Agenda - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:
Ystafell Bwyllgora 3 - Senedd
Dyddiad: Dydd Mercher, 8 Chwefror 2017
Rhag-gyfarfod Aelodau: 09.15
Amser: 09.30

I gael rhagor o wybodaeth cysylltwch a:
Sian Thomas
Clerc y Pwyllgor
0300 200 6291
SeneddIechyd@cynulliad.cymru

Rhag-gyfarfod anffurfiol (09.15 - 09.30)

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

2 Ymchwiliad i recriwtio meddygol - sesiwn dystiolaeth 3 - Cymdeithas Feddygol Prydain (BMA) Cymru Wales a Choleg Brenhinol y Meddygon

(09.30 - 10.30) (Tudalennau 1 - 62)

Dr Charlotte Jones, Cadeirydd Pwyllgor Meddygon Teulu (Cymru) y BMA
Dr Trevor Pickersgill, Cadeirydd Pwyllgor Meddygon Ymgynghorol Cymru y BMA
Dr Gareth Llewelyn FRCP, is-lywydd Coleg Brenhinol y Meddygon ar gyfer Cymru
Lowri Jackson, uwch gynghorwr polisi a materion cyhoeddus Coleg Brenhinol y Meddygon ar gyfer Cymru

Egwyl (10.30 - 10.35)

3 Ymchwiliad i recriwtio meddygol - sesiwn dystiolaeth 4 - Coleg Brenhinol yr Ymarferwyr Cyffredinol a GP Survival

(10.35 - 11.35) (Tudalennau 63 - 124)

Dr Rebecca Payne, Coleg Brenhinol yr Ymarferwyr Cyffredinol
Dr Isolde Shore-Nye, Coleg Brenhinol yr Ymarferwyr Cyffredinol

Dr Linda Dykes, Meddyg Ymgynghorol mewn Meddygaeth Achosion Brys, Ysbyty Gwynedd a Meddyg Teulu â Diddordeb Arbennig mewn Geriatreg yn y Gymuned, Bwrdd Iechyd Prifysgol Betsi Cadwaladr (Gorllewin)
Dr Sara Bodey, Partner Meddyg Teulu, Practis Bradley, Bwcle, Sir y Fflint (GP Survival)
Dr Heidi Phillips, Partner Meddyg Teulu, Canolfan Feddygol Fforestfach, Abertawe a Chyfarwyddwr Derbyniadau ar gyfer y rhaglen feddygaeth i raddedigion yn Abertawe (GP Survival)

Egwyl (11.35 - 11.40)

4 Ymchwiliad i recriwtio meddygol - sesiwn dystiolaeth 5 - yr Athro Dean Williams

(11.40 - 12.20)

Yr Athro Dean Williams, Ysgol Gwyddorau Meddygol Bangor

5 Papurau i'w nodi

Craffu ar Fil Iechyd y Cyhoedd (Cymru) yng Nghyfnod 1 - Gwybodaeth ychwanegol gan Weinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol

(Tudalennau 125 - 126)

6 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod

7 Ymchwiliad i recriwtio meddygol - trafod y dystiolaeth

(12.20 - 12.25)

8 Ymchwiliad i ofal sylfaenol – trafod y trefniadau ar gyfer cyfarfodydd y dyfodol

(12.25 - 12.30) (Tudalennau 127 - 128)

Mae cyfyngiadau ar y ddogfen hon

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 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)

Meddygon ar y rheng flaen

Y gweithlu meddygol yng Nghymru yn 2016

Prosiect: Iechyd

Rhagair

Yn ddiweddar, rhybuddiodd llywydd Coleg Brenhinol y Meddygon (RCP), yr Athro Jane Dacre, fod GIG heddiw 'heb ddigon o ddoctoriaid, heb ddigon o arian ac wedi'i orymestyn'.[1] Mae'r arsylwadau hyn yr un mor berthnasol i Gymru â gweddill y DU. Er mwyn i GIG Cymru gyflawni ei botensial llawn i wasanaethu pobl Cymru, mae angen digon o adnoddau a gweithlu gofal iechyd ymroddedig, hollol weithredol ac integredig, ynghyd â morâl da a boddhad proffesiynol.

Mae Cymru yn dioddef gan faterion sy'n ymwneud â recriwtio a chadw ymhlith y gweithlu meddygol, ar lefelau uwch ac is. Mae'r materion sydd wrth wraidd y problemau hyn yn amrywiol a chymhleth, ac yn cynnwys daearyddiaeth, canfyddiadau negyddol a diffyg cymhellion i annog doctoriaid i ddilyn gyrfa yng Nghymru. Mae'r RCP yng Nghymru yn credu bod llawer o fentrau y gallem eu mabwysiadu i oresgyn y materion hyn, a dylem eu mabwysiadu. Rwy'n gobeithio y bydd y syniadau hyn yn ysgogi dadl a thrafodaeth ac yn arwain at weithredu.

Cyflawni newid yng Nghymru

Yn 2014, cyhoeddodd y RCP *Mynd i'r afael â'r her: Gwella gofal acíwt, bodloni anghenion cleifion yng Nghymru*, sy'n dehongli gweledigaeth Ysbyty'r Dyfodol ar gyfer y gwasanaeth iechyd yng Nghymru.[2] Trwy ein hymweliadau 'sgwrs leol' ag ysbytai ar draws Cymru, rydym wedi casglu nifer o astudiaethau achos lle mae cymrodyr ac aelodau'n hyrwyddo gweledigaeth Ysbytai'r Dyfodol a gwella gofal cleifion.

