plan for long term demand and implementation of the Facing the Future standards in the context of the realities for paediatric trainees, including less than full time working, maternity and paternity leave etc.

4.5 Key factors that we know have a significant influence on the recruitment and retention of doctors are rotas (gaps on wards discourage trainees) and how good training is. We asked a panel of RCPCH members representing each region in Wales whether they could identify factors relating to geography, rural or urban areas, or areas of deprivation. The feedback we received included the following statements from RCPCH members:

4.6 “Biggest contributors towards recruitment and retention: rota gaps at tier 2 level are the biggest factor lowering morale across the 4 nations as they are having a material effect on the amount of work for trainees and the amount of time they spend out of hours. They also contribute to a feeling of being mainly for service delivery rather than training. All steps that can help ease this should be considered.”

4.7 “Often the adverts say you will be based at one hospital but you may be expected to travel all over the Health Board if necessary (or words to that

effect). As travel times in rural areas are not as simple as judging it on the mileage this again is a factor."

4.8 "Emphasis on training – for all medical groups."

4.9 "I personally believe that the factors that influence the recruitment and retention of doctors in general is that there simply isn't enough doctors when you consider that people leave medicine to pursue other careers, people leave the UK for a perceived better quality of life."

4.10 "From a Wales point of view, for prospective training doctors like myself, it is a large deanery in terms of geography and I don't think that it is clear to those from outside that if you train in Wales you can opt for either South Wales or North Wales (and link with Mersey for tertiary care). That to me is a major point to sell as it means that even though it's a huge deanery, from a practical point of view you can set up home somewhere central to the North or South and know you can commute easily to any placement in that area.

4.11 "I think the major card in Wales hand at the moment is the fact that the junior doctor contract is not being implemented here and that the Welsh Government are in discussions with the doctors."

5. The development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere; The extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce

5.1 RCPCH does not manage recruitment campaigns. Positions are advertised through the Oriel website centrally. RCPCH staff and members do, however, frequently attend careers fairs. These are primarily organised

locally, sometimes by hospitals. We are not aware of a central strategy or campaign to organise this work, either in Wales or at a UK level.

5.2 We asked a number of our members, particularly trainees with recent experience of going through this process or consultants who have been involved in recruitment work, for their feedback. Their responses are below:

5.3 “We rely heavily on overseas doctors which ethically means we're taking doctors from parts of the world that need them, and practically with the current political situation in the UK means that we'll be less attractive to overseas doctors soon, especially when we leave the EU.”

5.4 “Medical recruitment campaigns… have not been fruitful in my experience. These have generally been undertaken by medical professionals themselves (not really their job to do this surely?) with some help from staffing departments and have often taken a good deal of time and energy… Clearly there may be better strategies for targeting these recruitment drives but in my view these should be a short term solution to manpower shortages... increased production of local trainees must be the better long term plan. We need to move away from the concept that some clever recruitment strategy will provide the answer.”

5.5 “I don't know how 'joined up' we are in terms of recruitment but it certainly feels like we are not very joined up at the moment with the obvious workforce inadequacies.”

MR 09
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Coleg Brenhinol yr Ymarferwyr Cyffredinol
Response from: Royal College of General Practitioners

Royal College of GPs Wales:

Response to the Welsh National Assembly's Inquiry into Medical Recruitment

RCGP Wales represents GPs and GPs in training from across Wales. We welcome the opportunity to respond to the current consultation regarding the sustainability of the health and social care workforce focusing on medical recruitment being undertaken by the Health, Social Care and Sports Committee. Our response will be limited to general practice.

1. Currently there are severe problems in relation to retention and recruitment of GPs to all types of posts (partnered, salaried GPs and locums) across Wales. This applies to work within practices in and out of hours' services. The problems are more severe in more rural areas and in areas in north and west Wales New models of practice are developing and although expanding the general practice workforce to include other professionals is welcome, this means that the work of the GP is changing and becoming more complex, including managing a multidisciplinary team. GPs can then be left dealing with more complex cases and spending longer working at the top of the license and knowledge which can lead to increased stress and burn out Some GPs are already choosing to leave the profession due to stress and increasing workload. The skill set for managing a broad team is different and there are additional indemnity cost which can be high related to supervising a wider multidisciplinary team. Again, this may have implications for retention and recruitment both of new trainees and for GPs who wish to come to Wales for the rest of the UK and other parts of the world where the GP model exists.
2. Brexit will have implications for health and social care service. Many of the professionals currently come from the EU. Uncertainty about their future employment as well as the potential effects for their families whether those are in the UK or not, will make new applicants less likely. Those currently in

post may leave the UK. The terms of Brexit may prevent this but the current uncertainty will have its affect. Brexit may enable professionals from other countries to come here more easily but again we need to see how this develops and there is likely to be a negative impact on recruitment and retention in the next few years.
3. Several models are currently being tried to bridge the gaps in services. These models need to be assessed fully, including the cost implications. Lessons learnt need to be spread across Wales and potential benefits implemented more widely.
4. The future demographics of society with the increasing age of the population plus the urbanisation preferred by young people mean that the rural areas are being left with older more complex patients without family support. This has great implications for both health and social care models of delivery and the workforce as often younger doctors wish to work in more urban environments, where there is a broader range of opportunity for their partners and family including choice of schools, colleges and employment as well as social opportunities and travel.
5. In addition to ensuring recruitment of a strong GP workforce we have a major problem with practice nurse recruitment. Prior to the 80s there were few practice nurses as some of these functions were performed by district nurses and health visitors who were linked to GP surgeries. With time the roles of those professions have altered, which we welcome and practice nurses gradually developed to support their current indispensable role particularly in supporting the care of the chronically ill, the elderly and vaccinations. Their expertise has been developed often in house with support from GPs and is very different from the role of a hospital nurse and even an experienced district nurse or hospital nurse needs specialised training to provide the rounded services offered in practices to both adults and children.
Many of the practice nurses are reaching retirement and it is difficult for practices to get appropriate staff to fill the gaps. There needs to be dedicated training for these nurses with potential support for practices to enable them to receive the training. Training for practice nurses is being developed and nurses need supported exposure to general practice as part of their undergraduate training.
6. There are similar issues for the broader healthcare professionals who are now having placements in primary care. The way that they work in secondary

care is often very different from primary care. There needs to be supported undergraduate exposure and post graduate courses to ensure that these new and expanding roles are fit for purpose and meet the needs of the population as well as the practices of the future. As primary care employs more of these health professions there may be implications for secondary care. In some areas, this is already occurring.

7. There are currently difficulties for GPs, even among those who have been trained in the UK and have had a gap in service to return and there is an urgent need to ensure that these problems are tackled as a matter of urgency. This requires work with the Westminster Government and the GMC to look at recognition of training and also appraisal processes and revalidation. The issues around this are complex but need to be addressed.

8. We welcome the Welsh Government's recent offer for medical students choosing to train in Wales but this does little to help and support the current workforce. We do hope that the single point of access is supportive of all specialities as we recognise that GPs do need the support of secondary care. As this was recently launched its impact still needs to be assessed.

MR 10
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Age Cymru
Response from: Age Cymru

Inquiry Response

Medical Recruitment

November 2016

Introduction

Age Cymru is the leading charity working to improve the lives of all older people in Wales. We believe older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.

We are pleased to respond to the Health, Social Care and Sport Committee's inquiry into the medical recruitment. The proportion of the population aged 65 and over in Wales has been growing at a faster rate than the proportion of the population aged between 18 and 64 and this is a trend that will continue in coming decades. The number of individuals aged 65 and above in Wales is expected to increase from around 600 000 in 2013 to almost 900 000 in 2037[1]. The need for health and social care increases with age, and the number of those aged 85 or over is growing at an even faster rate than those aged 65 plus. In order to meet the health and social care needs of this population, we need to ensure sufficient recruitment of a relevant workforce that is suitably trained and integrated, with the appropriate skills mix available.

General comments

[1] LE Wales (April 2014): *Future of Paying for Social Care in Wales. First report to the Welsh Government*.

- It is imperative that training and recruitment (as well as funding) address existing gaps in provision. For example, we are aware that in some places older people's services in secondary care, for example older people's mental health services have not been available 24/7, whereas they are available 24/7 for what is known as the working population. The lack of such a service can be highly problematic if an older person with dementia, cognitive impairment or a chronic mental health condition is admitted outside these service hours. It is therefore essential that medical recruitment focuses not just on currently unfilled places, but also upon gaps in the service provision.
- As the Welsh population ages, increasingly frail older people are living with, and managing, multiple co-morbidities. It is therefore important that approaches to recruitment bring together multi-disciplinary teams in primary, community and secondary care, who are able to treat the person holistically. For example, we are aware of problems that have arisen due to people living with dementia being treated for other conditions by staff who are not well trained to deal with symptoms or behaviour that may arise from a dementia. As a consequence, we also believe that dementia care training is fundamental for a medical workforce to treat older people effectively, especially as the number of dementia cases continues to rise and with the recent evidence that dementia is now the leading cause of death in England and Wales. Appropriate support can have a significant impact on quality of life for people managing multiple long-term life-limiting illnesses.
- We would also argue that in light of Wales' ageing demographic profile that there is a need for more geriatric specialists in a range of healthcare professions. For example, we know from data collected by the Wales Cancer Intelligence and Surveillance Unit (February 2016) that the rate of new cancer cases generally increases with age, as does the rate of cancer deaths. We are therefore concerned that more attention should be given the recruitment of staff specialising in providing services, such as oncology, to older people.
- We welcome the recent move towards more innovative and pro-active recruitment campaigns to attract staff to the NHS in Wales, such as 'Work.Train.Live' for GPs and 'Mountain Medicine' from the Emergency Department in Ysbyty Gwynedd. Wales needs to be seen as an attractive environment in which to work, but also in which to live, if staff are to be recruited and retained in post. Such campaigns should be evaluated for the extent to which they have impacted upon recruitment rates to unfilled posts in Wales.

- With regard to the implications of Brexit for the medical workforce, at this point it is not possible to know what the final outcome will be. However, we note that the social care sector has also recruited at least as heavily from the EU migrant workforce. Further aggravating recruitment and retention problems in the social care workforce contains the potential for serious knock-on implications for the experience of staff in NHS Wales, meaning the impact of Brexit on the social care workforce cannot be ignored in this respect.

We hope these comments are useful and would be more than happy to provide further information if required.

MR 11
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Dr Kate Gower Thomas BSc, MB BCh, FRCR
Response from: Dr Kate Gower Thomas BSc, MB BCh, FRCR

RE INQUIRY INTO MEDICAL RECRUITMENT

These are personal comments from Dr Kate GOWER THOMAS

Background

I am a consultant radiologist who has worked in the NHS in Wales employed by both Public Health Wales (Breast Test Wales, Cardiff) and at Royal Glamorgan Hospital (Cwm Taf University Health Board) for 24 years.

I qualified in 1985 from University of Wales School of Medicine and have worked as a full time doctor since then.
I am currently the Chair of the Breast Specialist Advisory Group and was the Breast Test Wales QA radiologist for 14 years

My contact details are as follows

[redacted] CTUHB
[redacted] BTW

COMMENT

I have long had significant concerns regarding the sustainability of the medical work force in Wales, which has particular difficulties compared to the other UK nations. As a radiologist it is well known that the numbers of radiological examinations far outweighs the capabilities of the radiologist work force for timely reporting. This has been recently acknowledged again publically by the President of the Royal College of

Radiologists , Dr Nicola Strickland. The numbers of radiologists per capita in the UK is amongst the very lowest in Europe and radiology is one of the least appreciated yet most vital hospital disciplines to the smooth running of any care primary or secondary care system. Notwithstanding this there are massive short falls in the numbers of specialist doctor of other disciplines, I can only speak of those I know best, ie the cancer fraternity. There are very many vacant Consultant jobs in this field alone in the UK and especially Wales.

Health Boards give up in advertising for appropriate consultant staff members as there are never suitable recruits and it becomes a waste of valuable time and monies to continue, so posts are only advertised if someone comes forward seeking the role and even then it may fall through. I act as the RCR representative on Consultant Appointment panels and I can list 6 or 7 in the past year in Wales and the South West of England in which I have been involved, which have disbanded due to lack of applicants. At times there are applicants from abroad – mainly the EU, but often the standard of their training falls far short of that expected in the UK, for example recently an Eastern European radiologist applied for a specialist breast radiology post in West Wales who considered themselves to be suitably trained in reading mammograms having read around 300 (I read that number in a normal day's work). In Wales we demand at least 5000 to have been read even before considering someone competent to read them never mind appointable as a consultant responsible for a service. It goes without

saying that it is essential that the standards expected by our workforce should not be compromised in order to fill posts.

The recruitment phenomenon is particularly acute in West Wales to where it seems doctors are increasingly difficult to attract. In certain specialties, again I will site breast cancer as an example, the incumbent surgeons in two hospitals are continuing to work post retirement as there is no one else to take their place. This is non sustainable and leaves the service very vulnerable. Should they leave then there is no experienced senior colleague to mentor the incoming junior consultant, which is an essential aspect of one's development as a specialist post appointment. It also means that training for other members of the team and even medical students is compromised as it becomes the law of diminishing returns, the standard never gets to be greater than the most experienced member of the team.

Indeed this happened in the ABMUHB recently where a newly qualified surgeon consultant took on the responsibility of the breast cancer surgical management the whole area without any senior specialist colleague in the hospital from whom to seek advice.

My own HB has lost four senior radiology consultants in the past two years with none being directly replaced. We currently have very many hundreds of radiology examinations, I will not disclose the actual number, undertaken over recent weeks, waiting for someone to report them – patients are arriving at outpatients to learn of their results only to find that they are not ready. This is contributing to delays in

treatment, poorer outcomes and significant extra personal and hospital costs.

Over the years in Radiology we have developed many individuals (PAMS) into extended practice roles which has served to bolster the service. For example in many HBs virtually all the ultrasound studies are performed and reported by non clinical staff – sonographers. Now the health service depends heavily on such individuals, who then become sought after once they are trained and who can find jobs anywhere. So whilst one HB may have expended many hours training up such a person, it is vulnerable when these individuals leave to another HB which then reaps the rewards, this commonly happens, particularly if the persons expectations are not met with regards to working environment, shift patterns, responsibilities and remuneration. Such issues are also recognized amongst the consultant body; unlike 20 years ago it is common for established consultants to move HB where the grass appears greener for whatever reason.

HBs need to become more receptive to the issues of work life balance which may tempt a trained team member away to another trust – this is happening more and more frequently and is very destructive to a team when one person is forced to leave as the HB will not countenance even minor changes in working patterns – eg a reduction in the hours or sessions worked, or no weekend working that an individual may need due to personal commitment with family or

whatever. This has happened to my team very recently and was very upsetting to all concerned. We need to consider annualised hours agreements, out of hours working patterns and more flexibility to working patterns.

For whatever reason we have a problem in attracting doctors to work in Wales – this is not a new phenomenon – we recruited GPs to work in the Welsh Valleys 40 years ago and they have now all but retired. Wales is currently advertising on the London Underground for doctors to come and work in Bronglais hospital, what a sorry state of affairs! Could this be because we do not train enough of our own Welsh born doctors??

I, along with many colleagues have long felt very strongly that the Welsh medical schools overlook scores of very able Welsh school leavers who wish to study medicine in their home country, which they know, love and wish to stay in, and indeed work in once qualified. It is not that these individuals are non appointable – indeed they get offered to study medicine all around the UK and that is where the problem lies. As the medical course in long and intense they strike up allegiances where and with whom they train, frequently meeting a local spouse and they never come back to work in Wales – we are losing our 'life blood' in this way. Surely if Welsh school leavers wish to stay in wales they are far, far more likely to wish to stay here to work afterwards?

I know three school leavers, one a young man who was Welsh speaking with an exemplary CV and all the right qualifications to enter medical school – Cardiff overlooked him and he is now studying in Oxford – surely that says it all? The other two are now qualified, both young women now live in England having met there now partners at English medical schools in the locality of which they now intend to remain. Cardiff medical school needs to acknowledge and appoint these very able Welsh students. Wales is missing a very big trick here, I think it is scandalous this is being allowed to happen.

There also need to be far more sensible dialogue and joined up thinking with regards to work force planning, staff retention and medical student intake. There does not seem to be any dialogue in this regard in my field of work at all, hence the current crisis, which becomes bigger by the month. It is however heartening to learn that there are plans to increased the numbers of medical students in the UK, I am not party to the details of this, what will be happening in Wales? I am concerned that these individuals will need training and that the workforce is so very stretched that this will further add to the burn out so many doctors are experiencing,

Although I trained and have worked fulltime, despite having had four children, it is now very unusual for female doctors who are mothers to want to do this as flexible training is now more widely available. Once they become consultant or trained GPs they will work at less on whole

time contracts. The issue of part time working has of course reduced the number of hours these doctors are available to work from this largely female group. This was not well anticipated by the employers as there is a short fall contributing to the employment crisis.

With the ever increasing demands of training – including the frequent changes in hospitals they are required to train in from one end of the country to another – and often with the father elsewhere in the country this is not conducive to retaining the female work force who may consider it better to just stop working as a consequence. I have GP friends who have done this, with no current intention to go back to work. In addition with very erratic working hours and no provision of child care by HBs out of hours how is a young female doctor supposed to train and ensure her children are cared for at all hours of the day and night, particularly if she is a single parent – as I was? Not everyone has family close by willing or able to accommodate the fickle demands of the health care system. Vastly improved childcare provision will certainly contribute to staff recruitment and retention. I have colleagues who have now considered it appropriate to take several more weeks off work a year as unpaid leave rather than struggle with the child care arrangements, leaving the rest of us to pick up the extra work. If an HB were able to provide 5star childcare facilities for their staff they would surely be the place to work and the hospital would gain in the process.

ON a similar vein, something I have heard several times of late, the rota system is far too restricting with some reporting being unable to alter a shift many months in the future in order to attend important life events like a family wedding. What sort of a health service are we running if this is happening to its staff? It seems the service if becoming increasingly like an dictatorship with little regard to humanity and empathy towards its staff members. This must stop. It is little wonder that these valuable individuals are going abroad – so very many have and others intending to, that we must listen to what they a re telling us before it is too late.

In summary I have concerns that the workforce crisis will get worse before it improves, as it takes far longer then there is time to train competent doctors. The problems should have been more seriously considered long ago when we first raised our concerns. We need to listen to what the doctors are telling us with regards to their needs for work life balance, shift patterns and child care provision and we need to positively discriminate towards welsh students in our Welsh medical schools even if this means the Government pays a tariff to steer them away from the more tempting foreign students who bring more to the coffers of the universities.

If not then future (and even current) Welsh patients will most definitely pay the cost.

MR 12
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Bwrdd Iechyd Prifysgol Aneurin Bevan
Response from: Aneurin Bevan University Health Board

Our Ref: JP/RB/jr Direct Line: [redacted] 18 November 2016

Ms Zoe Kelland
Health, Social Care and Sport Committee
National Assembly for Wales
Zoe.kelland@assembly.wales

Dear Ms Kelland

Health, Social Care and Sport Committee's Inquiry into Medical Recruitment

I am pleased to provide below a response from Aneurin Bevan University Health Board in relation to the Committee's inquiry, as outlined above.

The capacity of the medical workforce to meet future population needs, in the context of changes to the delivery of services and the development of new models of care
The Health Board has been developing and refining it`s medical workforce model across all sites to ensure that safe and effective services are provided. This has involved the development of new roles and ways of working to address local and national recruitment challenges. The decreasing number of trainee junior doctors allocated to the HB has and will have an impact on services. Consequently the Health Board has looked to

Bwrdd Iechyd Prifysgol Aneurin Bevan
Pencadlys,
Ysbyty Sant Cadog
Ffordd Y Lodj
Caerllion
Casnewydd
De Cymru NP18 3XQ
Ffôn: [redacted]
E-bost: [redacted]

Aneurin Bevan University Health Board
Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
South Wales NP18 3XQ
Tel No: [redacted]
Email: [redacted]

new ways of delivering care and supporting medical rotas, for example, the use of. Hybrid Consultants Medical Training Initiatives (MTIs) Clinical Fellows and Responsible Clinicians under the Mental Health Act. Non-medical roles have been developed to reduce pressure on medical time such as Advanced Practice Nurses and Physicians Associate.

To help address gaps in the medical workforce the Health Board has continued to engage in overseas recruitment and this remains an important part of our resourcing strategy. Where we have been unable to recruit to substantive positions we have relied upon the use of locum and agency staff and the commitment and good will of our Consultants and juniors to provide cover.

General Practice is under pressure through an increase in demand for its services. This is compounded by a national shortage and ageing profile of GPs. 25% of GP`s in Wales are at retirement age now. . Additionally the increased feminisation of the GP workforce will present challenges in accommodating more flexible working practices. The Health Board has taken a number actions to help reduce GP workload for example the introduction of practice based Pharmacists and the use of advanced practice nurses within GP practices These interventions have evaluated well and will continue to be a keystone of our approach to supporting general practice and our strategy of providing care closer to home.

We also recognise the need to develop our Clinical Leaders both now and in the future as they are critically important in delivering service transformation. Accordingly we continue to review and develop our Clinical Leadership training and development programmes.

The implications of Brexit for the medical workforce
The exact implications of Brexit are unknown. The decision to leave the EU will have potential implications for the workforce as around 6% of people working within NHS Wales are EU migrants many of whom are medical staff. Any changes to their employability to work in the UK will have implications for all services. Protecting NHS employee`s rights to remain in the NHS is crucial for long term sustainability. The recent example of capping the number of tier 5 certificates of sponsorship for MTI doctors from abroad is a case in point.
The factors that influence the recruitment and retention of doctors, including

any particular issues in certain specialties or geographic areas
• Factors that influence the retention and recruitment of doctors are; o Doctors need to feel they are appropriately remunerated and valued o Wales must be considered a good place to work train and live. The national recruitment campaign sponsored by Welsh Government has started to address these issues. Local recruitment campaigns will support and underpin this approach. It is important that the Aneurin Bevan brand is about being an employer of choice and to this end the quality of the training experience as well as clinical research opportunities offered will be important. Some of the more deprived areas e.g. Blaenau Gwent are less attractive in terms of recruitment and special packages may be necessary to encourage staff to work and remain in these areas o In addition to training and research opportunities the values of the organisation must be appealing to applicants and evidenced by the actions of the Health Board o The opportunity to work in areas of special interest will help attract candidates i.e. a blended /flexible approach to their employment experience o The effects of the new junior doctor contract in England need to be fully assessed for the implications for NHS Wales
The development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere
The Welsh Governments recent launch of 'Train, Work, and Live' needs to be kept as a vibrant and dynamic brand. It could be developed further by bringing local businesses to promote what Wales can offer (I.e. private nurseries, letting agents, schools). We need to build on the campaign and evaluate its success in attracting the medical workforce to Wales. The development and delivery of overseas recruitment campaigns on an all Wales basis. Providing overseas doctors with specialty training outside of the MTI scheme could incentivise the prospects of working in Wales. This could also be offered to those UK doctors that have come out of the training programme to develop skills rather than just 'plugging gaps' on a rota. More work needs to be undertaken to promote the medical profession as a career choice. Delivering sessions to schools and sixth form colleges to promote the medical career path and provide more opportunities to growing

our own. Special attention needs to be given to encouraging interest in medical careers from children in deprived areas as they are more likely to want to work and live in these areas

Recruitment campaigns needs to be delivered in a variety of different ways to ensure we capture the younger generation. Better use of social media need to be used to capture a technically savvy audience.

The extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce

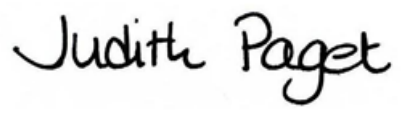
The recruitment process for Consultants is very traditional and needs modernising embracing the concept of values based recruitment used elsewhere in NHS recruitment.

The numbers of doctors going into training are inadequate and the handing back of unfilled posts from the Deanery to the Health Board are often at short notice. This creates particular issues when adhering to the 28 day resident labour market test. Unfilled vacancies leave rota gaps that are then covered by locum/agency. This is not ideal from a service or patient perspective.

Employment checks are an essential part of the recruitment process but greater portability of checks would ensure a slicker recruitment process and a better experience for the candidate.

I hope the above information is helpful to you. Should you require any additional information on any of the matters outlined above, please do not hesitate to contact me.

Yours sincerely



Judith Paget
Chief Executive/Prif Weithredwr

MR 13
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Ysgol Feddygaeth Prifysgol Caerdydd
Response from: Cardiff University School of Medicine

Inquiry into medical recruitment
Health, Social Care and Sport Committee
Prepared by Dr Stephen Riley
Dean of Medical Education
School of Medicine,
Cardiff University
08/11/16

1.0 In response to the proposed consultation by the Health, Social Care and Sport Committee inquiry into medical recruitment Cardiff University School of Medicine has prepared the following.
1.1 Undergraduate medical education in Cardiff has recently made a huge stride towards addressing recruitment and retention of doctors in Wales by the reform of its medical curriculum. The programme is 4 years into a 5-year implementation and so will not have data as to whether these outcomes have been achieved for another 18 months. The C21 Curriculum has refocused itself, emphasising patient and community centred education and the learning of relevant science within these contexts. The purpose behind this is to produce doctors who understand patients and the communities in which we all live and work. The aim is to attract, train and retain resilient, patient focused doctors who can work in interprofessional teams, and who are fully equipped to deal with the complexity and uncertainty of modern medical practice.

1.2 However, the changes we made, although they have been successful in terms of improving the student experience, are only the beginning. Cardiff still has some way to go before we can confidently say that the changes have been fully embedded and that there will be a continued impetus towards improvement and excellence. We therefore cannot relax.

2.0 The capacity of the medical workforce to meet future population needs, in the context of changes to the delivery of services and the development of new models of care.

2.1 There are problems with recruitment and retention of GPs in Wales. This is particularly noticeable in rural and deprived areas. GP training schemes are under filled or empty. Even if we could fill all the schemes, there is no point spending effort recruiting more people if the health service cannot retain the workforce it already has. Thus work is required to improve the workload of GP's by ensuring that the multidisciplinary team is available and trained to provide care delivery. Practices are running at maximum capacity and we are starting to see them refuse to be involved in teaching students as this is seen as an added burden. This threatens the future of medical education in General Practice in Wales. The same is true in hospital placements as medical teams are delivering increasing intensity of care, particularly in the winter months, undergraduate medical education and postgraduate training loses priority in favour of service delivery. As such the following seem pertinent.

2.2 More time for teaching for NHS doctors.

This seems paradoxical in the face of service pressures but we will never build capacity unless we train our future doctors quickly and efficiently. To do that, we need more and better teaching from people who are willing and trained to do it and given time to teach / train.

2.3 Further investment in teaching facilities in communities across Wales.

The South Wales Teaching Hospitals are at, or over, capacity but there is little justification for concentrating all our students in a secondary care location. A recent publication from a Community Based Medical School in the USA documents the recruitment potential of a rural located medical school(1). Graduates from these schools are more likely to adopt a rural practice or stay in health professional shortage areas. Investment in Wales for this type of approach might make a huge difference both in the ability to increase the number of medical students in Wales and educate them within the areas of need resulting in improved recruitment to these areas. The exact number of increased students would need to be determined. This will require additional staff to teach the students.

2.4 Give greater priority to developing the skills and competencies of the current workforce to better meet the needs of patients now and in the future.

Given the issues described above, it is likely to be relatively more difficult to attract senior practitioners, of all groups of the multidisciplinary team, to areas where there are currently shortages, therefore we need to attract junior staff and create an environment, which encourages them to improve their clinical abilities and remain in Wales. A series of postgraduate CPD courses which are either entirely eLearning or, in most cases, blended learning but with distributed teaching, whereby the face-to-face elements are not only taught in Cardiff but are also taught in medical centres throughout Wales. The latter can be achieved by either staff travelling to the Welsh regions or by the use of external teachers who are trained (or assessed for their suitability to teach at the appropriate level) and who use teaching and training material already created.

2.5 Ensure a robust, widening access policy of admission to medical school.
Ongoing work to develop the admissions process for medical school is required. The use of the multiple mini interview (MMI) is being implemented this year in the School of Medicine to help us further improve the fairness and transparency of our admissions system. Continued work with Welsh Schools and children to raise aspiration is necessary to ensure that we are able to recruit from all areas of Wales. This requires support for academic achievement so that we ensure successful progress through the medicine course.

2.6 To continue the innovations in medical education the Centre for Medical Education at Cardiff University School of Medicine will continue to review its programme delivery, utilising senior and experienced medical educators. We will utilise critical friends to help us move to the next phase of development, both at undergraduate and postgraduate level, to align the offering with the needs of the NHS in Wales to allow it to meet its goal of excellent, evidence based, prudent and patient centred healthcare. We have an excellent track record of programme development and delivery that could assist in training the workforce of NHS Wales.

3.0 The implications of “Brexit” for the medical workforce.

3.1 There is no precedent for the current situation with the UK relationship with the rest of Europe. The significant uncertainty makes predicting the implications difficult. The current admissions cycle for the study of Medicine in the UK has recently closed its initial applications and this has shown that the number of applications from Europe to study in the UK is down by 16% (1720 applicants), which is the lowest figure for at least 4 years (data from UCAS – 2016). In addition the number of international applicants from outside the EU is also down by 6% (3040 applicants). In an editorial published in the British Medical Journal, Prof Chris McManus describes how the demand for doctors in the UK has outstripped supply since the 1950’s(2). This has resulted in recruitment from abroad, meaning that 20% of all doctors working outside their training country are in the UK (only the USA has more at 60%). Although this has left the exporting countries with shortages, and consequent deficiencies in health delivery, a rebalancing of this shift could result in fewer overseas doctors in the UK leading to further shortages in hard-pressed posts.

4.0 The factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas.

4.1 This is a challenging area and we would refer you to the earlier discussion regarding the location medical education takes place and its influence on recruitment. As such developing prolonged, pre-registration medical education embedded within communities in Wales that are underserved may have positive effects on local recruitment. This would require an excellent, supported student experience to maximise this opportunity, in addition to aligned postgraduate training environment and support for families of the trainees. Cleland articulates this when describing the value placed, by doctors in training, on their posts(3).

4.2 Changing the expressed attitudes and culture of the NHS towards some of the hard pressed specialties, e.g General Practice and Psychiatry is also imperative to ensure that undergraduates and trainees are not discouraged during their training4. The School of Medicine is actively promoting

community clinical learning within the course and a number of student led societies related to rural health and primary care have developed.

5.0 The development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere.

5.1 This is a matter predominantly for the NHS and the Postgraduate Deanery. There does need to be a focus on the recruitment of excellent medical students from all over Wales. A coordinated strategy to ensure the best students from Wales are given the opportunity to study in Wales is essential. The recent S4C programme, Doctoriaid Yfory, detailing the life of medicals students as they study in and around Wales will hopefully help to raise expectations of the Welsh school children to consider a career in Medicine.

6.0 The extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce.

6.1 This requires a coordinated approach with data sharing from postgraduate programmes to work out which students are going into postgraduate training and where. By analysing data in this way we can develop new strategies to inform the provision of medical education to meet the needs of the population and the practitioners around Wales.

1. Phillips JP, Wendling AL, Fahey C, Mavis B. The Impact of Community-Based Undergraduate Medical Education on the Regional Physician Workforce. Academic Medicine. 2016.
2. McManus C. Hunt promises 25% more medical students in 2018. BMJ. British Medical Journal Publishing Group; 2016 Oct 11;355:i5480–2.
3. Cleland J, Johnston P, Watson V, Krucien N, Skåtun D. What do UK doctors in training value in a post? A discrete choice experiment. Med Educ. 2016 Jan 26;50(2):189–202.
4. Baker M, Wessely S, Openshaw D. Not such friendly banter? GPs and psychiatrists against the systematic denigration of their specialties. *Br J Gen Pract* 2016

MR 14
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Coleg Brenhinol y Meddygon
Response from: Royal College of Physicians

Inquiry into medical recruitment

RCP Wales response

We need to show vision and national leadership

- Develop an ambitious long-term vision for the NHS in Wales.
- Increase investment in new models of integrated health and social care.
- Develop a national medical workforce and training strategy.
- Show national leadership on the balance between service and training.
- Work with physicians to redesign acute and specialist medical services.
- Ensure that hospitals work within formal, structured alliances to deliver integrated care.
- Establish the role of chief of medicine, supported by a chief registrar.
- Publicly support and promote the patient-centred Future Hospital model of care.
- Increase health spending and invest in clinically led innovation and prevention.

We need to invest in the medical workforce

- Take a strategic approach to workforce planning.
- Ensure that the acute admissions workload is more evenly distributed between all specialties.
- Train a greater proportion of doctors in the skills of general medicine.
- Support physicians working in non-training jobs to develop their careers.
- Invest in data collection to provide a robust evidence base for medical recruitment planning.
- Make staff health and wellbeing a national priority.

We need to support the clinical leaders of the future

- Promote Wales as an excellent place to live and work as a doctor.
- Focus on addressing recruitment and training challenges.
- Increase the number of undergraduate and postgraduate training posts in Wales.
- Develop training pathways specialising in rural and remote healthcare in Wales.
- Increase the number of medical school places offered to Welsh domiciled students.
- Improve the support available to junior doctors in rural areas.
- Invest in clinical leadership and training programmes.
- Appoint chief registrars in every health board to give trainees a voice.

We need to develop a new way of working

- Encourage health boards to implement the RCP Future Hospital workforce model.
- Deliver more specialist medical care in the community.
- Invest in new innovative ways of working across the entire health and social care sector.
- Lead the way by developing new integrated workforce models in rural communities.
- Develop the role of community physician.
- Address nurse shortages and develop other clinical roles in the NHS workforce.
- Further embed telemedicine into everyday practice.

Inquiry into medical recruitment

1. Thank you for the opportunity to respond to the Health, Social Care and Sport Committee inquiry into medical recruitment. Following the recent launch of a new RCP Wales report on the medical workforce, *Physicians on the front line* (published on 17 November 2016) we would be extremely keen to give oral evidence on this inquiry to the Health, Social Care and Sport Committee. We would be very happy to organise evidence from consultants, trainee doctors or members of our patient carer network.

2. The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,200 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

The capacity of the medical workforce to meet future population needs

3. The NHS in Wales is facing a number of urgent challenges. Hospitals are struggling to cope with the combination of an ageing population and increasing hospital admissions. All too often, our most vulnerable patients – including those who are old, who are frail or who have dementia – are failed by a system that is ill equipped and seemingly unwilling to meet their needs. Furthermore, levels of ill health increase with levels of area deprivation. In general, those in the most deprived areas report the worst health. The rural geography of much of Wales means that some medical services are spread very thinly. This is having a negative effect on the quality of training and on workforce recruitment in some specialties. In addition, patient expectations are increasing as financial constraints grow tighter and, while advances in technology can save lives, the cost of providing specialist acute care continues to rise.

4. Legislative changes to working hours mean that we need more junior doctors to cover hospital rotas. This has happened at the same time as a reduction in training time due to the modernising medical careers programme, and a fall in international medical graduates coming to the UK. In 2011, almost half of the higher specialty trainee physicians told us that since the introduction of the European Working Time Directive, the quality of both training and patient care was worse or much worse.