Cyn etholiad Cynulliad Cenedlaethol Cymru yn 2016, gwnaeth y RCP hefyd lansio *Ffocws ar y dyfodol: Ein cynllun gweithredu ar gyfer llywodraeth nesaf Cymru*, lle gwnaethom ddadlau bod yr achos dros newid yn glir.[3] Mae gan y rheiny sy'n gweithio yn y GIG gyfrifoldeb i arwain y newid hwn, gyda chefnogaeth y sefydliadau sy'n eu cynrychioli ac wedi'u grymuso gan lunwyr polisi cenedlaethol. Mae'n rhaid i sefydliadau a gweithwyr proffesiynol sy'n gysylltiedig ag iechyd a gofal cymdeithasol – gan gynnwys doctoriaid, nyrsys, gwleidyddion, ysbytai a chyrff cenedlaethol – fod yn barod i wneud penderfyniadau anodd a gweithredu newid radical lle bydd hyn yn gwella gofal cleifion.

Dr Alan Rees MD FRCP
Is-lywydd ymadawol RCP ar gyfer Cymru

Trosolwg

- Mae'r sector iechyd yn cyflogi oddeutu 129,000 o weithwyr. Mae hyn yn cyfateb i 8% o'r swyddi yng Nghymru.[4]
- Mae gweithlu GIG Cymru yn cyfrif am 62% o wariant byrddau iechyd, neu bron i £3 biliwn y flwyddyn.[5]
- Y gweithlu meddygol yw 8.5% o gyfanswm gweithlu'r GIG yng Nghymru.
- Mae'r GIG yng Nghymru yn gwario oddeutu £350 miliwn i gefnogi oddeutu 15,000 o fyfyrwyr a hyfforddeion sy'n ymgymryd â rhaglenni addysg sy'n ymwneud ag iechyd.[6]
- Ni chafodd traean o leoedd hyfforddiant meddygol craidd (CMT) eu llenwi yng Nghymru yn 2016.[7]
- 30% yn unig o israddedigion ysgol feddygol Cymreig sy'n hanu o Gymru. Mae hyn yn cymharu ag 85% yng Ngogledd Iwerddon, 80% yn Lloegr a 55% yn yr Alban.[8]
- 39.5% yn unig o feddygon dan hyfforddiant yng Nghymru fyddai'n argymell meddygaeth i ddisgybl sy'n gadael ysgol.[9]
- Yn 2015, nid oedd yn bosibl gwneud 39.8% o benodiadau meddyg ymgynghorol yng Nghymru.[9]
- 43.7% yn unig o feddygon ymgynghorol sy'n cyfrannu at y rota acíwt yng Nghymru.[9]
- Mae bron i hanner y meddygon ymgynghorol yng Nghymru yn dweud bod adegau pan maent yn teimlo eu bod yn gweithio o dan bwysau gormodol.[9]
- Mae 76.7% yn unig o feddygon dan hyfforddiant yng Nghymru yn dweud eu bod yn fodlon â'u dewis o yrfa.[9]
- Mae gwariant GIG Cymru ar staff meddygol asiantaeth wedi codi gan 64% ers 2014–15 a rhagwelir y bydd yn fwy nag £8 miliwn erbyn diwedd 2016.[10]

Amser i weithredu

Mae'r GIG yng Nghymru yn wynebu nifer o heriau brys. Mae ysbytai'n cael trafferth i ymdopi â'r cyfuniad o boblogaeth sy'n heneiddio a mwy o dderbyniadau i ysbyty. Rhwng 2005 a 2014, cynyddodd poblogaeth Cymru o oddeutu 2.97 miliwn i 3.09 miliwn, a rhagwelir y bydd yn cynyddu i dros 3.3 miliwn yn 2036.[11] Yn 2014, roedd un mewn pump o drigolion Cymru dros 65 oed ac mae gan Gymru gyfran uwch o bobl 85 oed neu hŷn na gweddill y DU.[12]

Yn rhy aml, mae ein cleifion mwyaf agored i niwed – gan gynnwys y rheiny sy'n hen, sy'n eiddil neu sydd â dementia – yn cael eu methu gan system sy'n anghyflawn ac ymddengys ei bod yn amharod i ddiwallu eu hanghenion. At hynny, mae lefelau o afiechyd yn cynyddu â lefelau o amddifadedd ardal. Yn gyffredinol, mae'r rheiny yn yr ardaloedd mwyaf difreintiedig yn adrodd yr iechyd gwaethaf.[13] Yng Nghymru mae'r cyfraddau uchaf o salwch cyfyngus hirdymor yn y DU, ac mae hyn yn cyfrif am gyfran fawr o dderbyniadau brys diangen i ysbyty. Mae oddeutu hanner yr oedolion yng Nghymru'n cael eu trin ar gyfer salwch neu gyflwr fel pwysedd gwaed uchel, clefyd y galon, arthritis, salwch resbiradol, salwch meddwl neu ddiabetes ac mae traean yn adrodd cyfyngiad yn eu gweithgareddau bob dydd oherwydd problem iechyd neu anabledd.[14] Mae un oedolyn mewn pump yn adrodd iechyd cyffredinol gweddol neu wael ac mae'r ganran sy'n adrodd eu bod yn cael eu trin ar gyfer salwch penodol yn gyffredinol yn cynyddu gydag oed.[13]