5. As the population grows older, and an increasing number of people develop complex chronic conditions, there is an increased need for consultants with qualifications in general internal medicine so that patients can be managed holistically. However, in Wales, only 43.7% of consultant physicians contribute to the acute rota while 52% participate in the general medical rota. There is also a great deal of variation between RCP specialties. For example, almost all consultants working in stroke, respiratory or acute

internal medicine in Wales participate in the acute take. However, the figures for renal medicine (36.4%) and cardiology (36.8%) are much lower, and in some specialties, there are no consultants at all who participate in the acute take in Wales. In the future, the acute admissions workload will need to be more evenly distributed between all specialties in order to allow more flexibility and prevent the unmanageable workload of acute medicine falling on the few.

6. At the same time, the composition of the workforce is also changing. More consultants are working flexibly or part time. To some extent, this is because there are now more women in the medical workforce – between 2007 and 2012, the number of female doctors under 30 years old increased by 18%, and in 2012, 61% of doctors under 30 years old were women. The 2015 census of consultant physicians found that 33.3% of female consultants in Wales work part time, compared with 8.8% of male consultants. This trend in changing working patterns raises issues about the total number of doctors that will be required in the future if the proportion of those working part time continues to grow. If a consultant works part time, their relative contribution to the acute medical take can vary hugely. We will need to see an increase in training posts to allow for an increase in less-than-full-time working in the future.

7. Trainee rota gaps are reported by 42.9% of respondents in the 2015-16 RCP census of consultants in Wales as 'frequently causing significant problems in patient safety' and by a further 45.8% as 'often [causing problems] but there is usually a work-around solution so patient safety is not usually compromised'. Only 11.3% of respondents told us that rota gaps infrequently or never cause a problem. More than a third of higher specialty trainees told us that they regularly or occasionally act down to cover gaps in the core medical trainee rota. Almost two-thirds of these specialty trainees told us that they feel as though they are sometimes, often or always working under excessive pressure, with 63.2% telling us that this was down to insufficient trainee numbers.

The implications of Brexit for the medical workforce

8. The RCP is keen to engage with both the UK and Welsh governments on the implications of Brexit, especially its effect on the medical workforce. Above all, patients must be the first priority. The UK government must guarantee that EU nationals working in the NHS will be able to stay in the UK and continue to deliver excellent care for patients. Non-UK doctors must not be restricted from working in the NHS. Both governments should engage with health and social care employers, royal colleges, professional bodies and trade unions, as Brexit negotiations continue.

9. Furthermore, the UK's withdrawal from the EU must not affect patients' ability to participate in high quality research and clinical trials. Patients must continue to have access to innovative new technologies, and the UK must continue to be a world leader in medical research through the ability to access Framework 9 (FP9) funding as well as regional development funds and bursaries. The UK should also retain the ability to influence EU legislation that affects medical research. Finally, those EU frameworks that underpin the protection of public health must be protected. If replaced, these should be strengthened and enshrined in UK or Welsh legislation.

The factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas

10. It is worth noting that there are difficulties recruiting for many specialties in most parts of the UK, not just in Wales, and 72.7% of higher specialty trainees would still choose to train in Wales if they could turn back time. However, there are trainee vacancies in every acute hospital rota in Wales, and last year, the NHS in Wales was unable to fill 39.8% of the consultant physician posts it advertised. In a majority of cases, health boards were unable to appoint because there were simply no applicants.

What can we do to recruit doctors in the short-term?

- NHS Wales should adopt a more joined-up, nationally coordinated approach to recruitment.
- Health boards should invest in physician associate roles which can free up trainee time for education.

• Health boards should reinvest unspent trainee money in new roles, eg clinical fellowships.
• Community placements for medical students and trainees should be further developed.
• Graduate entry into medical school should be encouraged, especially for Welsh domiciled students.
• Both undergraduate and postgraduate medical training should focus on long-term conditions.
• Accreditation and structured support for teaching hospitals should be considered.
• Using technology in a more innovative way, especially in rural areas, should be encouraged.
• Rural medicine, especially in mid-Wales, should be developed as an advanced medical specialty.
• Structured CESR conversion courses with structured mentoring and support for SAS doctors.

The development and delivery of medical recruitment campaigns

11. Wales currently struggles to recruit enough trainees to fill hospital rotas; 33% of core medical trainee places were unfilled in 2016. The 2015-16 census found that 16.7% of higher specialty trainees have considered leaving the medical profession entirely in the past year, and only 31.7% think that they are finding an appropriate balance between training in general medicine and in their main specialty. Even worse, 11.6% of higher specialty trainees told us that they rarely enjoy their job, and 62.8% said their job sometimes, often or always gets them down.

What could we offer junior doctors in Wales?

• Structured mentoring and support programmes
• More clinical leadership and quality improvement opportunities
• More innovation and academic research opportunities
• Taught MSc and MD degree opportunities
• More flexible working patterns and training pathways
• One-off grants to ease the financial burden of professional exams

12. This problem must be tackled head on; the Welsh government and NHS Wales must take action to promote Wales as an excellent place to live and work as a doctor. However, we are concerned that medical recruitment campaigns are not involving all relevant stakeholders or learning from good practice elsewhere. We are worried that the Welsh government has previously taken a narrow approach to the problems in medical recruitment by focusing on one area of the medical workforce without considering how we might build resilience in other areas at the same time. We would welcome more innovative thinking about how we develop the future NHS workforce, especially how we might support our GP colleagues – by developing specialist physician roles in the community, for example. We have a real opportunity in Wales to drive this agenda and show real vision, but it will need an open and inclusive conversation with a wide range of stakeholders, including all the royal colleges.

The extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce

13. It is important that future investment into the health service does not go towards propping up the old, broken system. Spending money on the existing system will not change anything in the long term; health boards must invest in the prevention and treatment of chronic conditions and allow clinicians to innovate. Those living in rural and remote areas must not be forgotten either; it is these areas where the crisis in primary care is hitting hardest, and where a new ambitious model of care has the most potential.

14. A clear, refreshed strategic vision for NHS Wales should be developed, based on rigorous data collection that provides a robust evidence base. This must put clinicians at the very centre of change and should be developed bottom-up through patient and professional groups. Successive reviews in the past few years have repeated this call to action (including the health professional education investment review and the Jenkins review of the NHS workforce) yet it is still not clear how the Welsh government intends to work with patients and clinicians to do this.

15. We need to move away from a workforce model in which we invest in either primary or secondary care, and towards more integrated team working

– the hospital without walls – where specialists hold more of their clinics in the community, and GPs spend part of their time working with colleagues at the front door of the hospital.

16. The Welsh government must now lead the development of a long-term plan for the future of the Welsh health service. Ministers must show national leadership to create stability and support the long-term transformation of the health service. This will require better communication and real investment, especially in clinical delivery plans. All spending decisions should be underpinned by a long-term objective to increase investment in new models of integrated health and social care. Above all, we need a clear vision of how the service will look in the future in order to plan effective medical training.

17. All of this will need a drastic change in mindset. The RCP has long called for more clinical leadership and engagement, and more joined-up thinking between service planning and training needs. Now it is time to rethink how the future NHS workforce will train, develop their skills and practise medicine – and health professionals, including doctors, must be involved and genuinely engaged from the very start.

More information

18. We would like to submit the recent RCP Wales report, *Physicians on the front line*, as an appendix to this consultation response. All the statistics in this evidence are referenced in this report. It provides a great deal more detail about our research, the 2015-16 RCP census results and the case studies we have gathered about the future of the NHS workforce in Wales.

19. More information about our policy and research work in Wales can be found on our website. **We would be delighted to provide oral evidence to the Committee or further written evidence if that would be helpful.** For more information, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at [redacted].

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Consultation on the implications for Wales of Britain exiting the EU

RCP Wales response

Key recommendation: The UK and Welsh governments should prioritise action around the implications of Brexit on the health and social care workforce, medical research, public health and NHS finance.

- EU nationals working in the NHS must be able to stay in the UK and continue to deliver excellent care for patients.
- The current workforce crisis facing the NHS must not be exacerbated by restricting non-UK doctors from working in the NHS.
- Migration rules must not adversely impact on the supply of care workers.
- The UK's withdrawal from the EU must not affect patients' ability to participate in high quality research and clinical trials. Patients must continue to access innovative new technologies.
- Workforce pressures must not be allowed to have a negative effect on the time available to doctors to conduct clinical research. Restrictions on the mobility of researchers and clinicians may add further pressures.
- The UK must retain access to FP9 funding, in addition to regional development funds, facilities and bursaries.
- The UK must retain the ability to influence European legislation on research.
- Frameworks that underpin health protection must be replaced by equivalent or even stronger safeguards.
- The UK must have continued access to European structures and networks that provide effective surveillance of health threats.

Lowri Jackson
RCP senior policy and public affairs adviser for Wales
[redacted]

Royal College of Physicians (Wales)
Baltic House, Mount Stuart Square
Cardiff CF10 5FH
[redacted]
www.rcplondon.ac.uk/wales

External Affairs and Additional Legislation Committee
National Assembly for Wales
Cardiff CF99 1NA

From the RCP vice president for Wales
O'r is-lywydd yr RCP dros Gymru
Dr Alan Rees MD FRCP
[redacted]

SeneddEAAL@assembly.wales

From the RCP registrar
O'r cofrestrydd yr RCP
Dr Andrew Goddard FRCP
[redacted]

28 November 2016

Consultation on the implications for Wales of Britain exiting the EU

1. Thank you for the opportunity to respond to your consultation on the implications for Wales of Britain exiting the European Union. This response is based on the views and experiences of our fellows and members who are mainly hospital-based doctors working in 30 medical specialties. We would be very happy to organise oral evidence from consultant physicians, trainee doctors or members of our patient carer network.

2. The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,200 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

What should be the top priority for Wales in advance of the UK Government triggering of Article 50?

3. The RCP is keen to engage with both the UK and Welsh governments on the implications of Brexit, especially its effect on the health and social care workforce, medical research, public health and NHS finance. Above all, patients must be the first priority. The UK government must guarantee that EU nationals working in the NHS will be able to stay in the UK and continue to deliver excellent care for patients. Non-UK doctors must not be restricted from working in the NHS. Both governments should engage with health and social care employers, royal colleges, professional bodies and trade unions as Brexit negotiations continue.

4. Furthermore, the UK's withdrawal from the EU must not affect patients' ability to participate in high quality research and clinical trials. Patients must continue to have access to innovative new technologies, and the UK must continue to be a world leader in medical research through the ability to access Framework 9 (FP9) funding as well as regional development funds and bursaries. The UK should also retain the ability to influence EU legislation that affects medical research. Finally, those EU frameworks that underpin the protection of public health must be protected. If replaced, these should be strengthened and enshrined in UK or Welsh legislation.

NHS workforce and staffing

5. The NHS in Wales is facing a number of urgent challenges. Hospitals are struggling to cope with the combination of an ageing population and increasing hospital admissions. All too often, our most vulnerable patients – including those who are old, who are frail or who have dementia – are failed by a system that is ill equipped and seemingly unwilling to meet their needs. Furthermore, levels of ill health increase with levels of area deprivation. In general, those in the most deprived areas report the worst health. The rural geography of much of Wales means that some medical services are spread very thinly. This is having a negative effect on the quality of training and on workforce recruitment in some specialties. In addition, patient expectations are increasing as financial constraints grow tighter and, while advances in technology can save lives, the cost of providing specialist acute care continues to rise.

6. Legislative changes to working hours mean that we need more junior doctors to cover hospital rotas. This has happened at the same time as a reduction in training time due to the modernising medical careers programme, and a fall in international medical graduates coming to the UK. The recent RCP Wales publication, *Physicians on the front line*, reported that trainee rota gaps are reported by 42.9% of consultant physicians in Wales as 'frequently causing significant problems in patient safety' and by a further 45.8% as 'often [causing problems] but there is usually a work-around solution so patient safety is not usually compromised'. Only 11.3% told us that rota gaps infrequently or never cause a problem. More than a third of higher specialty trainees told us that they regularly or occasionally act down to cover gaps in the core medical trainee rota. Almost two-thirds of specialty trainees say they feel as though they are sometimes, often or always working under excessive pressure, with 63.2% telling us that this was down to insufficient trainee numbers.

7. Doctors from the EU and across the globe play an important role in the delivery of care and in filling the significant rota gaps outlined above. Around 10% of doctors working in the NHS come from EU countries. The RCP has heard from members and fellows that doctors from EU countries and internationally are feeling increasingly uncertain about their future within the NHS. This is exacerbating the current crisis in morale among the NHS workforce. Therefore, **the most important workforce priority, whatever form Brexit takes, is to ensure those EU nationals already working in the NHS do not leave voluntarily or as a result of changes to migration policy and legislation**. While the RCP strongly welcomes comments supporting the role of EU doctors, the UK and Welsh governments must do whatever is in their power to provide assurances that doctors from the EU will be able to continue to work in the NHS and care for patients.

8. A number of leading care organisations have also highlighted the potential impact of Brexit on the wider health and social care workforce, as post-Brexit migration restrictions could cause a shortage of care workers. This could exacerbate the current financial and workforce challenges facing the social care sector and the knock-on effects on hospitals. **It is unrealistic for the NHS to absorb these pressures and migration restrictions on care workers could worsen the crisis facing the wider health and social care systems.**

Key asks of government

- EU nationals working in the NHS must be able to stay in the UK and continue to deliver excellent care for patients.
- The current workforce crisis facing the NHS must not be exacerbated by restricting non-UK doctors from working in the NHS.
- Migration rules must not adversely impact on the supply of care workers.

Medical research

9. Changes to the medical research landscape following Brexit could adversely affect the delivery of care. Patients in research active institutions have better outcomes than those in other institutions and are more likely to benefit from earlier access to new treatments, technologies and approaches. Doctors are uniquely well placed to contribute to research, as they are able to discern patterns and disseminate research findings through regular clinical contact with patients; they also have an understanding of what is translatable into practice. This is an incredible opportunity to drive forward the research capability within the NHS and improve care for patients, but this will only happen with a supportive culture of collaboration, adequate funding and resources and suitable safeguards.

10. Patients must have access to the latest treatments and clinical trials. The EU plays a significant role in terms of researching rare diseases as it is not always possible to conduct research within one population and conducting research across multiple countries ensures that there is a large enough sample size in addition to providing the opportunity for patients across several countries to be involved. **Retaining access to innovative treatments for patients should be an important element of negotiation, to ensure that they are not negatively affected**.

11. The RCP is concerned that mobility will be restricted and seeks to ensure that this does not adversely affect the NHS workforce and medical research taking place in the UK. Many physicians do not have research formally identified in their role, yet contribute in a variety of ways through patient recruitment, quality improvement and clinical trials. Freedom of movement in Europe is essential to collaborate, ensure a skilled and full workforce, in addition to sharing facilities and resources for the advancement of healthcare for patients.

12. Funding is also a significant concern for medical research. Continued involvement and access to Horizon 2020 is essential, but it is unclear how the sector would continue to fund research if the UK is not included in FP9 (the Research, Technological and Development Framework Programme - FP9 - will take place 2021-2027) in addition to other opportunities such as regional development funds, shared facilities and fellowships. In the short term, the reassurance to those seeking to participate in Horizon 2020 through the commitment to underwrite the funding is welcome; however in the long term, further reassurance will be needed. The charities currently funding around a third of non-commercial research in the NHS, will be unable to fill the funding void. The referendum vote also brings opportunities to diversify research funding through commercial and international partnerships which could be pursued.

13. There are concerns over the future of regulatory frameworks, many of which the UK has had the privilege to shape. This has enabled the UK faster access to new technologies, a cost effective approvals and distribution process and is attractive for the pharmaceutical industry, which invests heavily in the UK. The UK currently benefits from the ability to influence the direction of scientific pursuit and shape priorities for funding and regulation but it may need to harmonise with future EU legislation to ensure that it is an attractive place to do research. **It remains unclear how the UK would be able to harmonise legislation. Greater investigation is needed into the feasibility and impact this would have**.

14. There could be opportunities to revisit and refine regulation during Brexit negotiations, developing pragmatic and proportionate approaches that give the UK a competitive advantage. However, there are potential risks in divergence. For example, the UK is a world leader in research using health data. Information from patient records provides the foundation for health

research, and offers significant potential to answer questions about the factors that influence health and disease. The Data Protection Regulation, awaiting implementation in the UK, should provide safeguards to ensure personal information is used appropriately and remains secure when shared across borders. If the UK's data protection laws were to develop in a way that is incompatible with the EU regulation, it could undermine this research. The UK should take this opportunity to maintain its position as a leader in global research and innovation and the potential impact on patients.

Key asks of government

- The UK's withdrawal from the EU must not affect patients' ability to participate in high quality research and clinical trials. Patients must continue to access innovative new technologies.
- Clinicians are a vital part of the research community. Workforce and mobility are key concerns for the UK role as a global leader in research. Increasing pressure on the workforce including unfilled positions can decrease the time available to physicians for research purposes. Restrictions on the mobility of researchers and clinicians may add further pressures.
- The UK is a significant recipient of funding from the EU for research purposes. It is unclear how the UK can maintain its position as a world leader in research if it was excluded from accessing FP9 funding, in addition to regional development funds, facilities and bursaries.
- Harmonised legislation across Europe is an important part of the UK research sector and it would be valuable to ensure this continues as much as possible. However, there is the risk that the UK will lose its ability to influence future legislation, which has been a considerable benefit in the past.

Public health

15. Leaving the EU will also have important consequences for the public health framework that has been built over the years which helps to protect and improve the health of people in the UK. The UK and Welsh governments must consider the following areas of public health in its approach to Brexit negotiations:

    a. **Environment and consumer protection**

        i. The EU has developed wide-ranging frameworks for controlling environmental pollutants, including water and air quality, as well as risks from chemical products, health and safety in the workplace and the safety of consumer products. No less important are the frameworks for control and marketing of pharmaceuticals (based on the European Medicines Agency, currently based in London), and medical devices. In all these areas EU systems and standards underpin health protection in the UK, and it is crucial that either the UK maintains its involvement in them, or that they are replaced by equivalent or stronger national ones.

        ii. The RCP is particularly concerned that the UK and Welsh governments should maintain strong EU air quality standards against any pressure to weaken them. Air pollution does not recognise national boundaries and the EU has played a significant role in driving measures to control air pollutants and has provided a vital enforcement regime, allowing the UK to be held to account on meeting air quality targets. The National Emissions Ceiling (NEC) Directive sets binding emission ceilings to be achieved by each member state; it covers four air pollutants - sulphur dioxide, nitrogen oxides, non-methane volatile organic compounds and ammonia. Given the important role that trans-boundary sources play in local air pollution, it is essential that the UK continues to work with the EU in responding to the challenges posed by air pollution.

b. **Disease prevention and control**

i. There is a need to provide effective surveillance of health threats, including communicable disease outbreaks and natural disasters. The EU has established several important alert, coordination and response mechanisms, many of which are operated via the European Centre for Disease Prevention and Control. **The UK in isolation cannot effectively tackle what are inherently transnational threats and therefore needs to have continued access to these European structures and networks.**

Key asks of government

- Frameworks that underpin health protection must be replaced by equivalent or even stronger safeguards.
- The UK must have continued access to European structures and networks that provide effective surveillance of health threats.

NHS finances

16. The financial challenge facing the NHS is having a real impact on the delivery of patient care. It is widely acknowledged that the amount of funding available for the NHS is highly dependent on the health of the national economy. We cannot know with certainty what the impact of Brexit will be on the national economy as much of this depends on the details of the deal negotiated with the remaining EU members and future trade arrangements with other countries. However, in the run up to the referendum, a number of leading economic organisations including HM Treasury and the National Institute of Economic and Social Research (NIESR) published forecasts of the effect on the economy of the UK leaving the EU, based on a number of different scenarios. The overwhelming majority of these forecasts project a negative effect on the economy. The NIESR's analysis suggests that economic growth might slow to around 1.5% a year up to 2019/20. Lower economic growth will result in a bigger public deficit which will have a direct impact on public spending, including the Welsh government's budget, and by default, the health budget in Wales.

17. There is a substantial financial challenge facing the NHS in both the short and long term and a real possibility that the UK's withdrawal from the EU will exacerbate this challenge. The UK and Welsh governments must do all they can to safeguard the NHS from any adverse impact that Brexit could have on the national economy.

Conclusion

18. The UK and Welsh governments must ensure that safeguarding patient safety and public health remain the overriding priorities during the Brexit negotiations. Any changes to migration policies must consider the impact on the free movement of doctors, nurses, allied health professionals and care workers and should not exacerbate the workforce crises facing the NHS and social care system. Any future negotiations must not neglect key public health issues such as the control of air pollution and climate change. Finally, changes to the research landscape must not adversely affect patients.

19. More information about our policy and research work in Wales can be found on our website. **We would be delighted to provide oral evidence to the Committee or further written evidence if that would be helpful.** For more information, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at [redacted].

MR 15
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Coleg Brenhinol y Meddyginiaeth Brys Cymru
Response from: Royal College of Emergency Medicine Wales

Welsh Assembly Health Social Care and Sport Committee

Inquiry into medical recruitment

Written evidence submitted on the behalf of the RCEM Wales (18 November 2016)

The Royal College of Emergency Medicine Wales (RCEM Wales) is the single authoritative body for Emergency Medicine in the Wales. RCEM Wales works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

Views on: The capacity of the medical workforce to meet future population needs, in the context of changes to the delivery of services and the development of new models of care.

1. NHS Wales' medical workforce faces a significant challenge to meet the health needs of a growing and aging population with increasingly complex needs.

2. The number of people over 65 years of age is predicted to grow by 292,000 by 2039. This is an increase of 44%. Moreover, the total population of Wales has grown from 2,872,998 in 1991 to 3,099,086 in 2015. This is an increase of nearly 8% in the space of 24 years. By 2039, the population of Wales is forecasted to grow by at least 5%.[1]

3. This in turn is reflected in an increasing propensity to access health services. Demand from people over 65 years of age, for instance, continues to grow considerably and has resulted in rising numbers of GP appointments both in person and over the phone. This increase in demand in primary care services inevitably leads to increasing pressures in secondary care services, including A&E departments.

4. The latest results from the GP Patient Survey, for example, show that one in three patients (32.9%) who were unable to get an appointment at their GP surgery out of hours went to Emergency Departments instead.[2] Furthermore, between 2014-15 and

[1] Stats Wales National level population estimates by year, age and UK country
[2] GP Patient Survey, July 2016

2015-16 attendances at major A&Es in Wales has increased by 11,125 or 1.41%, and this figure is set to grow.

5. This increase in pressure on emergency services is also evidenced by the declining performance of the four hour standard in Wales. According to Stats Wales, the percentage of patients spending less than the 4 hour target has been in decline since 2013 and this downward cycle has continued into 2016/17.[3]

6. In order to address this increase in demand, Welsh Emergency Departments require a workforce of sufficient size and with the necessary number of senior decision makers to treat patients effectively and in a timely fashion.

7. However, although there were considerable increases in the A&E workforce between 2010 and 2013, since then that progress has stalled. Between 2013 and 2015 the workforce expanded by no more than 0.28%, despite the growing and ageing population.

8. Moreover from 2013-14 the number of consultants per attendance has deteriorated. This has gone from one to every 11,575 attendance in 2013-14 to one to every 12,230 in 2014-15. This echoes our wider concerns about on-going difficulty recruiting staff to support the speciality in Wales. (See the figures below.)[4]

Staff Category	2010	2011	2012	2013	2014	2015	% Change since 2010	% Change since 2013
All Grades	260.19	274.29	263.42	287.28	286.03	288.08	9.68	0.28
Consultant	49.00	53.50	54.60	61.20	66.80	63.20	22.47	3.16
Specialty Doctor	28.30	36.45	43.20	39.30	45.60	47.85	40.86	17.87
Staff Grade	3.10	2.10	1.00	1.00	1.00	1.00	-210.00	0.00
Associate Specialist	20.72	17.52	17.50	15.86	12.50	11.50	-80.18	-37.94
Foundation House Officer 2	55.00	51.00	51.00	52.00	58.00	50.00	-10.00	-4.00
Foundation House Officer 1	14.00	12.00	15.00	12.00	12.00	14.00	0.00	14.29

[3] Stats Wales Performance against 4 hour waiting times target by major hospital and NHS Wales Informatics Service Monthly Accident and Emergency Report - After April 2013
[4] Stats Wales Medical and dental staff by grade and year

9. There are plans in all Welsh Emergency Departments to increase the number of Consultants and future models estimate that a minimum of 100 Emergency Medicine Consultants will be required within the next six years.

10. However, around 15-20 of the current 65 substantive Emergency Medicine Consultants working in the 13 Welsh A&E's are planning to retire within the next few years. This means that Health Boards will be required to at least double current consultant numbers to meet demand.

11. Furthermore, many junior doctors working within emergency medicine are not necessarily training to qualify in that speciality. Indeed, out of the current 91 junior grade training posts in Wales, 41 places are occupied by F2 doctors, 39 by GP trainees and only 11 places are taken up by doctors who wish to train in emergency medicine.

12. In short, supply is not keeping pace with demand. If decisions about the recruitment and retention of A&E staff do not accurately reflect the nature of demand then performance cannot reasonably be expected to improve, the morale of staff will inevitably decline and the health and wellbeing of Wales' population could be compromised.

Views on: The implications of Brexit for the medical workforce.

13. The decision to leave the EU could have a significant impact on health and social care in Wales.

14. According to the Nuffield Trust, 10% of doctors and 4% of nurses are from the EU and are working in the UK. Data also shows that around 6% of doctors working in Wales were trained in another EU country.[5]

15. The huge contribution made of staff trained outside the UK who now work in the health and social care sectors in Wales is beyond doubt. Without more non-UK nationals joining the NHS, the health and social care systems will struggle to function as our current workforce, as evidenced above, is insufficient to meet increasing demand.

16. Moreover, the volatile Pound Stirling could make competitive salaries more unattractive in the UK compared to other EU nations, especially given the UK's average salary only ranked 10th out of the 28 EU countries.[6] Since the Brexit vote, the value of the Pound has dropped by c.16% compared to the Dollar and c.6% compared to the

[5] Nuffield Trust Fact Check: migration and NHS staff and Stock of doctors by country of first qualification
[6] Average Salary in European Union 2016

Euro. The uncertainty of when the Pound might recover might also play a part in dissuading healthcare professionals from immigrating to the UK.

17. Therefore, we strongly agree with the message Vaughan Gething AM and many others have sent in stressing how much we value all of our staff who have moved from other countries to work in the NHS. RCEM Wales believes that EU staff need to be further reassured of their value. We must also continue to attract vital medical professionals from the EU and around the world as the current system cannot be sustained if workforce and trainee numbers do not increase.

Views on: The factors that influence the recruitment and retention of doctors.

18. Whilst emergency medicine training posts at year one (ST1) have a 100% fill rate in Wales, only 61% of higher specialist training posts in Emergency Medicine are being filled.[7] This, coupled with existing vacancies, means that the current emergency medicine workforce remains significantly short at 44% of the baseline recommendations advocated by the College.

19. Paradoxically, there are not enough ST1 training posts available for the increasing demand.

20. There is also a real and current issue that more of our NHS staff are emigrating to work abroad. This is due to dissatisfaction caused by working in understaffed and under-resourced A&E departments and the attraction of more lucrative work outside the UK.

21. The figures shown below, for instance, give a snapshot of the varying workloads of A&E consultants around the globe by estimating the average number of patients one emergency medicine specialist treats on one day.

1 A&E Consultant	Estimated number of patients 1 Consultant treats per day
Canada[8]	34
Wales	33
Italy[9]	29
Australia	18
New Zealand[10]	12

[7] RCEM Essential facts regarding A&E Services in Wales
[8] Canadian Institute for Health Information Emergency Department Visits in 2014-2015 and Canadian Medical Association Emergency Medicine Profile
[9] NCIB Paediatric emergency room activities in Italy: a national survey and Eurostat Physicians by medical speciality
[10] ACEM Specialist Emergency Medicine Workforce and Ministry of Health Emergency department use 2014/15

22. There were around 768,000 patient attendances to major A&Es in 2015.[11] These cases were dealt with by 63 A&E Consultants. Therefore, each doctor would see an average of 33 patients per day with varying levels of need, as shown above.

23. By comparison, in Australia in 2014-15, there were almost 7.4 million emergency department attendances in public hospitals: around 20,000 presentations per day. There are an estimated 1132 emergency specialists in the Country.[12] This equates to around 18 cases per doctor each day. Therefore, A&E consultants in Wales have a 46% higher workload than their Australian counterparts.

24. Inexorably rising workloads increasingly mean that NHS staff on the front-line of services are more likely to suffer from burn-out and stress. Indeed, across the UK health system, over 60% of the current consultant workforce reported that their job was not sustainable in its current form.[13]

25. Furthermore, the average basic salary of an emergency medicine specialist also varies considerably between English speaking countries.

26. NHS Consultants can earn a basic salary of between £75,249 and £101,453 per year. This is similar to emergency medicine specialists in Canada who earn on average £111,200.[14] However, salaries can be more attractive elsewhere. For consultants in New Zealand, average salaries will range from approximately £118,550 to £177,830 which is around 43% greater that the UK's highest basic salary for A&E Consultants.[15]

[11] Stats Wales, Performance against 4 hour waiting times target by major hospital
[12] Australian Government, Medical workforce 2012 and Australia's hospitals 2014-15
[13] RCEM Stretched to the limit
[14] Physician / Doctor, Emergency Room (ER) Salary (Canada)
[15] NZ Doctors' Guide

27. In addition, 'Out of Hours' working is currently recognised by paying doctors the same sum for working 1am to 4am on a Sunday night as they receive for working 1pm to 5pm on a weekday afternoon.[16] In Australia, basic salary assumes a working week of 38 hours. After this, staff are paid approximately 15-25% higher than their basic salaries for all overtime and on call work.[17]

28. When considering the factors that influence the recruitment and retention of doctors, the location of departments can also be crucial in determining their popularity, especially with younger trainees.

29. As a primarily rural country, some emergency departments experience recruitment challenges due to its remote location. This is seen in Mid Wales where public transport systems are less robust and travel times to major Cities are longer. Therefore, these departments need to offer other incentives, for example, competitive salaries, to lure staff.

30. However, it is important to note that A&E medical staff who train in Wales tend to choose Wales to live and work – around two thirds of current substantive ED Consultants were trained in Wales. This is in part due to the relative affordability of Wales and also because, according to the GMC National Training Survey 2016, Wales' emergency medicine training services scored three "above outliers", or examples of excellence. On this basis, if more training places were made available, retention rates should rise.

Views on: The development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere.

31. RCEM Wales supports new initiatives that will entice people into the emergency medicine speciality in Wales.

32. One such new initiative is the Emergency Medical Retrieval & Transfer Service (EMRTS Cymru) which has the potential to support recruitment into Wales if sessions with the Service were offered as a supplementary part of training.

33. Cardiff University will also be hosting an intercalated BSC in Emergency Medicine to help attract undergraduate trainees into a future career in Emergency Medicine.

34. Furthermore, emergency medicine consultants are looking at other staffing models which strengthen the workforce and help with resilience and retention of staff.

[16] NHS Consultant Contract Terms and Conditions
[17] Salaries In Australia

Advanced Nurse Practitioners (ANPs), for example, have recently been introduced in some areas and work as non-medical practitioners to support emergency medicine staff.

35. Recently, a developmental programme has also been introduced in Wales to train more Emergency Nurse Practitioners (ENPs). However, the scope of ENP Minor Injury practice is limited and whilst the regional programme is welcomed, the numbers on the programme are very small. Currently there are only 13 ENPs in the programme.

Conclusions and Recommendations

36. There are too few senior and Middle Grade medical staff in A&E departments to deliver effective and efficient care alongside too little training places.

37. Government and NHS Wales providers need to ensure that more trainee places are made available to fill the current workforce spaces and to also keep up with demand. To achieve seven day coverage of EM consultants between 8am and midnight, the College believes that a minimum of 10 whole time equivalent consultants in each ED is required, rising to 16 or more in larger units.[18]

38. Both current staff and future trainees, from the UK, EU and beyond, need to be valued and supported. Without their support, we will not be able to staff the consultant posts for the future or continue to deliver the invaluable services that are already under significant pressure.

39. The College continues to call for safe and sustainable staffing of all Welsh emergency departments. We must ensure that the working environment, shift patterns, competitive salaries and work-life balance promote rather than discourage recruitment and retention. This would mitigate the attraction of more lucrative work offered by other countries, decrease staff burn-out rates and would also improve patient satisfaction.

RCEM Wales has been campaigning for some time for the reform of emergency medicine around the elements of our STEP campaign. If acted upon this would ensure that A&E were properly staffed and resourced and improve services for patients in need. Details of that campaign can be found here.

[18] RCEM Wales STEP Campaign

MR 16
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Awen Iorwerth
Response from: Awen Iorwerth

Ymgynghoriad recriwtio meddygol Tachwedd 2016

Awen Iorwerth
Llawfeddyg Trawma ac Orthopaedic, Ysbyty Brenhinol Morgannwg
Cyfarwyddwr Rhaglen Hyfforddi LLawfeddygaeth Crai Cymru
Darlithydd Clinigol Coleg Cymraeg yn Ysgol Meddygol Prifysgol Caerdydd

1. Dewis Gyrfa

a. CYDWEITHIO

i. Ers tro, mae'r pwyslais wedi bod ar roi gwybodaeth ac annog disgyblion blwyddyn 11 ac ymlaen i ddewis meddygaeth a mae sawl asiantaeth a nifer o unigolion wedi bod yn gweithio yn annibynnol mewn ysgolion.
ii. Rhaid cyfuno ymdrechion y byrddau iechyd, prifysgolion, y Coleg Cymraeg, BMA, Colegau Brenhinol ayb. Bydd hyn yn sicr yn arbed arian a rhoi cyfle i ddatblygu adnoddau defnyddiol. Bydd hyn hefyd yn golygu nad ydi ysgolion yn cael eu llethu gan ormod o ddigwyddiadau sydd yn gwrthddweud eu gilydd. Bydd y meddygon a'r asiantaethau yn siarad a'r un neges. Bydd dim gofyn i'r un meddygon fynd i sawl digwyddiad gan achosi dadymafael y rhai sydd yn holl bwysig i ysbrydoli'r genhedlaeth nesaf.
iii. Rhaid cefnogi'r gwasanaeth gyrfaeodd mewn ysgolion – gan roi un pwynt cyswllt am wybodaeth, nid dim ond dibynnu ar rieni cymwynasgar neu ar feddygon lleol sydd wedi ymddeol.

b. YSGOLION CYNRADD

i. Rhaid cyflwyno meddygaeth fel gyrfa bosibl o oedran ysgol gynradd.

ii. Mewn ardaloedd lle nad oes ysbyty na meddygon yn byw yn lleol yn enwedig, mae'n hollbwysig cyflwyno delfrydau ymddwyn ar bwrpas i'r oedran ifanc yma gan na ddown ar draws neb fel arall.

iii. Gellid gwneud hyn drwy gysylltu gyda'r prifysgolion fel bod myfyrwyr sydd ar leoliadau ar hyd a lled Cymru yn ymweld yn rheolaidd fel rhan o'u cwrs.

c. BLWYDDYN 9 YMLAEN

i. Mae'n bwysig rhoi gwybodaeth i ddisgyblion blwyddyn 9 pa bynciau i ddewis ar gyfer eu TGAU a beth yw'r graddau gofynnol. Mae wedi hynny yn rhy hwyr.