Mae daearyddiaeth wledig llawer o Gymru yn golygu bod rhai gwasanaethau meddygol wedi'u lledaenu'n denau iawn. Mae hyn yn cael effaith negyddol ar ansawdd hyfforddiant ac ar recriwtio gweithlu mewn rhai arbenigeddau. Yn ogystal, mae disgwyliadau cleifion yn cynyddu wrth i gyfyngiadau ariannol dynhau fwyfwy ac, er y gall datblygiadau mewn technoleg achub bywydau, mae cost darparu gofal acíwt arbenigol yn parhau i gynyddu.

Mae newidiadau deddfwriaethol i oriau gwaith yn golygu bod angen mwy o ddoctoriaid iau arnom i gyflenwi rotâu ysbyty. Mae hyn wedi digwydd ar yr un pryd â gostyngiad mewn amser hyfforddiant oherwydd y rhaglen Moderneiddio Gyrfaoedd Meddygol, a gostyngiad yn nifer y graddedigion meddygol rhyngwladol sy'n dod i'r DU. Yn 2011, dywedodd bron i hanner y meddygon dan hyfforddiant arbenigol iawn wrthym, ers cyflwyno'r Gyfarwyddeb Oriau Gwaith Ewropeaidd, mae ansawdd hyfforddiant a gofal cleifion yn waeth neu lawer yn waeth.[15]

Wrth i'r boblogaeth heneiddio, ac wrth i nifer gynyddol o bobl ddatblygu cyflyrau cronig cymhleth gynyddu, ceir mwy o angen am ymgynghorwyr â chymwysterau mewn meddygaeth fewnol gyffredinol er mwyn gallu rheoli cleifion yn holistaidd. Fodd bynnag, yng Nghymru, dim ond 43.7% o feddygon ymgynghorol sy'n cyfrannu at y rota acíwt ac mae 52% yn cyfrannu at y rota meddygol cyffredinol.[9] Hefyd ceir llawer o amrywiad rhwng arbenigeddau'r RCP. Er enghraifft, mae bron iawn pob ymgynghorydd sy'n gweithio ym meddygaeth strôc, resbiradol neu fewnol acíwt yng Nghymru yn cyfrannu at y broses dderbyn acíwt. Fodd bynnag, mae'r ffigyrau ar gyfer meddygaeth arennol (36.4%) a chardioleg (38.8%) llawer yn is, ac mewn rhai arbenigeddau, nid oes unrhyw ymgynghorwyr o gwbl sy'n cymryd rhan yn y broses dderbyn acíwt yng Nghymru.[9] Yn y dyfodol, bydd angen i'r llwyth gwaith derbyn acíwt gael ei ddosbarthu'n fwy cyfartal rhwng yr holl arbenigeddau er mwyn caniatáu mwy o hyblygrwydd ac atal bod llwyth gwaith anhydrin meddygaeth acíwt ar ysgwyddau nifer fach yn unig.

Ar yr un adeg, mae cyfansoddiad y gweithlu'n newid hefyd. Mae mwy o ymgynghorwyr yn gweithio'n hyblyg neu'n rhan amser. I ryw raddau, mae hyn oherwydd bod mwy o ferched yn y gweithlu meddygol bellach – rhwng 2007 a 2012, cynyddodd nifer y doctoriaid benywaidd o dan 30 oed gan 18%, ac yn 2012, roedd 61% o ddoctoriaid o dan 30 oed yn ferched.[16] Darganfu cyfrifiad RCP 2015 o feddygon ymgynghorol bod 33.3% o ymgynghorwyr benywaidd yng Nghymru'n gweithio'n rhan amser, o'u cymharu ag 8.8% o ymgynghorwyr gwrywaidd. Mae'r duedd hon mewn patrymau gwaith sy'n newid yn codi materion ynglyn â chyfanswm nifer y doctoriaid a fydd yn ofynnol yn y dyfodol os bydd cyfran y rheiny sy'n gweithio'n rhan˜amser yn parhau i dyfu. Os yw ymgynghorydd yn gweithio'n rhan amser, gall ei gyfraniad cymharol at y broses dderbyn feddygol acíwt amrywio'n fawr. Bydd angen i ni weld cynnydd mewn swyddi hyfforddiant i ganiatáu ar gyfer cynnydd mewn gweithio llai nag amser llawn yn y dyfodol.

Mae'n werth nodi bod anawsterau recriwtio ar gyfer llawer o arbenigeddau yn y rhan fwyaf o rannau o'r DU, nid yng Nghymru'n unig, a byddai 72.7% o hyfforddeion arbenigol iawn yn parhau i ddewis i hyfforddi yng Nghymru petaent yn gallu troi amser yn ôl.[9] Fodd bynnag, ceir swyddi gwag i hyfforddeion ar rota pob ysbyty acíwt yng Nghymru, a llynedd, nid oedd y GIG yng Nghymru, yn gallu llenwi 39.8% o'r swyddi meddyg ymgynghorol roedd yn eu hysbysebu.[17] Yn y rhan fwyaf o achosion, nid oedd byrddau iechyd yn gallu penodi oherwydd nid oedd unrhyw ymgeiswyr yn syml.

Mae cymhlethdod yr her

Roedd adroddiad RCP *Hospitals on the edge?*[18] yn manylu ar faint a chymhlethdod yr heriau sy'n wynebu staff gofal iechyd ar draws y DU, a'r effaith y gall hyn ei chael ar ofal cleifion. Disgrifiodd:

- **system iechyd sy'n anghyflawn i ymdopi ag anghenion poblogaeth sy'n heneiddio ag anghenion fwyfwy cymhleth clinigol, gofal a chymorth**
- **ysbytai sy'n cael trafferth i ymdopi â chynnydd mewn galwadau clinigol**
- **methiant systematig i ddarparu gofal cydgysylltiedig, sy'n canolbwyntio ar y claf, â chleifion yn gorfod symud rhwng gwelyau, timau a lleoliadau gofal heb lawer o gyfathrebu neu rannu gwybodaeth**
- **gwasanaethau iechyd, gan gynnwys ysbytai, sy'n cael anhawster i ddarparu gwasanaethau o ansawdd uchel ar draws 7 diwrnod, yn enwedig ar benwythnosau**
- **argyfwng sy'n dod i'r amlwg yn y gweithlu meddygol, ag ymgynghorwyr a doctoriaid dan hyfforddiant o dan bwysau cynyddol.** ■

Heb ddigon o arian, heb ddigon o ddoctoriaid ac wedi'i orymestyn

Mae'r GIG yn cynnig rhywfaint o'r gofal iechyd o'r ansawdd uchaf, mwyaf effeithlon a mwyaf hygyrch yn y byd, ar y brig ar restr Cronfa'r Gymanwlad o systemau iechyd y byd.[19] Mae gan y DU draddodiad hir o arloesi meddygol,[20] ac mae doctoriaid sy'n gweithio ar draws y GIG yn parhau i wneud darganfyddiadau meddygol arloesol sy'n newid y ffordd rydym yn trin clefydau ac yn gofalu am gleifion. Mae ein canllawiau clinigol yn cael eu hallforio o amgylch y byd, ac rydym yn denu doctoriaid rhyngwladol â'n rhaglenni o hyfforddiant ac addysg feddygol sy'n enwog yn fyd eang.

Mae hynny'n llawer i ymfalchïo ynddo. Fodd bynnag, nid yw'n esgus i fod yn hunanfodlon. Mae'r RCP wedi dadlau ers tro bod angen i ni ail-feddwl y ffordd rydym yn darparu gofal iechyd: chwalu rhwystrau rhwng ysbytai a'r gymuned, a gweithio mewn partneriaeth â chleifion i ddarparu gofal di-dor.[21] I gyflawni hyn, mae angen gwasanaeth iechyd arnom sy'n cael ei ariannu i fodloni'r gofynion arno gan ein poblogaeth sy'n tyfu.

Nid yw cyllideb y GIG wedi cadw i fyny â galw cynyddol am wasanaethau. Nid ydym yn hyfforddi digon o ddoctoriaid chwaith. Mae nifer y myfyrwyr meddygol wedi gostwng a cheir diffyg doctoriaid sy'n hyfforddi i ddod yn arbenigwyr meddygol. Mae mwy na thraean o hyfforddeion arbenigol uwch yng Nghymru yn gweithredu i lawr yn rheolaidd neu'n achlysurol i lenwi bylchau ar rota.[9] Mae'r argyfwng gweithlu hwn wedi cael effaith ddilynol ar swyddi ymgynghorwyr, â byrddau iechyd Cymru yn methu â llenwi dwy mewn pump o'r swyddi maent yn eu hysbysebu.[9]

Mae staff y GIG yn teimlo fwyfwy fel difrod ystlysol yn y frwydr rhwng galw sy'n cynyddu a chyllidebau sy'n cael eu gwasgu – a phan fydd lles staff y GIG yn dioddef, bydd profiad a diogelwch cleifion yn dioddef hefyd. Mae 95% o ddoctoriaid dan hyfforddiant RCP yn y DU yn adrodd bod morâl staff gwael yn cael effaith negyddol ar ddiogelwch cleifion yn eu hysbyty.[22]

Mae GIG Cymru angen gweledigaeth tymor hir newydd – dim mwy o atebion cyflym neu ddatrysiadau dros dro. Mae angen i ni weithredu ar frys i fynd i'r afael ag effaith uniongyrchol GIG heb ddigon o arian, heb ddigon o ddoctoriaid ac wedi'i orymestyn. Cred y RCP bod cleifion yn haeddu GIG sydd â digon o arian a staff i ddiwallu eu hanghenion, yn awr ac yn y dyfodol.