ii. Unwaith eto, mae'n holl bwysig bod y disgyblion yn cael delfrydau ymddwyn a phwynt cyswllt. Gallwn ddefnyddio myfyrwyr ar leoliadau neu feddygon ifanc mewn system reolaidd, drefnus i gysylltu a PHOB ysgol.

iii. Mae Cemeg yn bwnc sydd yn cael ei ddysgu'n wael yng Nghymru ac mae'n ofynnol i wneud meddygaeth. Felly, mae angen edrych ar safon y gwaith yma a sut ellid ei wella yng Nghymru – neu bod gradd yn is yn y pwnc yma yn dderbyniol gan ddisgyblion Cymru.

iv. Rhaid derbyn bod gan y Gymraeg a Saesneg statws cyfartal a bod TGAU yn y Gymraeg gyfwerth a Saesneg.

v. Rhaid cael consensws ar ba fath o brofiad gwaith sydd yn dderbyniol yn yr oedran yma – dydy profiad meddygol uniongyrchol ddim yn bosibl mewn sawl ardal o Gymru.

vi. Rhaid comisiynnu ymchwil ffurfiol i'r rhesymau pam nad ydi disgyblion yr oedran yma yng Nghymru yn dewis meddygaeth fel gyrfa pan mae yna sefydlogrwydd gwaith am oes yn ardal eu mebyd a ledlyd y byd wrth ddewis hyn.

vii. Rhaid i ysgolion gefnogi dyheadau eu disgyblion a'u hannog. Mae'r gefnogaeth ddilychwin yma yn hanfodol.

ch. CHWECHED DOSBARTH

i. Nid egluro beth ydi meddygaeth ddylai fod y ffocws erbyn yr oedran yma ond hyfforddiant i gael eu derbyn mewn i ysgol meddygol.

ii. Mae Cemeg yn bwnc sydd yn cael ei ddysgu'n wael yng Nghymru ac mae'n ofynnol i wneud meddygaeth. Felly mae angen edrych ar safon y gwaith yma a sut ellid ei wella yng Nghymru – neu bod gradd yn is yn y pwnc yma yn dderbyniol gan ddisgyblion Cymru.

iii. Dylai'r Bagloriaeth Gymraeg gael ei derbyn yn gyfartal a lefel A.

iv. Ar hyn o bryd, mae gwasanaeth gwych ar gael gan adran Olraddedig Ysbyty Gwynedd lle mae disgyblion lleol yn cael ymarfer cyflwyno, cyfweliad, profiad gwaith. Dyliai'r patrwm yma gael ei ddilyn ar draws Cymru.

v. Rhaid comisiynu ymchwil ffurfiol i weld i ble mae'r disbyglion fyddai flynyddoedd yn ol yng Nghymru, neu yn gyfredol yn Lloegr, yn astudio meddygaeth yn mynd? Ydyn nhw'n aros yng Nghymru I astudio rhywbeth arall? Neu ydyn nhw yn gadael Cymru'n llwyr? Ydyn nhw'n dod yn ol byth?

Hyfforddiant

a. YSGOL MEDDYGOL

i. Mae angen i bob Ysgol Meddygol yng Nghymru dderbyn eu bod yn rhan o gynllun hirdymor y gweithlu gwasanaeth iechyd YNG NGHYMRU.

ii. Rhaid ystyried cwotau o fyfyrwyr o Gymru, yn union fel y mae ysgolion meddygol yr Alban yn ei wneud.

iii. Os na, rhaid ystyried, gostwng y graddau derbyniol i fyfyrwyr o Gymru yn enwedig mewn Cemeg.

iv. Rhaid ystyried rhoi pwynt ychwanegol am TGAU Cymraeg (iaith gyntaf neu ddysgwyr) i fanteisio disgyblion Cymru. Gall hyn gael y fantais o ddisgyblion o lefydd eraill ym Mhrydain yn cymryd TGAU Cymraeg er mwyn cael pwynt ychwanegol.

v. Rhaid ystyried rhoi pwynt ychwanegol am Fagloriaeth Cymreig. Gall hyn gael y fantais o roi statws uwch I'r cymwyster yma.

vi. Rhaid i'r ysgolion meddygol sylweddoli mai dim ond dwy ysgol feddygol ym Mhrydain sydd yn cynnig addysg drwy gyfrwng y Gymraeg felly mae'n hollbwysig bod y rhai sydd yn cael y gofynion yn cael cynnig lle os ydynt yn dymuno astudio'n Gymraeg. Fel arall, maent o dan anfantais.

vii. Rhaid bod tim derbyniadau ysgolion meddygol yn cael hyfforddiant mewn ymybyddiaeth o'r Gymraeg.

viii. Rhaid bod systemau derbyn yr ysgolion meddygol yn safonol. Does dim lle i'r system hen ffasiwn o dderbyn darpar fyfyrwyr ar fympwy un aelod o staff. Mae hyn yn rhoi lle i resymau hiliol neu ddiwyllianol gael eu defnyddio i wrthod llefydd i ddarpar fyfyrwyr gwych.

ix. Rhaid cynnig cyfweliadau yn Gymraeg.

x. Rhaid cael rhestr gynhwysfawr o feddygon ar draws Cymru sydd yn siarad Cymraeg y gellid cysylltu a nhw i helpu gyda'r broses o gyfweld arholi ac addysgu.

xi. Rhaid gwneud cwrs ymwybyddiaeth o'r Gymraeg yn orfodol i fyfyrwyr meddygol yng Nghymru.

xii. Rhaid defnyddio'r gwasanaeth iechyd ar draws Cymru i hyfforddi'r meddygon ifanc. Os ydynt wedi bod mewn ardal wledig tra'n hyfforddi, maent yn fwy tebygol o fynd yn ol yno i weithio.

b. OL-RADD

i. Rhaid i ddeoniaeth Cymru ei bod yn hyfforddi meddygon i Gymru a chael gwared o'r agwedd wrth-Gymreig.

ii. Rhaid sylweddoli bod ein pobl ifanc yn dra-gwahanol i'r cenedlaethau o feddygon a fu.Dydyn nhw ddim yn fodlon symud o le i le yn ystod eu hyfforddiant.

iii. Maent yn dewis sefydlogrwydd lleoliad yn hytrach na arbenigedd bellach. Gall y ffaith yma fod o ddefnydd i ni fel gwlad fel y gallwn gynnig hyfforddiant arbenigol mewn ardal gyfyng. Yr hiraf y maent mewn un ardal, y mwyaf tebygol y maent o aros yno yn hir-dymor.

iv. Mae meddygon sail (foundation doctors) yn cael cynnig llety am ddim mewn rhai mannau. Mae hyn yn sicr yn ddeiniadol iawn i feddygon ifanc sydd yn gadael y brifsygol gyda dyledion enfawr. Beth am ymestyn y cynnig hyn I'r blynyddoedd sail hefyd (core)? Y tebyg ydi na fyddai pawb yn ei gymryd ond byddai'n sicr yn syniad I'r llefydd sydd yn ei chael yn anodd recriwtio.

v. Mae oriau anghymdeithasol y meddygon ifanc hefyd yn ei gwneud hi'n llai tebygol iddynt dderbyn swyddi neu lleoliad

mewn cylchdroad ymhell o gymar felly beth am gynnig swyddi ‘dwbl’ i feddygon ifanc?

vi. Y mwyaf o gefnogaeth y caiff y meddygon ifanc yn gynnar yn eu gyrfa, y mwyaf tebygol ydynt o aros yn yr ardal honno.

vii. Felly beth am gynnig y cyrsiau hanfodol iddynt gymwyso yn ei arbenigedd ddewisol i gyd am ddim yng Nghymru? Mae mil o bunnau i feddyg ifanc a dyledion yn ddrud iawn i dalu am gwrs neu arholiad gorfodol – ond hyn mae byrddau iechyd yn ei dalu i un meddyg locum am un shift yn aml. Faint o arian sydd wedi ei wario ar locums ar draws Cymru yn ddiweddar allai fod wedi ei wario ar arholiadau a chyrsiau a llawer o ewyllys da?

viii. Yn olaf, mae’n rhaid cael sefydlogrwydd a chynllun hirdymor i’r gwasanaeth iechyd yng Nghymru. Mae’n anodd recriwtio heb gynllun penodol o beth fydd I’w ddisgwyl yn y degawd nesaf ac os bydd swydd briodol at ddiwedd hyfforddiant.

Mae cyfyngiadau ar y ddogfen hon

MR 17
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Iechyd Cyhoeddus Cymru
Response from: Public Health Wales

Response to the Health, Social Care and Sport Committee Inquiry into Medical Recruitment	
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Our Reference: PRID/C/018	

Public Health Wales welcomes the opportunity to share views towards this inquiry.

In relation to **the capacity of the medical workforce to meet future population needs, in the context of changes to the delivery of services and the development of new models of care**, Public Health Wales has seen a change in demands placed on Consultant Microbiologists (move towards a more clinical infectious disease role), coupled with a shortfall in experienced consultant staff, the latter due to transition in response to curriculum and training changes (national issue) and staff age profile and retirement (Wales and nationally). This presents both a risk and an opportunity. The opportunities include development of new roles for biomedical scientists and establishing a clinical scientific interface around infection management in which non-medical staff provide more specialist technical advice.

The Screening Division of Public Health Wales directly employs Consultant Breast Radiologists and Speciality Doctors, and also relies on doctors in particular specialities (pathology, radiology, gastroenterology, breast surgery and paediatric audiology) to deliver the diagnostic elements of our screening programmes. Breast radiology and histopathology in particular are facing significant shortfalls in staff, with little prospect of increased recruitment in the near future.

Regarding **the implications of Brexit for the medical workforce**, the full impact of Brexit for the medical workforce remains to be seen and will only become clearer as the details of the UK's exit plan from the EU become evident.

However we need to ensure that we are able to attract candidates with the right knowledge and experience to fill the roles we have available, and some of these candidates may be outside the UK. Public Health Wales also has a range of links with EU bodies or EU funded agencies and will be anxious to secure these relationships post Brexit.

On **the factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas**, Public Health Wales experiences difficulty recruiting within the speciality of Microbiology and in particular Consultant Microbiologists. Appointing to

posts within the speciality has become a key concern for the organisation and at the time of writing (November 2016), there were advertisements for 5 Consultant Microbiologist posts live (3 for North Wales and 2 for South/West Wales) in an established workforce of 30 Consultant Microbiologists.

With all consultant appointments being advertised through the BMJ, Public Health Wales contacted the BMJ directly to ascertain how many Consultants are registered with them as having an interest / experience of working within the speciality of Microbiology, who were either actively or passively interested in knowing about vacancies within the specialism of Consultant Microbiology.

The BMJ advised that their records indicated that the potential interest in Microbiology Consultant posts (as held by their records) could reach an audience of 112 potential candidates across the UK (as at June 2016).

In Breast Test Wales, we rely increasingly heavily on Speciality Doctors to maintain service continuity, as we have been unable to appoint breast radiologists. Recent recruitments to the Speciality Grade have attracted able candidates who have declined appointments as the entry level of the Speciality payscale is unattractive.

The ability to offer a recruitment premium for the posts just described would be welcomed.

Regarding the point on **the development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere,** as an organisation, Public Health Wales like many organisations utilise the NHS jobs portal and publishing adverts in the BMJ for Consultant opportunities.

To broaden the scope further, for a campaign which ran in June 2016, Public Health Wales developed a one off Microsite/landing page which was posted on the web. The intention of the page was to provide prospective candidates (i) the nature and details about the posts and Microbiology, (ii) what the organisation had to offer and (iii) what the country of Wales could offer them as an employment and living opportunity. http://www.phwmicrobiologyconsultants.co.uk/working--living-in-wales.html

In addition to the standard BMJ advert, Public Health Wales gained information from the BMJ that 112 Consultants are registered with them as holding an interest in the specialism of Microbiology. A specific 'mail drop' targeting all potential 112 Consultants was arranged and distributed at extra cost by the BMJ.

Public Health Wales promoted the Microsite/landing page further by utilising professional social media in the form of LinkedIn. This approach widened the scope of the campaign and reached out to as many professionals within the NHS as possible through our own organisational social media network and that of our followers networks.

As an organisation, we are also looking at further initiatives to engage Consultants which include a dedicated named staff member who can create dialogue, follow up applicant queries, and more specific emailed information to candidates, in effect offering a more dedicated and tailored approach to the recruitment process.

Going forward the organisation is now beginning to review potential careers fairs / conferences where Public Health Wales can exhibit employment opportunities for future workforce needs.

Finally, regarding **the extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce**, Public Health Wales employs 110 consultants and there is a dedicated Medical Workforce staffing employee who manages up to a maximum of 4 vacancies for the organisation a month. The process of joined-up vacancies is therefore reviewed continuously to avoid duplication and enhance campaigns where possible.

Breast Test Wales employs several Breast Radiologists and recruitment of speciality doctors is undertaken jointly with Health Boards, with the lead being taken by the organisation with the higher number of sessions identified in the individual job plan.

Public Health Wales is of course happy to assist the committee's inquiry going forward.

MR 18
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Cymdeithas Fferyllol Frenhinol
Response from: Royal Pharmaceutical Society

Dear Sir / Madam

RE: Inquiry into medical recruitment

The Royal Pharmaceutical Society (RPS) Wales welcomes the opportunity to respond to the Inquiry into medical recruitment.

We strongly believe that a holistic approach to recruitment and workforce planning is needed for healthcare, taking into account the contributions of all professional groups across primary, secondary and tertiary care in Wales. It is vital that patients are supported by the right healthcare professional with the right skills and knowledge at the right time. We believe community pharmacists, primary care pharmacists, specialist clinical pharmacists and consultant pharmacists provide opportunities across the care pathway and are a key part of turning prudent healthcare principles into reality. The Welsh Government's national plan for primary care already refers to using the skills and expertise of the wider primary care team, including pharmacists.

We are supportive of the need to ensure a strong and sustainable medical workforce and believe that a coherent workforce strategy including all healthcare professions across all sectors should be developed. This would ensure all professionals are working at the top of their registration – a key aspiration in the Governments primary care plan and one we believe should apply equally to all sectors. We believe that workforce and recruitment strategy should be based on data that takes account the current and future need of the health care workforce and take into account new models including the roles of specialist and consultant pharmacists to provide care traditionally provided by medical consultants.

The pharmacy profession makes a significant and unique contribution to the healthcare of the people of Wales. As the third largest professional group in the NHS there is increasing recognition of the benefits of extended clinical roles for pharmacists and medicines management roles for pharmacy technicians. Their inclusion in primary and secondary care multi-disciplinary teams acts as an enabler and catalyst to ensuring better patient care. With this inclusion comes the requirement for increased multiprofessional team working.

We believe that pharmacists should be an integral part of referral systems within the multidisciplinary team, being referred to for common ailments, medicines advice and long term conditions support as well as signposting and referring directly to other health and social care professionals. Medicines are the most common interventions in the NHS today. It is essential for patients that their medicines and pharmaceutical needs are overseen and coordinated at all points of the health and social care pathway to ensure they can benefit from their medicines and suffer no harm. Direct referral arrangements would allow GPs to focus on diagnosing and more complex conditions. This would also ensure the patient journey is streamlined, reducing duplication and improving cost effectiveness and efficiency of services.

Community pharmacies in Wales should be fully integrated with GPs and hospitals, treating and caring for patients across the care pathway and in the context of their daily lives. The Welsh Government's Efficiency Through Technology Fund investment in choose pharmacy provides a significant opportunity to deliver greater integration of the pharmacy profession into models of care. The IT platform which allows community pharmacists access to appropriate parts of the Welsh GP patient records has the potential to allow pharmacists to play a greater role in patient facing care. We hope that this investment will be fully utilized with the development of more services through community pharmacy to better support patients with their medication and health needs. By focusing on the medication management of long term conditions for example, the pharmacy profession can help to ease pressures on other primary care professionals, including GPs. In order to make prudent healthcare happen in Wales it is essential that our highly-educated and skilled health professionals are used appropriately, spending

time on work that cannot be undertaken by other, less expensive members of staff.

The development of 64 cluster networks, tasked with ensuring that the health and social care needs of their local population are met, provides new opportunities to think differently about how health and social care is delivered in Wales. Many of the clusters have funded new clinical roles for pharmacists to work alongside their doctor and nurse colleagues in general practice. These new models not only provide new opportunities for patient to be supported but also new ways of working for healthcare professionals which could be very appealing in the recruitment of GPs, knowing that they will have the opportunity to work in a multidisciplinary team, where they will have the capacity to focus on what only they can do.

There is currently a lack of multi-disciplinary educational funds to facilitate learning programs across healthcare teams which we envisage would encourage multidisciplinary working. We appreciate current educational funding streams from WEDS are available but are concerned these are only accessible by the managed hospital sector for both pharmacists and pharmacy technicians and there is no investment in up-skilling the community pharmacy team to enable new professional services to be offered to patients. We are also concerned that primary care clusters are not releasing educational funds to pharmacy. We recommend that either a directive to ring fence monies or to re-allocate the funds to WEDS or a similar body would provide a helpful solution to enable the pharmacy team to be incorporated into funding streams for multidisciplinary training. GPs and pharmacists must be given the opportunity to develop specialisms that support the complexity of conditions within their clusters. There is currently no central funding for foundation programmes for community pharmacists to further develop their skills and to provide protected time to support community pharmacists in offering new clinical services for patients.

We are supportive of new and innovative approaches to attract high calibre healthcare professionals to Wales and feel that this should be done on a multidisciplinary basis. As with other professions, pharmacy also faces recruitment challenges, particularly in rural and deprived areas of Wales and have relied on European pharmacists to fill this gap. We are concerned that

the Brexit process may have an adverse effect on recruiting from Europe in the future.

I trust this information is helpful. Please do not hesitate to get in touch if you require any further information.