Argymhellion allweddol

Mae'r RCP wedi nodi'r blaenoriaethau allweddol canlynol:

Dangos gweledigaeth ac arweinyddiaeth genedlaethol

- Datblygu gweledigaeth dymor hir uchelgeisiol i'r GIG yng Nghymru.
- Cynyddu buddsoddiad mewn modelau newydd o ofal cymdeithasol ac iechyd integredig.
- Datblygu strategaeth hyfforddiant a gweithlu meddygol genedlaethol.
- Dangos arweinyddiaeth genedlaethol ar y cydbwysedd rhwng gwasanaeth a hyfforddiant.
- Gweithio gyda meddygon i ail-ddylunio gwasanaethau meddygol acíwt ac arbenigol.
- Sicrhau bod ysbytai'n gweithio mewn cynghreiriau ffurfiol, â strwythur, i ddarparu gofal integredig.
- Sefydlu rôl pennaeth meddygaeth, wedi'i gefnogi gan brif gofrestrydd.
- Cefnogi a hyrwyddo yn gyhoeddus model gofal Ysbyty'r Dyfodol sy'n canolbwyntio ar y claf.
- Cynyddu gwariant ar iechyd a buddsoddi mewn arloesi ac atal dan arweiniad clinigol.

Buddsoddi yn y gweithlu meddygol

- Dilyn dull strategol o ymdrin â chynllunio gweithlu.
- Sicrhau bod y llwyth gwaith derbyniadau acíwt gael ei ddosbarthu'n fwy cyfartal rhwng yr holl arbenigeddau.
- Hyfforddi cyfran fwy o ddoctoriaid yn sgiliau meddygaeth gyffredinol.
- Cefnogi meddygon sy'n gweithio mewn swyddi nad ydynt yn swyddi hyfforddiant i ddatblygu eu gyrfaoedd.
- Buddsoddi mewn casglu data i ddarparu sylfaen dystiolaeth gadarn ar gyfer cynllunio recriwtio meddygol.
- Gwneud lles ac iechyd staff yn flaenoriaeth genedlaethol.

Cefnogi arweinwyr clinigol y dyfodol

- Hyrwyddo Cymru fel lle gwych i fyw a gweithio fel doctor.
- Canolbwyntio ar fynd i'r afael â heriau recriwtio a hyfforddi.
- Cynyddu nifer y swyddi hyfforddi israddedig ac ôl-raddedig yng Nghymru.
- Datblygu llwybrau hyfforddi sy'n arbennig mewn gofal iechyd gwledig ac anghysbell yng Nghymru.
- Cynyddu nifer y lleoedd ysgol feddygol sy'n cael eu cynnig i fyfyrwyr sy'n hanu o Gymru.
- Gwella'r gefnogaeth sydd ar gael i ddoctoriaid iau mewn ardaloedd gwledig.
- Buddsoddi mewn rhaglenni hyfforddiant ac arweinyddiaeth glinigol.
- Penodi prif gofrestryddion ym mhob bwrdd iechyd i roi llai i hyfforddeion.

Datblygu ffordd newydd o weithio

- Annog byrddau iechyd i roi model gweithlu Ysbyty'r Dyfodol RCP ar waith.
- Darparu mwy o ofal meddygol arbenigol yn y gymuned.
- Buddsoddi mewn ffyrdd newydd arloesol o weithio ar draws yr holl sector gofal cymdeithasol ac iechyd.
- Arwain y ffordd trwy ddatblygu modelau gweithlu integredig newydd mewn cymunedau gwledig.
- Datblygu rôl meddyg cymunedol.
- Mynd i'r afael â phrinder nyrsys a datblygu rolau clinigol eraill yng ngweithlu'r GIG.
- Sicrhau ymhellach bod telefeddygaeth yn rhan annatod o ymarfer bob dydd.

Yr angen am arweinyddiaeth genedlaethol

Mae cleifion yn haeddu mynediad at ofal ansawdd uchel oddi wrth weithlu cymwysedig. Yn yr un modd, mae doctoriaid a gweithwyr iechyd proffesiynol eraill yn haeddu gweithio mewn amgylcheddau â chefnogaeth dda, â lefelau staffio sy'n hyrwyddo gofal effeithiol, ansawdd uchel, diogel ac yn galluogi iddynt wneud cynnydd yn eu gyrfaoedd.

Mae storm berffaith yn prysur agosáu: i fynd i'r afael â'r argyfwng recriwtio meddygol sy'n tyfu, costau locwm ac asiantaeth sy'n cynyddu a gorddibyniaeth ar ddoctoriaid dan hyfforddiant, mae'n rhaid i'r GIG yng Nghymru gael y pwer a'r adnoddau i ddatblygu datrysiadau radical a chymryd camau ar y cyd, chefnogaeth ymrwymiad cryf gan lywodraeth ac arweinyddiaeth genedlaethol. .

Gweledigaeth i'r dyfodol

Dylid datblygu strategaeth glir, wedi'i diweddaru ar gyfer GIG Cymru. Mae adolygiadau olynol yn yr ychydig flynyddoedd diwethaf wedi ailadrodd yr un alwad hon i weithredu (gan gynnwys yr Adolygiad o Fuddsoddiad mewn Addysg Gweithwyr Iechyd Proffesiynol[23] ac adolygiad Jenkins o weithlu'r GIG yng Nghymru[24]) ac eto nid yw eto'n glir sut mae llywodraeth Cymru yn bwriadu gweithio gyda chleifion a chlinigwyr i wneud hyn.

Bellach mae'n rhaid i Lywodraeth Cymru arwain datblygiad cynllun tymor hir ar gyfer dyfodol y gwasanaeth iechyd yng Nghymru. Mae'n rhaid i weinidogion ddangos arweinyddiaeth genedlaethol i greu sefydlogrwydd a chefnogi trawsnewidiad tymor hir y gwasanaeth iechyd. Bydd hyn yn gofyn am gyfathrebu gwell a buddsoddiad go iawn, yn enwedig mewn cynlluniau cyflawni clinigol. Dylai amcan tymor hir i gynyddu buddsoddiad mewn modelau newydd o ofal cymdeithasol ac iechyd integredig fod wrth wraidd pob penderfyniad gwario. Yn anad dim, mae angen gweledigaeth glir arnom o sut y bydd y gwasanaeth yn edrych yn y dyfodol er mwyn cynllunio hyfforddiant meddygol effeithiol.

Gweithlu cynaliadwy yw'r her fwyaf sy'n wynebu GIG Cymru yn y blynyddoedd i ddod ... Ceir pryderon hysbys ynglyn â phrinder staff mewn rhai ardaloedd, ac a yw'r niferoedd a rolau cywir o staff meddygol a gofal iechyd yn cael eu recriwtio a'u cadw i ddarparu gofal yn y dyfodol.[25]

Cynllunio'r gweithlu meddygol

Yn fwy penodol, nid oes unrhyw wir ddull strategol genedlaethol o ymdrin â chynllunio gweithlu meddygol yng Nghymru. Dros y blynyddoedd, mae hyn wedi cyfrannu at heriau recriwtio a chadw yn y gweithlu meddygol, yn enwedig ymhlith doctoriaid dan hyfforddiant. Fel mater o frys, mae'n rhaid i Lywodraeth Cymru weithio gyda'r GIG a chyrff addysg feddygol i ddatblygu strategaeth hyfforddiant a gweithlu meddygol genedlaethol, o dan arweiniad clinigol, sy'n sicrhau bod staff yn cael eu defnyddio a'u hyfforddi yn effeithiol, yn awr ac yn y dyfodol. Mae gan Gymru gyfle gwirioneddol i ddatblygu model arloesol, ac anogwn roi arweinyddiaeth glinigol wrth galon y broses honno.

Mae'r rhaid i Lywodraeth Cymru, byrddau iechyd a darparwyr addysg feddygol gydnabod y cydbwysedd bregus rhwng anghenion gwasanaeth a materion hyfforddiant a datblygu modelau gweithlu arloesol. Mae pob ysbyty yng Nghymru yn dibynnu ar ei hyfforddeion a cheir goblygiadau enfawr pan fydd uned yn colli ei statws hyfforddi. Dylai meddygon sy'n gweithio mewn ysbytai gwledig ac anghysbell gael eu cefnogi gan gydweithwyr sy'n gweithio mewn ysbytai eraill, nid yn unig o ran darpariaeth gwasanaeth, ond hefyd ag amser addysgu. Dylai ysbytai ar draws Cymru weithio fel casgliad o gynghreiriau ffurfiol, â strwythur sy'n gweithredu fel rhwydweithiau gofal integredig neu brif ganolfan a lloerennau. Mae'n rhaid i wleidyddion ddangos arweinyddiaeth genedlaethol a chefnogi datrysiadau arloesol i gadw'r unedau hyn yn gynaliadwy.

Newid mewn gwasanaeth sy'n canolbwyntio ar y claf

Mae'n rhaid i ad-drefnu ganolbwyntio ar y claf, gael ei arwain yn glinigol a bod yn seiliedig ar dystiolaeth. Mae'n rhaid i hyn beidio ag ymwneud â thorri costau'n unig. Mae'n rhaid ail-ddylunio gwasanaethau ysbyty gan ddefnyddio dull system gyfan o weithredu a dylai clinigwyr gofal eilaidd fod yng nghanol y cynllunio gwasanaeth hwn. Dylai ysbytai a byrddau iechyd sefydlu rôl pennaeth meddygaeth, â chefnogaeth prif gofrestrydd, sy'n darparu cyswllt clinigol uniongyrchol rhwng rheolwyr, meddygon a hyfforddeion.

Dylai gweinidogion gefnogi a hyrwyddo'r model Ysbyty'r Dyfodol sy'n canolbwyntio ar gleifion fel templed ar gyfer ail-ddylunio gwasanaeth dan arweiniad clinigol. Dylai llywodraeth Cymru siarad â gwasanaethau gofal cymdeithasol ac iechyd lleol am sut maent yn ymgorffori egwyddorion Ysbyty'r Dyfodol. Dylai cynllunwyr iechyd gefnogi clinigwyr trwy gael gwared ar rwystrau i gyflawni ysbyty'r dyfodol. Bydd y RCP yn parhau i weithio'n uniongyrchol â byrddau iechyd a chlinigwyr trwy rannu ymarfer da oddi wrth bartneriaid Ysbyty'r Dyfodol ar draws y DU.

Bydd hyn i gyd angen newid drastig mewn meddylfryd. Ers tro, mae'r RCP wedi galw am fwy o ymgysylltu ac arweinyddiaeth glinigol, a mwy o feddwl cydgysylltiedig rhwng cynllunio gwasanaeth ac anghenion hyfforddiant. Nawr yw'r amser i ailfeddwl am sut bydd gweithlu'r GIG yn y dyfodol yn hyfforddi, yn datblygu eu sgiliau ac yn ymarfer meddygaeth.

Ar y rheng flaen: Beth mae meddygon ymgynghorol yn ei wneud?