Yours sincerely

Suzanne Scott-Thomas, Chair, Welsh Pharmacy Board

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

MR 19
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Bliss
Response from: Bliss

Bliss submission to Health, social care and sport committee inquiry into medical recruitment
November 2016

About Bliss
Bliss is the UK charity dedicated to ensuring that premature and sick babies survive and go on to have the best possible quality of life. We provide information and support to families, work with doctors and nurses to ensure the very best care is given to babies, and campaign for essential change within government and the NHS.

Introduction

1. Over 2,700 babies are born in Wales each year who need specialist neonatal care.[i] [ii] That means one in 12 of all babies born is admitted to neonatal care because they are premature or sick.[iii]

2. Many of these babies will grow up with no ongoing health conditions, but some children will face a range of health complications in later life.[iv] The care that these babies receive while in hospital is crucial for both their survival and their long-term quality of life.

3. However, recent research by Bliss, outlined in the *Bliss baby report 2016: time to change* published in July 2016, shows that many neonatal services in Wales do not have the medical and other key staff they need to provide safe, high quality care in line with national guidelines. The findings set out in this report are based on a survey of all 11 units across Wales conducted in November 2015 – all of which responded. Unless otherwise stated this report is the source of the statistics used in this submission.

4. Premature and sick babies are currently cared for in 11 neonatal units across Wales.[v] The service provided across these units is co-ordinated by the Wales Neonatal Network which advises Health Boards and works with units and neonatal transport services to ensure that babies receive the care they need, as close to home as possible.

5. Neonatal units must have the right mix of medical staff to safely manage babies' care. It is very important that guidelines on the minimum number of medical staff are met. There are fewer medical staff than nurses working on neonatal units, so even one or two gaps on a medical rota can have a big impact on babies' care and how well the unit runs.

6. The British Association of Perinatal Medicine (BAPM) *Service standards* set out guidelines for the minimum number of medical staff needed at each level of seniority.

Shortfall in medical staff

7. Over half of neonatal units, including two out of three local neonatal units and four out of five special care baby units, did not have enough medical staff to meet minimum standards for safe, high quality care. This could underestimate the scale of the problem, as some units may need staff in addition to the minimum requirements, depending on the demands of the service.

8. Six units did not have enough tier three (expert) staff members and five of these units also did not have enough tier two (middle grade) staff members. One unit did not have enough tier one (junior) staff on its medical rota.

9. This means that half of the neonatal units in Wales do not have the expert and middle grade medical staff they need to be able to meet minimum standards for quality and safety. These shortages are at more than one level of seniority which could make it especially difficult for units to cope and to provide a safe level of care.

10. Local neonatal units should have tier one (junior) staff whose time is dedicated to the neonatal unit, ensuring that they can focus on babies in neonatal care rather than dividing their attention with other paediatric patients. However, only one local neonatal unit had a tier one rota that was fully dedicated to neonatal care. One local neonatal unit had a partially dedicated tier one rota, but staff shared their time with general paediatric care during nights and weekends. The tier one staff at another local neonatal unit did not have any of their time dedicated to the neonatal service at all.

Funding

11. An important factor causing the shortfalls in medical staff is that neonatal units in Wales are often not funded to recruit the doctors and advanced neonatal nurse practitioners that they need. Even if all medical vacancies were filled at the six units unable to meet minimum standards on medical staffing levels, four units would still not have had enough medical staff in place during 2014/15 to meet minimum standards for safe, high quality care.

Recruitment

12. Another substantial barrier to achieving the right staffing levels is that neonatal units in Wales struggle to recruit the medical staff they need to provide a safe level of care. Eight out of 11 units reported at least one unfilled medical vacancy, with tier one (junior) and tier two (middle grade) medical posts particularly difficult to fill.

13. The 2014/15 Royal College of Paediatrics and Child Health (RCPCH) workforce survey also found that there were a very high number of vacancies in neonatal and paediatric inpatient services in Wales, at 28 per cent for tier two (middle grade) rotas.[vi] Wales also had a comparatively low rate of locum cover, with only 16 per cent of vacancies being filled by locums.[vii] This suggests that it is very difficult for many Welsh units to cope with rota gaps by finding locums to take on shifts, leaving them short-staffed on a day-to-day basis.

14. There are many possible reasons for these shortages. For example, there are a limited number of medical training places available

due to long-term workforce planning considerations about the number of consultants that will be needed in the future. This issue will become more acute in September 2016, as one of the three neonatal intensive care units in Wales will no longer be a training centre. This means that it will have to fill its medical rota entirely without medical trainees.

15. Another factor is that paediatric medicine, which includes neonatal medicine, has high numbers of international medical graduates so visa restrictions on international workers may be having an impact on medical recruitment in neonatal care.[viii]

16. Finally, nurse staffing shortages and barriers to training also make it difficult for units to fill medical rota gaps with advanced neonatal nurse practitioners.

17. This combination of factors has left many neonatal units struggling to meet minimum requirements for medical staffing. This is an urgent problem and a long-term challenge for many neonatal units and the babies they look after. In recent years, Health Boards across Wales have undertaken reviews of neonatal care and other hospital services with a view to making the staffing of services more sustainable. It is vital that the Welsh Government and Health Boards now commit to making sure that all units are appropriately staffed to meet national standards and ensure the safe care of babies. This will require investment and a commitment to ongoing collaborative workforce planning.

18. Quotes from health professionals:

"There are insufficient doctors on the training scheme to fill the posts, and that is across specialties, including neonates. It is even harder to fill the non-training posts – most of these are with doctors from outside of the UK." (Consultant Neonatologist)

"There is huge pressure as there are gaps in the tier two rota. The posts are not filled by the deanery and there are not enough non-training doctors around." (Senior Nurse)

"The shortage of junior doctors (trainees and specialty doctors – we have a shortage of both!) is a great concern." (Consultant Neonatologist)

For further information please contact Helen Kirrane, Campaigns and Policy Manager, t: 020 7378 5742 e: helenk@bliss.org.uk

References

[i] Wales Neonatal Network (2014) *Annual Report 2014: Report on achievements, transport, staffing, activity and outcomes*, p.25

[ii] Admissions data for 2014 provided by the Neonatal Data Analysis Unit

[iii] There were 33,648 live births in 2014 to Welsh residents: Statistics for Wales (2015) *Births in Wales 2004 - 2014: Data from the National Community Child Health Database*

[iv] For example, children born extremely prematurely are more likely than other children to have cerebral palsy, learning difficulties, behavioural problems and breathing difficulties. More information available at: epicure.ac.uk/overview/main-challenges

[v] The number of hospitals providing neonatal care in Wales will be reduced to nine following implementation of the South Wales Programme, which looked at the safety and sustainability of a range of services: wales.nhs.uk/sitesplus/documents/1077/Final%20Report%20of%20the%20South%20Wales%20Programme%20Board%204%20February%2020141.pdf

[vi] Royal College of Paediatrics and Child Health (2015) *Rota vacancies and compliance survey: Winter 2014/15*

[vii] RCPCH (2015)

[viii] General Medical Council (2014) *The state of medical education and practice in the UK 2014*, p.53

MR 20

Ymchwiliad i recriwtio meddygol

Inquiry into medical recruitment

Ymateb gan: Cymdeithas Feddygol Prydain (Cymru)

Response from: British Medical Association (Wales)

INQUIRY INTO MEDICAL RECRUITMENT

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

Response from BMA Cymru Wales

18 November 2016

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the Health, Social Care and Sport Committee into medical recruitment.

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 almost 8,000 members in Wales from every branch of the medical profession.

RESPONSE

We note that this short, focussed inquiry into medical recruitment forms part of the Health, Social Care and Sport Committee's wider programme of work on the sustainability of the health and social care workforce. Committee members will be aware that BMA Cymru Wales has already submitted written evidence to this wider inquiry,[1] and our submission already focussed primarily on the medical workforce.

This submission should therefore be read in conjunction with that earlier response, which in many ways forms the basis of our response to this new inquiry.

[1] https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/sustainability-of-workforce.pdf?la=en

In addressing this additional call for evidence, however, we have given consideration to the issues contained within the new inquiry's terms of reference and wish to submit some additional points for the Committee's consideration as follows:

The capacity of the medical workforce to meet future population needs, in the context of changes to the delivery of services and the development of new models of care:

A key point we would wish to highlight is the need for the development of a strategic vision for the NHS in Wales around which effective and sustainable workforce planning can be undertaken. Indeed a key finding of the 2015 report of the Welsh Government-commissioned *Health Professional Education Investment Review,*[2] carried out by a review panel chaired by Mel Evans, identified the need for '*a refreshed strategic vision for NHS Wales which provides the longer term context for shaping the workforce of the future*'. We would reiterate the point we have made previously that 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.

As we also outlined in our submission to the wider inquiry into the sustainability of the health and social care workforce, the capacity of the medical workforce is failing in many regards 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 acute recruitment and retention challenge 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

[2] 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

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.

As we referred to in our earlier response, Welsh vacancy rates have not been published officially since 2011. Data acquired through the use of Freedom of Information (FOI) requests by the BBC,[3] however, showed a vacancy rate of 7.8% for doctors in Welsh health boards in December 2015, having risen sharply over the preceding year, and with significant variation across health boards.

Through our own use of FOI requests, we have additionally collected data on locum consultant usage. These revealed that such usage equates to 7.5% of whole time equivalent (WTE) consultant posts. While there are issues around when and for how long locum use is the most cost-effective solution, this does suggest the true vacancy rate will be higher than the headline figures. The Welsh Government-commissioned *NHS Wales Workforce Review*[4] also confirmed this increase in locum use, with an increase in agency and locum spend (not just at consultant grade) of 62% in 2014-15 to a figure of £88 million. Moreover, there appears to have been a fall in the number of doctors per head in Wales to 2.8 per thousand population from 3.1 last year.

Within the last year, the BBC has also uncovered a 61% increased cost of overtime payments for consultants in Welsh hospitals over three years,[5] which reflects existing staff having to undertake additional work to cover for vacancies and rota gaps.

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 as demand for service provision increases.

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[3] BBC (2016) *NHS doctor vacancies are 7.8% in Wales*. Available at: http://www.bbc.co.uk/news/uk-wales-35686903

[4] 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

[5] BBC (2016) *Consultants' overtime costs soar in Welsh hospitals*, available at: http://www.bbc.co.uk/news/uk-wales-36895871

As we have already noted, an ageing population and an increasing prevalence of chronic disease are contributing to this increase in demand. Other factors that can also fuel increased demand include improvements in technology and the development of new treatments.

Other challenges can result from changes in the make-up of the workforce. For instance, the proportion of medical staff who are female has rightly been increasing. Whilst we would certainly view this as something to be celebrated, it does need to be recognised that female doctors are, quite reasonably, more likely to choose to take career breaks or work less than full time for family reasons. In addition we have previously suggested that work should 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. These factors mean that a greater number of doctors needs to be trained and/or recruited to maintain workforce provision.

The current age profile is also a cause for concern in regard to certain sections of the medical workforce where an increasing proportion are nearing retirement age. For instance, in 2014, 23.4% of Welsh GPs were aged 55 and over. Another example from secondary care can be found within the specialty of radiology. Figures recently published by the Royal College of Radiologists[6] suggest that around 30% of Welsh consultant radiologists will retire between 2015 and 2020, compared to a UK average of 20%. By the same token, 12% of current Welsh consultant radiologists are aged 60 or over, compared to an average of 8% across the UK as a whole.

BMA Cymru Wales believes there is a clear and immediate need to invest more into general practice in Wales. As we previously touched upon in our written evidence to the *NHS Wales Workforce Review* (which was attached as Appendix 1 to the evidence we submitted to the committee's wider inquiry into the sustainability of the health and social care

[6] Royal College of Radiology (2016) *Clinical* radiology UK workforce census 2015 report. Available at: https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr166_cr_census.pdf

workforce), the share of NHS Wales expenditure that is allocated to services within Welsh general practice commissioned through the General Medical Services (GMS) contract has dropped from 10.3% in 2007. The latest figures supplied to us by the Welsh Government shows that it now only constitutes 7.6% of expenditure on the NHS in Wales. This is despite the fact that the number of consultations within general practice has increased by around 20% over the same time period.

This failure to increase the funding going into Welsh general practice to match increasing demand is contributing to a substantial increase in workload for GPs in Wales. This is undoubtedly contributing to more Welsh GPs suffering from burnout and leaving the profession early, thereby placing further strain on the GP workforce. This, in turn, is impacting negatively on the attractiveness of general practice as a career choice for new trainees. The funding shortfall for general practice needs to be addressed as a matter of priority, in our view, if we are to stand a chance of breaking out of this cycle.

The implications of Brexit for the medical workforce:

The outcome of the referendum on the UK's membership of the EU has created great uncertainty for EU nationals currently living and working in the UK regarding their future status. Reassurance and clarity is vital, particularly in key public services such as the NHS, to aid workforce planning to and ensure safe staffing levels are maintained. While we acknowledge that the exact terms of the process by which the UK will depart the EU are unclear and may remain so for some time, it is vital that these individuals are offered the clarity and reassurance they deserve regarding their future status.

The UK's decision to leave the EU may also result in a domestic economic downturn, or in the very least, economic uncertainty. This in turn, is likely to reduce public spending in general and, specifically, the level of funding which is available to the NHS in Wales. This could clearly have an impact on staffing levels.

A significant number of EU nationals work in health and social care organisations across the UK, including here in Wales. The EU's policy of freedom of movement and mutual recognition of professional qualifications facilitates this, helping NHS organisations ensure gaps in the medical workforce are filled quickly by qualified workers with the appropriate level of training and education.

In 2014, more than 10,000 doctors working in the NHS across the UK (6.6% of the UK medical workforce) received their primary medical qualification in another European Economic Area (EEA) country with additional staff working in public health and academic medicine – these individuals are vital to our NHS and the health and success of the country.

The ongoing political uncertainty surrounding the future of EU nationals living and working in the UK will inevitably lead to some of these doctors choosing to leave. While we welcome comments from the UK Secretary of State for Health that the UK Government wants these doctors 'to be able to stay post-Brexit', governments must offer these highly skilled professionals the confirmation and reassurance they need regarding their rights to live and work in the UK. Specifically, we believe these highly skilled professionals should be granted permanent residence in the UK, although we appreciating that this is a matter for the UK Government. This would, however, provide stability both to these individuals and to NHS workforce numbers.

The UK's decision to leave the EU will have wide ranging consequences for current EU students studying at UK medical schools and their family members. These include funding arrangements, transferability and recognition of medical degrees, and postgraduate medical training.

Following the UK's departure from the EU, we believe it is essential that the immigration system remains flexible enough to recruit doctors from overseas, especially where the resident workforce is unable to produce enough suitable applicants to fill vacant roles.

In relation to science and medical research, BMA Cymru Wales is deeply concerned about the impact of the UK's decision to leave the EU. Safeguards must be put in place to maintain access to research funding, the right regulatory environment, and the mobility of research staff.

There may be wide ranging ramifications for the regulation and education of health professionals, including language testing, clinical skills and knowledge testing, and the transferability and recognition of qualifications for doctors. This will need to be urgently addressed.

BMA Cymru Wales is satisfied with the European Working Time Directive (EWTD) and the measures it has introduced, including a reduction in the maximum hours worked to an average of 48 per week, as transposed into the UK Working Time Regulations. We urge governments not to repeal these Regulations for new workers.

The factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas:

Our views on these issues were largely outlined in our earlier submission to the wider inquiry on the sustainability of the health and social care workforce, including on issues impacting on recruitment and retention in certain geographic areas. We would therefore refer the Committee to the points that we previously made.

One additional factor that may also now need to be considered, however, is the impact of the new junior contract being imposed in England. BMA Cymru Wales very much welcomes the reassurances we've received from the Welsh Government that it won't impose a new contract here and wants to proceed by dialogue and agreement. We feel this presents a great opportunity to promote Wales to junior doctors as a more welcoming place to train and work.

In the case of a few specialties, however, the differences which will now start to exist in the way pay is structured between Wales and England may pose a barrier to recruitment on this side of the border. This largely

impacts on posts which are ‘unbanded’, which means they do not attract a banding supplement on top of the basic rate of pay. Banding supplements are paid to remunerate junior doctors in posts where they ordinarily are required to work more than 40 hours of week and/or are frequently required to work antisocial hours.

With England moving to a pay structure which offers all trainees a higher level of basic pay, this will mean the pay offered for such unbanded posts in Wales may no longer be seen as competitive because holders of these posts only receive basic pay. The Welsh Government may have to give thought to how this pay disparity can be addressed for these specific posts, including for a specialty such as histopathology where posts are unbanded throughout the entire length of the time a junior doctor undertakes specialty training. This might, for instance, be achieved through the use of a market supplement for such specialties, similar to the supplement which is currently paid to GP registrars so that trainees working in GP practices maintain pay parity with their hospital counterparts. In raising this point, however, we would wish to make it clear that this should not be interpreted as us advocating the overall adoption of a pay structure similar to that introduced by the new English contract.

As we outlined in our earlier submission on the wider topic of the sustainability of the health and social care workforce, factors which can influence where junior doctors choose to locate to undertake their training 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 England, we are aware that provision has now been established for junior doctors who are partners or spouses to be able to submit linked applications. This can assist them to secure training posts within the same geographic area. We would support such an initiative also being introduced in Wales.

One factor that could be worth building upon going forward is the fact that Wales scored highest amongst the four UK nations for trainee satisfaction in the GMC's most recent national training survey.[7] We need to ensure Wales develops and build upon a good reputation for medical training. It is important that education and training are viewed as core values of the NHS in Wales alongside high quality patient care.

With regards to staff retention, which in many ways may be more of a concern than recruiting new staff, we would reiterate the points we made in our earlier response. There is a need to address the factors which are driving doctors to reduce their working hours, leave the profession or retire. 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.