Doctor uwch sy'n ymarfer mewn un o'r arbenigeddau meddygol yw meddyg ymgynghorol. Ar ôl cwblhau hyfforddiant arbenigol, mae doctoriaid yn gallu gwneud cais am swyddi ymgynghorydd. Efallai y bydd amser meddyg ymgynghorol nodweddiadol yn cael ei rannu rhwng gweithio gyda thimau cleifion mewnol, mewn clinigau cleifion allanol, ymgymryd â rhestrau gweithdrefnol a gweld cleifion newydd eu derbyn.

- **Cyfrifoldebau i gleifion mewnol.** Bydd gan feddyg ymgynghorol gyfrifoldeb terfynol ar gyfer unrhyw gleifion mewnol sy'n cael eu neilltuo i'w ofal. Bydd yn arwain y tîm cleifion mewnol, ac yn helpu i ddatrys materion parhaus mewn perthynas â phenderfyniadau diagnosis, triniaeth a rhyddhau.
- **Clinigau cleifion allanol.** Bydd cleifion sy'n cael eu hatgyfeirio, o ofal sylfaenol yn nodweddiadol, yn cael eu gweld gan feddygon ymgynghorol ar gyfer cyngor arbenigol. Gallai'r clinigau hyn fod ar gyfer cyngor cyffredinol neu mewn perthynas â chyflwr neu anhwylder penodol.
- **Rhestrau gweithdrefnol.** Mae gan lawer o arbenigeddau restrau gweithdrefnol y mae disgwyl i feddygon ymgynghorol ymgymryd â hwy, fel colonosgopi (gastroenteroleg) neu froncosgopi (resbiradol).
- **Y broses dderbyn acíwt.** Bydd gan lawer o ymgynghorwyr gyfrifoldeb dros yr holl gleifion sy'n cael eu derbyn i ysbyty dros gyfnod penodol o amser. Bydd y cleifion hyn yn cael eu gweld a bydd y meddyg yn sicrhau y cytunir ar ddiagnosis a chynllun rheolipriodol.

Mae'r rôl yn amrywio'n fawr rhwng arbenigeddau oherwydd natur y gwaith. Er enghraifft, nid oes gan rai meddygon ymgynghorwyr unrhyw gleifion mewnol wedi'u neilltuo i'w gofal ac yn treulio'r rhan fwyaf o'u hamser mewn clinigau cleifion allanol. Yn aml maent ar gael ar gyfer cyngor ac ymgynghori.

Mae gwaith yr ymgynghorydd yn mynd y tu hwnt i ofal uniongyrchol am gleifion. Hefyd disgwylir i feddygol ymgynghorol gymryd rhan mewn addysgu a hyfforddi myfyrwyr a doctoriaid iau a goruchwylio datblygiad clinigol ac addysgol meddygon dan hyfforddiant.

Hefyd mae'n rhaid iddynt sicrhau bod eu dysgu eu hunain yn gyfoes trwy ymgymryd â datblygiad proffesiynol a pharhau i ddysgu sgiliau a gweithdrefnau newydd. Efallai y byddant yn cyfrannu at y ddealltwriaeth o'u harbenigedd trwy ymchwil.

Mae'n arferol i feddygol ymgynghorol gymryd cyfrifoldebau arweinyddiaeth, fel cydlynu rota i'r tîm neu ddatblygu polisïau i'r adran. Efallai y byddant hefyd yn ymgymryd â rôl fwy ffurfiol â'r bwrdd iechyd, fel cyfarwyddwr clinigol; â'r RCP fel tiwtor coleg brenhinol; neu â'r ddeoniaeth, fel cyfarwyddwr rhaglen hyfforddi. ■

Dr Richard Gilpin a Dr Charlotte Williams
Meddygon dan hyfforddiant, GIG Cymru

Mae problemau â recriwtio staff meddygol yn bygwth bodolaeth llawer o ysbytai a meddygfeydd yng Nghymru. Mae angen i ni hyfforddi mwy o ddoctoriaid a nyrsys yng Nghymru â'r nod o'u cadw i weithio yng Nghymru. Mae angen mynd i'r afael â'r tensiwn rhwng anghenion hyfforddi ac anghenion gwasanaeth trwy ddatblygu strategaeth gweithlu genedlaethol.

Meddyg ymgynghorol yng Nghymru

Mae angen i ni symud i ffwrdd o fodel gweithlu lle rydym yn buddsoddi mewn naill ai gofal sylfaenol ynteu ofal eilaidd, a thuag at fwy o weithio tîm integredig – yr ysbyty heb waliau – lle mae arbenigwyr yn cynnal mwy o'u clinigau yn y gymuned, ac mae meddygon teulu yn treulio rhan o'u hamser yn gweithio gyda chydweithiwr wrth ddrws ffrynt yr ysbyty. Mae hefyd yn bwysig cofio bod 80% o'r gweithwyr iechyd proffesiynol a fydd yn darparu gofal ymhen 10 mlynedd eisoes yn gweithio yn y GIG heddiw.[5] Mae angen i ni adeiladu ar set sgiliau ein gweithlu presennol i gyflawni modelau gofal newydd yn y dyfodol.