The development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere.

The extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce.

Taking these two topics together, we would again refer the Committee to our earlier submission on the wider topic of the sustainability of the health and social care workforce where we made a number of points in relation to both recruitment and retention and the factors which will impact on our ability to attract and retain doctors at different stages in their careers.

[7] GMC (2016) *National Training* Survey. Available at: http://www.gmc-uk.org/education/surveys.asp

MR 21
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Conffederasiwn GIG Cymru a Cyflogwyr GIG Cymru
Response from: Welsh NHS Confederation and NHS Wales Employers

	The Welsh NHS Confederation and NHS Wales Employers response to the Health, Social Care and Sport Committee inquiry into medical recruitment.
Authors:	Richard Tompkins, Director, NHS Wales Employers. [redacted] Tel: [redacted] Jayne Dando, Head of Workforce Strategy & Planning, Workforce, Education & Development Services (WEDS). Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation. [redacted] Tel: [redacted]
Date:	16 November 2016

Introduction

1. We welcome the opportunity to contribute to the Health, Social Care and Sport Committee inquiry into medical recruitment. We hope that our response, which has been developed with our members, including Directors of Workforce and Organisational Development (OD) and representatives from the All Wales Strategic Medical Workforce Group. The Welsh NHS Confederation and Directors of Workforce and OD would be more than happy to provide further information to Members of the Committee.

2. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

3. NHS Wales Employers is hosted by and operates as a part of the Welsh NHS Confederation. NHS Wales Employers supports the strategic workforce agenda of the NHS in Wales from an NHS employers' perspective. NHS Wales Employers supports the employers with workforce policy development, practical advice and information, and enables the NHS Wales Workforce and OD community to network and share knowledge and best practice.

Key points

4. The health service is Wales' biggest employer, currently employing around 86,500[i] staff and providing a significant contribution to both the national and local economy. As changes in demographics and our lifestyles have resulted in a dramatic rise in demand on the health and care services, it has become increasingly clear that a transformation in the way treatment is delivered is required if the NHS is to meet the needs of a future population. A sea-change in the way services are designed is vital. A key aspect to driving this, and successfully putting NHS Wales on a sustainable footing, is the workforce.

5. With an ageing population and a rising number of people with complex and chronic conditions, the workforce must be ready to evolve and respond to the challenges ahead. As well as meeting the future needs of the population, the workforce must also develop new ways of working to address concerns about an expected shortfall in the future NHS workforce, especially for certain types of jobs and in different regions of Wales.

6. The Welsh Government (WG), through cross-party support, must help facilitate sustainable long-term workforce planning according to the needs of local communities. Future demand for health and social care will not be met unless we plan, develop and use the health and social care workforce differently. The Welsh NHS Confederation Policy Forum, consisting of health and social care organisations from across Wales, has recently developed the "One workforce: Ten actions to support the health and social care workforce in Wales"[ii] document which has been endorsed by nearly 40 organisations. The document considers the ten key areas to ensure a

sustainable health and social care workforce in the future, including having a long-term vision for health and social care in Wales.

7. We now have an opportunity in the fifth Assembly to put forward a long-term vision for the health and social care workforce, acknowledging that the workforce needs to change to deliver integrated, personalised care closer to home.

Background

8. Across the UK, emerging trends over the last six years show significant challenges in recruiting doctors to a number of medical specialties. Each area and region in the UK has its own unique factors and challenges but there are common issues contributing to the current position in Wales. As a consequence, agency and locum usage has increased to cover the rota gaps and vacancies.

9. The size of the total medical workforce has grown by 10% between 2010 and 2016. 2.5% of this growth has been between 2014 and 2016. Compared to other parts of the workforce the Consultant grade has grown significantly, a growth of 17% since 2010 illustrated in **chart 1** below. The comparative growth across all grades is shown in **chart 2**.

10. Despite the overall growth in the medical workforce there is a supply – demand gap in a number of medical specialties in Wales.

11. In relation to the table below SAS relates to specialty and associate specialist doctors and HT refers to higher grade doctors in training.

Chart 1: Percentage change in NHS employed staff 2010-2016

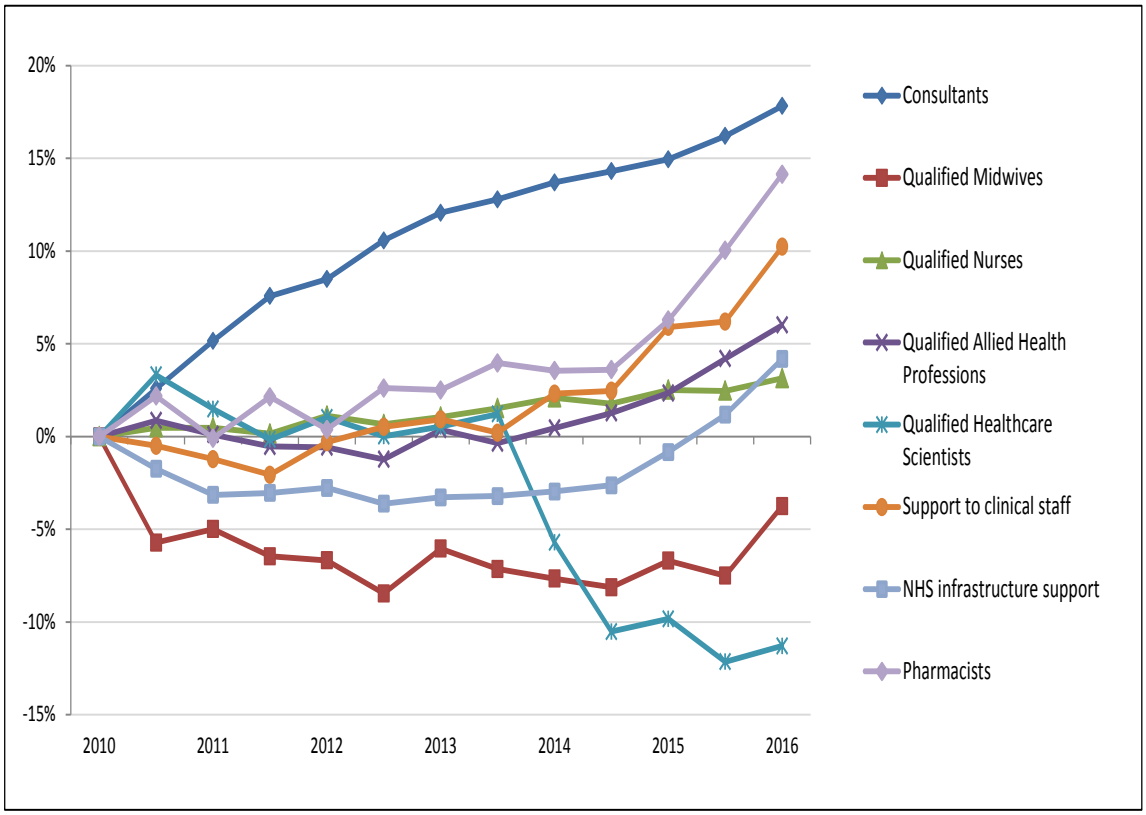
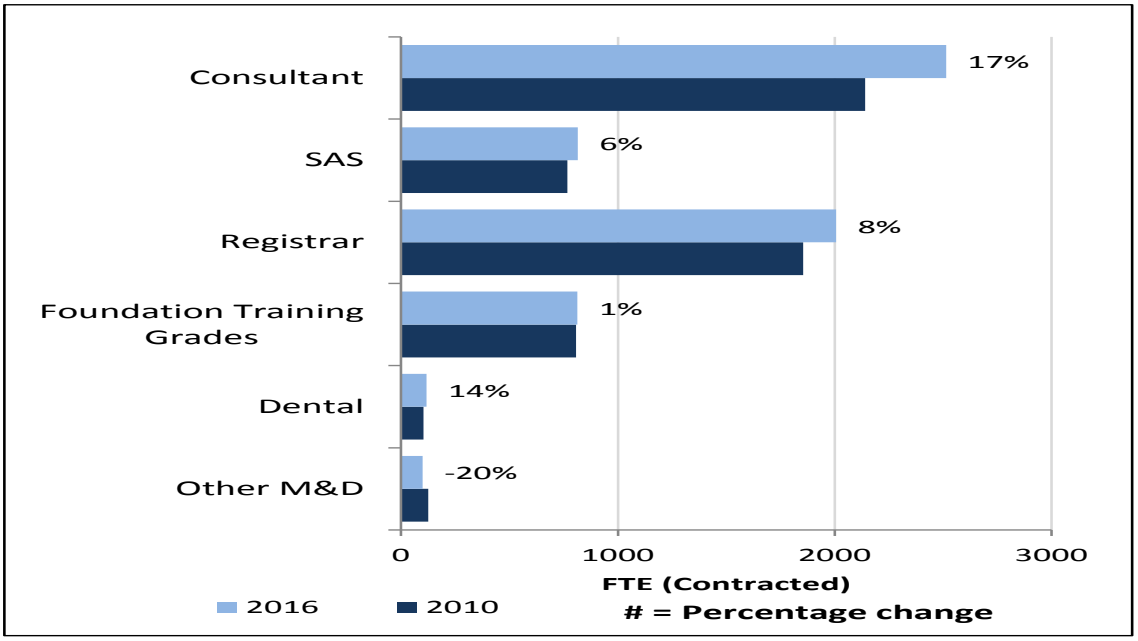


Chart 2: FTE comparison and % variance between 2010-2016 for Medical & Dental grades



Health Board Vacancies and Recruitment Pressures.

12. To illustrate the vacancy and recruitment pressures that the NHS in Wales is facing, the following figures are the reported vacancy and recruitment pressures from the six large Health Boards (Abertawe Bro Morgannwg University Health Board (ABMU), Aneurin Bevan University Health Board (ABUHB), Betsi Cadwaladr University Health Board (BCUHB), Cardiff and Vale University Health Board (CVUHB), Cwm Taf University Health Board (CTUHB) and Hywel Dda University Health Board (HDUHB)) as at July 2016. These figures have now changed due to success with recent international recruitment.

HB Vacancies	Junior	SAS/HT	Consultant
Totals for six large HBs	132	253	154

Specialty Pressures

13. The following table expands upon the areas where Consultant recruitment is presented as a pressure or for the other grades where four or more gaps appear per specialty.

Organisation and Grade	Specialty
ABMU	
SAS/HT	Emergency Medicine (EM), Anaesthetics , Neonatology, General Surgery and Psychiatry
Cwm Taf	
Consultant	Pathology and EM
SAS/HT	General Medicine, Psychiatry and EM
Junior	General Medicine and General Surgery
Hywel Dda	
Consultant	Ophthalmology, General Medicine, Radiology, General Surgery and Anaesthetics
SAS/HT	Anaesthetics, EM and General Medicine
Junior	Anaesthetics and Orthopaedics
Aneurin Bevan	
Consultant	Acute Medicine and Anaesthetics
SAS/HT	Anaesthetics and Trauma and Orthopaedics
Cardiff and Vale	
Consultant	Occupational Health and EM
SAS/HT	EM and Intensive Care
BC UHB	
Consultant	Pathology, Radiology , Anaesthetics , EM and General Medicine
SAS/HT	Anaesthetics and General Medicine
Junior	EM, Orthopaedics, Anaesthetics and General Medicine

14. Work on recruitment programmes is underway across NHS Wales, including:

- All Wales/ UK recruitment campaigns;

- All Wales approaches to international recruitment;
- Promoting Wales as a place to train, work and live (e.g. branding and career fairs);
- Development of standard relocation packages, developing the "Wales Offer"; and
- Exploring different solutions (e.g. new roles such as Physicians Associates).

15. The service is working closely with Welsh Government and the Deanery regarding the future funding and commissioning of training places to support the future supply of doctors, particularly increasing numbers where there are predicted shortages.

Questions

Q1. The capacity of the medical workforce to meet future population needs in the context of changes to the delivery of services and the development of new models of care.

16. Workforce planning for medical staff presents a considerable challenge given the length of training and the time frame for the NHS Integrated Medium Term Plans (IMTP) of three years. Health Boards and Trusts undertake local workforce planning which feeds into IMTP scoping retirements, turnover and service change. While planning is linked to supply and demand, some medical students and qualified doctors are making a choice to either not enter the profession, not stay in it, or to work as locums.

17. Some modelling has been undertaken within Wales for a number of specialties. To supplement this the Workforce Education and Development Service, which is part of the NHS Wales Shared Services Partnership (NWSSP), commissioned the Centre for Workforce Intelligence (CfWI) to undertake basic supply/demand modelling for specialties with 20 or more consultants on behalf of the All Wales Strategic Medical Workforce Group.

18. The CfWI modelling was based on:

- Baseline supply projections including data on the numbers projected Certificate of Completion of Training (CCT) holders that will be produced based on the numbers in and length of training; and
- Demand projections were based on ONS data (changes in the size and demographic of the population in Wales including age and gender) and Hospital Episode statistics for Wales.

19. This modelling provided baseline projections only and did not take account of policy changes, changes in service delivery / skill mix or changes in technology.

20. In addition to the baseline modelling work additional intelligence, included organisations' Integrated Medium Term Plans, identified medical staff shortages for consultants across a range of specialties, including general practice, clinical radiology and emergency medicine in addition to shortages at middle grade.

21. Working with Welsh Government, Chief Executives within Health Boards have agreed an interim process for the consideration of medical training numbers pending the outcomes of the Health Professions Education Investment Review and the establishment of a single body for Wales to undertake workforce planning /education commissioning.

22. Following the CfWI analysis work undertaken with the Wales Deanery and NWSSP WEDS and consideration by the All Wales Strategic Medical Workforce Group, recommendations were made by Chief Executives to Welsh Government with regard to a number of specialties with the highest priority being given to:
- Clinical Radiology;
- Pathology; and
- General Practice.

23. Additional places have been agreed for 2017/18 and further work is underway to identify the requirements for medical training posts for 2018/19 onwards for all specialties including core surgical training posts. The Welsh Government is also seeking to be flexible in supporting and

taking advantage of any opportunities which may arise to increase the number of places in priority areas.

24. Health Boards and Trusts have been developing their medical workforce models to be able to provide the level of service delivery required across all sites and services. New roles and ways of recruitment are constantly being developed to help support and overcome the challenges faced with the recruitment of Medical Staff. In addition new ways of delivering care, such as Medical Training Initiatives (MTIs), Advance Nurse Practitioners (ANPs), Physician Associates (PAs), Nurse Prescribers and Responsible Clinicians under the Mental Health Act 2007 are being utilised.

25. Overseas recruitment is significant in filling vacancies in the medical workforce. This process is often lengthy due to the time it takes for the approval of visa applications. This, in turn, provides untimely gaps in rotas which often require locum cover, which in itself affects service delivery.

26. General Practitioners' (GP) surgeries are already feeling the pressure in delivering their service to the population. There is currently a shortage of GPs to meet this demand and with 25% of GPs already at retirement age the ability to deliver a service this way will not be sustainable, therefore alternative roles are being explored as a potential substitute role.

27. The increased number of women in the medical workforce also needs to be acknowledged as this may increase the requests for flexible working in line with a better work/life balance. There is already evidence that Out of Hours rotas are being impacted with an increase in the requests for Less Than Full Time (LTFT).

28. Collaborative work is ongoing between Health Boards and Trusts to consider and plan for risks in the medical workforce and opportunities to mitigate increases by changes in skill mix, developing MDTs and maximising delegation.

Q2. The implications of Brexit for the medical workforce.

29. Many aspects of the UK's health and social care services have been influenced by European Union policies and legislation. Depending on the settlement, the UK's exit from the EU could have a profound impact on the UK economy, our workforce and the delivery of public services. On workforce, our priority will be to ensure a continuing 'pipeline' of staff for the sector, including recognising health and social care as a priority sector for overseas recruitment. We have asked the UK Government to provide clarification as soon as possible that EU professionals who are already working for the NHS, or who will be recruited during the leave negotiations, will be allowed to remain after Brexit.

30. Across the UK, the NHS is heavily reliant on EU workers. In September 2015 there were 1,139 EU Nationals directly employed by the NHS. The current percentage of doctors who are recorded on the Electronic staff record as being from the European Union is **8%** (compared to 10% in England).

Nationality (March 16)	UK	EU	Non EU
Consultant	74%	7%	19%
SAS	43%	13%	43%
Training Grades	74%	7%	20%
Other M&D	87%	5%	8%
Grand Total	**70%**	**8%**	**22%**

31. Further analysis was also carried out on GMC numbers to identify the place of qualification to provide an additional perspective.

Country of Qualification (March 16)	UK	EU	Non EU
Consultant	65%	5%	30%
SAS	30%	11%	59%
Training Grades	74%	5%	22%
Other M&D	84%	4%	12%
Grand Total	**65%**	**6%**	**30%**

32. While the figures for the whole NHS Wales workforce are relatively small there are some points to note:

- Irish staff form by far the largest group and in particular there are significant numbers in the professional/medical staff groups;
- Staffing levels in the service operate on very fine margins as can be seen by the need to use high levels of agency and locum staff. Any decrease in staffing numbers will exacerbate the problem;
- One of the solutions to the current staffing shortages since September 2015 has been to recruit from the EU, so these numbers may have increased since then; and
- The current uncertainty as to the timetable for leaving the EU may potentially lead to staff looking for opportunities outside of the UK and for potential applicants to be deterred from applying. In addition, the incidents of harassment of foreign workers and feeling that they are may no longer be welcome may have an impact on EU/EEA workers' willingness to remain in the UK, even if permanent freedom to remain is granted.

33. Our reliance on EU workforce has increased in the last few years, probably due to tightening of UK immigration policy on non-EU workers. The priority after Brexit should be to ensure that the UK can continue to recruit and retain much needed health and social care staff from the EU and beyond, while increasing the domestic supply, through robust workforce planning.

34. While we welcome the recent announcement that more healthcare professionals will be trained domestically from now on, we are also aware that workforce planning is an inexact science and that it is extremely difficult to predict the number of professionals needed to ensure the smooth and safe operation of a health and care system in continuous change. Shortages in specific areas can take only 2-3 years to develop, but may need 10-15 years for the UK trained workforce to respond, by which time other solutions have usually been found and different workforce shortages may have emerged. It is to be expected, therefore, that our sector will need to continue to recruit overseas trained professionals, including from within the European single market, to operate smoothly and to offer safe and high quality services to patients in the future.

35. The freedom of movement provisions of the EU single market make it possible for healthcare professionals qualified in other parts of the EEA to access the employment market in the UK without having to obtain visas and work permits, unlike citizens from non-EU countries. This makes it quicker and easier for the NHS to recruit staff from the EU, especially into shortage areas and specialties. The UK benefits enormously from the single market in this respect, as we are a net importer of healthcare professionals qualified in other parts of the EU.

36. In addition the EU legislation on mutual recognition of qualifications means that currently many EU healthcare professionals are "fast-tracked" for registration with the General Medical Council, the Nursing Midwifery Council or other relevant regulatory bodies. EU rules mean the process for professional registration and the right to practise legally in the UK is different to non-EEA trained practitioners, for example it does not systematically require pre-registration competency and language testing by the regulator. These arrangements are reciprocal so that UK-qualified practitioners can also practise relatively easily elsewhere in the EU, although the outbound flow is less.

37. Our priority will be to ensure a continuing 'pipeline' of staff for the sector. The immigration system that is in place after the UK leaves the EU will need to ensure that, alongside our domestic workforce strategy, it supports the ability of our sector to provide the best care to our communities and people who use our services.

38. If the UK continues to have full access to the single market in future, entailing freedom of movement for EU citizens to live and work in the UK and vice-versa, not much would change in terms of our ability to recruit from the EU. At the other extreme, a total exit from the single market would leave the UK completely free to determine its own policies on immigration, with possibly much greater implications for the NHS. Under this latter scenario, it would be crucial to ensure that any future UK immigration rules recognise health and social care as a priority sector for overseas recruitment, from both within and outside the EU.

39. The full implications obviously depend on the terms of the arrangements which will be in place post the UK leaving the EU. To date the UK appears to have benefitted from migration within the EU/EEA and many Health Boards and Trusts have employed doctors from the EU and EEA. The future of those doctors remaining in the UK may be uncertain until the position is clarified. There is also uncertainty in relation to the potential impact on visa arrangements which may be required in future, for example applicants may require Tier 2, or Tier 5 visas. If additional visas are required this will increase costs and impact NHS budgets.

40. Brexit could have an impact on rotas and service delivery, if current EU doctors leave or there are reduced numbers of EU doctors coming into the country then this may significantly impact on the delivery of rotas and services. Some services may become unsustainable with the difficulties which Health Boards have recruiting potentially being compounded.

41. European Working Time Directive – The EWTD has had a positive impact for hospital doctors. If the UK ended the application of these Regulations then there may be a return to the long hours culture which existed until the late 1990s/early 2000s. While it is expected that the current legislation would be retained, the situation moving forward is less clear.

42. In relation to workforce planning, there will be uncertainty in the short term until the arrangements for employing doctors from outside of the UK is clear. Many organisations currently face recruitment challenges, this potentially becomes a far greater challenge as there may be a higher level of reliance on doctors who require visas. This may be compounded by a reduction in applications, due to the uncertainty regarding the post Brexit arrangements and the lower value of the pound making UK salary levels less internationally competitive. Anecdotally, Brexit may have already adversely impacted on overseas recruitment because of the uncertainty and impression it presents for overseas recruits. Small reductions in the numbers of doctors employed in the service can have a significant impact on the ability to provide sustainable services and we need to ensure that the provision of care and services to patients is not compromised by the current uncertainty.

43. In a post-Brexit environment there will need to be clarity regarding how doctors from the EU will be granted access to the UK medical register and how any concerns will be raised with other countries as well as the continued impact and application of EU Directives and other European legislation, such as Agency Worker Regulations.

Q3. The factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas.

44. Consideration needs to be given to the overall medical education strategy for Wales including numbers of medical undergraduate training places in Wales and those available to Welsh domiciles, the role of feeder schemes and graduate entry places.

45. A report[iii] produced in 2013 showed that 30% of students in medical schools in Wales were Welsh domiciled compared to the percentages of locally domiciled students being 85% in Northern Ireland, 80% England and 55% in Scotland. The latest available figures suggest that this may now be as low as 8-10% between the two Welsh medical schools. More work needs to be undertaken to promote the medical profession as a career choice, including delivering sessions to schools and sixth form colleges to promote the medical career path and provide more opportunities to growing our own.

46. It must also be remembered that educational experience, and how undergraduate medical students and post graduate trainee doctors are treated and valued (reflected in GMC surveys), have a major input into recruitment and retention. Opportunities exist for Wales in maximising the Education Contract recently developed by the Wales Deanery.

47. Factors that influence the retention and recruitment of doctors are:
- Geographical locations and small numbers on a rota sometimes resulting in a lack of peer support and limited options for cross cover;
- Out of hours arrangements are not attractive to junior doctors due to a feeling of isolation;

- Deanery placements can often be geographically challenging between rotations which can be off-putting to junior doctors requesting placements in Wales;
- Creating a better working/living environment will always be an attraction for recruitment;
- Reputation of service;
- Opportunities for staff to work in areas they find particularly stimulating. Good family support, child care, schools, affordable housing, travel networks, well maintained work environments and local culture/leisure offer;
- Rurality of some services and the need to provide remote rural practice as employment experience so as to influence/ incentivise working in those areas.

Q4. The development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere.

48. Health Boards and Trusts have co-ordinated activity to promote working in NHS Wales and worked with Welsh Government to develop the 'Train, Work, Live' campaign. Features of the recruitment approaches include:
    - Attendance at all Wales BMJ Careers Fairs annually;
    - Developing individual Health Board/Trust branding in line with the National Campaign for all hard to fill posts;
    - Continuous advertising in professional journals in hard to fill posts, including the branding in future campaigns and adverts;
    - Continuous presence on social media platforms e.g. LinkedIn, Facebook, twitter and Health Board/Trust websites;
    - Headhunting on LinkedIn;
    - Development of individual Health Board recruitment websites with new branding thread;
    - Need to expand on current attendance at recruitment fairs;
    - Specific hospital based open days;
    - Working with schools and potential applicants for Medicine;
    - Links with agencies to recruit into NHS contracted posts;
    - International recruitment;
    - Stakeholders involved throughout all of the above; and

- Participation in Medical Training Initiative (MTI) and BAPIO (British Association of Physicians of Indian Origin) initiatives.

49. Work has also been undertaken to develop an offer for GPs. Recruitment campaigns needs to be delivered in a variety of different ways to ensure we capture the younger generation. Better use of social media need to be used to capture this audience.

50. Workforce & OD Directors have recently set up a Wales work stream focusing on reducing spend on temporary medical locums. Reporting into Chief Executives, this has a recruitment arm, looking at opportunities for collaborative work on recruitment across Wales – any gaps – building on best practice.

Q5. The extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce.

51. Organisations are working on ensuring that recruitment practice and administration is joined up from the processes of a doctor resigning to recruitment of their replacement to ensure that any workforce gaps are kept to a minimum. The recruitment process for Consultants is lengthy due to the statutory requirements and the difficulties that can arise from organising interviewing panel members for Advisory Appointment Committees (AAC). Organisations have been enhancing their interview process and consideration is being given to changing/relaxing the prescriptive requirements for AAC panel members.

52. Employment checks are vital for good governance and public safety, however they do impact on the recruitment timeline. Consideration is being given to the portability of checks throughout NHS Wales.

53. The Medical Training Initiative (MTI) and BAPIO (British Association of Physicians of Indian Origin) initiative in India has been undertaken on an all-Wales basis, with representatives from NHS Wales travelling to India in November 2016.

54. Joint rotations have been devised across and between Health Board. For example, Cardiff and Vale UHB, Abertawe Bro Morgannwg UHB and Cwm Taf UHB have developed a scheme for Trauma and Orthopaedics administered and managed by the Cardiff and Vale UHB Medical Workforce Team.

Conclusion

55. People working within the NHS and social care are our biggest asset. Without their hard work and dedication the health and care service would collapse. We need to think about the workforce we have today for our current service delivery requirements but also focus on creating a pipeline for the future, which will include many of today's health and social care employees. This will require innovation and perhaps new regulation mechanisms for new roles. We now have an opportunity in the fifth Assembly to put forward a long term vision for the health and social care workforce, acknowledging that the workforce should change to deliver integrated, personalised care closer to home.

[i] Stats Wales, May 2016. NHS staff by staff group and year 2015.
[ii] Welsh NHS Confederation Policy Forum, September 2016. One workforce: Ten actions to support the health and social care workforce in Wales.
[iii] NHS Education for England, March 2013. Domicile of UK undergraduate medical students.

MR 22
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Coleg Brenhinol y Seiciatryddion
Response from: Royal College of Psychiatrists Wales

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is a satellite of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

For further information please contact:

Siobhan Conway
RCPsych in Wales Manager
Tel: 029 22 33 1081
www.rcpsych.ac.uk
@RCPsychWales

The RCPsych in Wales is encouraged that the National Assembly for Wales are seeking stakeholder comments into their inquiry into medical recruitment.

This response has been produced in consultation with the members of the College in Wales and relevant stakeholders.

The RCPsych in Wales has previously submitted responses to Welsh Government consultations on workforce which include relevant information on recruitment and retention as below:

- Welsh Government – Health Professional Education Investment review
- Welsh Government (commissioned) – review into the NHS Workforce

RCPsych Workforce Census

- In March 2016 the RCPsych published the results of its Workforce Census

NHS ten- year plan on workforce

In March 2015, the minister announced that a 10-year national workforce plan for the NHS will be developed, bringing together work already underway, including prudent healthcare principles. It will be informed by two areas of work – the primary care workforce plan and the independent review of the NHS Wales workforce (see above).

Inquiry questions:

1. The capacity of the medical workforce to meet future population needs in the context of changes to the delivery of services and new models of care.

The current psychiatry workforce does not have the capacity to meet future population needs in Wales. Psychiatry professionals in Wales work hard to meet the demands of a growing and changing population. They are treating more people with different needs in a variety of settings including hospitals, clinics, prisons, secure units and in the community. With limited funds and few resources, services are at risk of collapse. We are calling for Welsh

Government to address workforce issues more generally and within their specialties. It must be Welsh Government's priority to develop a workforce plan and training programme to attract the calibre of healthcare professionals to meet these demands as stated in RCPsych in Wales Manifesto 2016.

Current numbers of trainees in General Adult Psychiatry and Old Age Psychiatry are particularly concerning. There are gaps in training schemes for these specialties and this shortfall will, in the near future, have an impact on consultant numbers working within these specialties. Workforce demand in Old Age Psychiatry will continue to increase as our population ages and supply is not predicted to meet this demand and a significant shortfall expected. Retirement rates of Old Age psychiatry consultants has increased along with vacancy rates across the UK.

The RCPsych in Wales acknowledges the future changes in the delivery of care in Wales as stipulated by the South Wales Programme Board which is now being implemented. The ambition is to:

- Centralise services and strengthen primary care and community services so people can keep well at home. When people do need hospital care, provide as much as locally as possible but only when it is safe to do so.
- Develop a new system where hospitals work together across health board boundaries to provide high-quality, timely care for patients in the most appropriate place.
- Improve care and standards by concentrating consultant-led services and emergency medicine (A&E) for the most seriously ill and injured in fewer hospitals.

Mental Health service provision in Wales has improved over the last 20 years with most services now being delivered in the community setting. To enable improvements to specific DGH services as detailed above, the psychiatry workforce in emergency/crisis/DGH settings must be robust. There have been improvements in Liaison psychiatry with additional funding from Welsh Government which has been welcomed. However, there are still gaps in services across Wales.

2. The implications of Brexit for the medical workforce.

Brexit is predicted to have a negative impact on the medical profession throughout the UK. The numbers of doctors entering psychiatry in Wales was inadequate before the referendum to leave Europe. The result means that the need for more doctors is now more acute. We would stress that we need to expand the number of Wales' medical students to ensure a high level of domicile doctors of the future, that are likely to study, train and work in Wales post CTT. Currently, 40% of all UK doctors are trained outside the UK. The College in Wales is acutely aware that this situation is likely to change when Brexit has been implemented.

The future post Brexit is uncertain. We are concerned that doctors from outside the UK already working in Wales, settled in jobs and who have set up homes may consider leaving due to the uncertainty of the future. We are also concerned that the UK post Brexit is now not considered a stable place to come and work due to the ongoing uncertainty.

Brexit puts doctors from EU countries, who thus far relied on their automatic residence rights, into a precarious situation. To make matters worse, the UK Government's announcements seem to imply that doctors from EU countries will only be tolerated in the UK for a limited period which is essentially until sufficient numbers of British doctors have been trained. This prospect is likely to have a demoralising effect and will make it very difficult to recruit and retain doctors from EU countries. This will add to the difficulty in covering clinical areas which are affected by a shortage of doctors (such as psychiatry, and particularly its subspecialties/ special interest areas) in this interim period. The interim period could easily last for 20 years if not longer, anyone starting medical school now would need at least 20+ years training to replace current experts. It was disappointing not to see a clear response from the Welsh Government on this matter, but hopefully this inquiry will result in representations being made both to the Welsh and the UK Governments.

3. The factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties of geographical areas

Historically Psychiatry has had difficulty in recruiting and retaining staff. It is well evidenced that recruitment into psychiatry is very poor. Psychiatry faces a stigma of its own, with low popularity rates globally. The reasons that medical students choose careers in medical specialties other than psychiatry

are well documented. Despite this, the key issues have not been addressed collectively in the UK. Data from the College show that the size of Wales' consultant psychiatrist workforce only grew by an average of 0.7 FTE (3.5 headcount) per year from 2011-2013.

Psychiatry has very high levels of job satisfaction, which can be attributed to its focus on the bio-psycho-social model with a holistic approach to care and treatment. Psychiatry is regarded to be at the forefront of modern healthcare services, spearheading co-production and service user involvement, psychological as well as medical therapies, and working with physical health and social needs.

Retention of Psychiatrists and trainee psychiatrists is a major issue. Factors that influence this include lack of good quality training experience in some areas, stigma within the medical profession and pressure on services. Wales specifically has issues with the rurality of some areas and some Health Boards have difficulty in recruiting into rural posts. Recent discussions with our membership in Wales have revealed that pay is not *the* major factor in recruiting and retaining staff in Wales. Quality of service provision, support services, work-life balance and job satisfaction are higher priorities for psychiatrists.

The RCPsych in Wales is aware of the impact that the new junior doctor contract is having in England. We are encouraged that no plans to implement such a contract have been announced in Wales. This would lead to a further reduction in Recruitment and Retention of psychiatry doctors in Wales

4. The development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere

The RCPsych (UK) has recently revised its recruitment and retention action plan. This document provides a detailed set of initiatives developed to improve recruitment and retention across the UK.

The RCPsych in Wales believes that in order to improve rates of recruitment, young people should be targeted at secondary school age and medical schools to be well informed of NHS careers. Work experience, careers fairs and Young People's debates on Mental Health provide young people the experience and knowledge to make an informed decision about their future career.

The RCPsych in Wales has published its Recruitment and Retention Action Plan 2015 - 2017 and works constantly to improve the rates of recruitment and retention in Wales. We strive to:

- Reduce stigma and promote good mental health within secondary schools in Wales.
- Reduce stigma and promote psychiatry within medical schools in Wales.
- Ensure high quality and supported training at core and higher level within psychiatry in Wales.

Retention of Psychiatrists and trainee psychiatrists is a major issue. Factors that influence this include lack of good quality training experience in some areas, stigma within the medical profession and pressures on services.
The Royal College of Psychiatrists offers Pathfinder Fellowships, which provide a unique and exciting opportunity for medical students in their penultimate year of study who are interested in pursuing a career in psychiatry. The Fellowship Award has expanded to offer 20 places. We are seeking the next generation of psychiatrists to lead the profession into the future.

5. The extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce.

The RCPsych in Wales works proactively on recruitment. We have organised and delivered joint working in this area with Swansea University School of Medicine and Cardiff medical school. The RCPsych in Wales would welcome the opportunity to work collaboratively with other related organisations on improving current rates of recruitment and retention in Wales.

Further comments:

The Welsh Government has just announced the creation of a new body, Health Education Wales, which will lead strategic workforce planning, workforce design and education commissioning for NHS Wales.
This follows the report of the Health Professional Education Investment (HPEI) review.

Key points

- The report proposes a new “arm’s length body” with a board accountable to Welsh Ministers, working within an overall framework provided by the Welsh Government.
- It proposes members of the board be appointed for their expertise in specific areas such as understanding changing health needs, workforce planning, educational design, quality assurance and equity.
- The removal of boundaries between medical and non-medical planning, workforce design and commissioning will provide new opportunities for multi-professional approaches.
- The focus on widening access, raising awareness about more than 300 different roles and opening up more flexible career pathways needs a co-ordinated national approach, supported with local initiatives.
- Overseen by a board, the new HEW body will deliver a national co-ordinated approach to delivering workforce education and training to meet the specific geographical needs of Wales.

The Welsh Government expects the body to be in place by 1 April 2018.
The RCPsych in Wales stresses the importance of having robust support in place whilst the planning and implementation of the new body is taking place. We would be concerned to see a break or any disruption to recruitment of doctors in Wales in this crucial time period.
The College in Wales would welcome the opportunity to assist Welsh Government and the National Assembly for Wales on issues around recruitment and retention of doctors in Wales.

November 2016