Buddsoddi mewn ffordd newydd o weithio

Mae lefel y cyllid i'r gwasanaeth iechyd yn ddewis gwleidyddol. Ar sail amcangyfrifon yr Ymddiriedolaeth Nuffield y gallai fod bwlch cyllido digynsail o £2.5 biliwn erbyn 2025/26 yng Nghymru,[12] bydd angen i Lywodraeth Cymru gynyddu gwariant ar iechyd. Fodd bynnag, mae'n hanfodol nad yw'r arian hwn yn mynd tuag at gynnal yr hen system sydd wedi torri. Mae'n rhaid i weinidogion hyrwyddo modelau arloesol o integreiddio a chyflwyno cyllidebau a rennir sy'n sefydlu deilliannau a rennir ar draws y sector gofal ac iechyd lleol. Ni fydd gwario arian ar y system sydd eisoes yn bodoli yn newid unrhyw beth yn y tymor hir; mae'n rhaid i fyrddau iechyd fuddsoddi mewn atal a thrin cyflyrau cronig a chaniatáu clinigwyr i arloesi.

Mae'n rhaid i Lywodraeth Cymru hyrwyddo dadl gyhoeddus ddeallus ar ail-ddylunio gwasanaeth iechyd lleol, yn genedlaethol ac yn lleol. Mae gan wleidyddion ym mhob plaid gyfrifoldeb gwirioneddol i gefnogi newid dan arweiniad clinigol, sy'n seiliedig ar dystiolaeth, a fydd yn darparu gwell gofal i gleifion. Mae'n rhaid i fyrddau iechyd a llywodraeth Cymru sicrhau bod newid yn cael ei arwain gan gleifion a chlinigwyr yn wirioneddol, ac nid yw'n cael ei gyflwyno fel 'penderfyniad terfynol' yn hwyr yn y broses gynllunio.

Buddsoddi yn y gweithlu meddygol

Mae'n rhaid i gynllunio'r gweithlu fod yn flaenoriaeth allweddol. Mae'n rhaid gwerthfawrogi meddygaeth gyffredinol a chymryd camau brys i sicrhau bod mwy o feddygon yn cyfrannu at y broses dderbyn acíwt.

Mae'n rhaid i Lywodraeth Cymru weithio gyda chydweithwyr yn y GIG, ysgolion meddygol israddedig ac ôl-raddedig, a'r colegau brenhinol i asesu sut mae angen i'r gweithlu meddygol presennol addasu i ddarparu'r model gofal yn y dyfodol y mae cleifion ei angen. Bydd angen i'r gweithlu meddygol addasu i ddarparu parhad gofal ac integreiddio gofal ysbyty a chymunedol mewn modd cynaliadwy. Mae'n rhaid diffinio siâp a set sgiliau'r gweithlu sy'n ofynnol ar lefel cenedlaethol a lleol.

Dilyn dull strategol o weithredu

Mae gan y DU lai o ddoctoriaid y pen nag unrhyw wlad fawr arall yn y DU bron iawn.[1] Ynghyd â phrinder nyrsys,[26] mae hyn wedi gadael ein hysbytai'n brin o staff yn gronig, sy'n rhoi mwy o bwysau ar staff y GIG sy'n gweithio'n galed, yn rhoi cleifion mewn perygl ac yn bygwth dyfodol y GIG. Mae angen i ni weithredu ar unwaith i leddfu'r pwysau presennol ar weithlu'r GIG, a chynllun dewr a chydgysylltiedig i sicrhau bod gan y GIG staff ac yn gynaliadwy yn y tymor hir.

Mae angen i'r GIG yng Nghymru ddechrau cynllunio yn awr i sicrhau gweithlu meddygol cryf i'r dyfodol. Dros y blynyddoedd nesaf, bydd angen mwy o feddygon cyffredinol arnom, yn enwedig wrth i ni weithio tuag at ddarparu mwy o ofal arbenigol yn y gymuned.

Mae'n hanfodol ein bod yn ymuno cynllunio'r gweithlu ag ad-drefnu gwasanaethau. Dylid alinio strategaeth hyfforddiant ac addysg â chynlluniau integredig tymor canolig GIG Cymru 2017–18.[25] Mae angen i ni edrych yn genedlaethol ar ddyfodol ein gwasanaeth iechyd: mae'n debygol, mewn Cymru ôl ad-drefnu, y bydd gennym nifer lai o brif ysbytai acíwt sy'n darparu gofal arbenigol, â safleoedd eraill llai yn darparu gofal eilaidd parhaus, yn ogystal â mwy o ddarpariaeth o ofal yn y gymuned.

Lledaenu'r llwyth

Mae ymgynghorwyr a hyfforddeion RCP yn rheoli'r rhan fwyaf o dderbyniadau meddygol brys i'n hysbytai yng Nghymru ac yn darparu'r holl wasanaeth y tu allan i oriau ar gyfer wardiau oedolion bron iawn. Mae llawer yn cyfuno meddygaeth gyffredinol ag arbenigedd arall fel cardioleg, strôc neu feddygaeth resbiradol. Mae meddygon yn gofalu am amrywiaeth eang o gleifion a allai fod yn dioddef gan unrhyw un o blith nifer o anhwylderau cyffredin, efallai bod ganddynt nifer o gyflyrau neu anghenion cymhleth, neu'n cynrychioli pos diagnostig; cyfrifoldeb y meddyg yw cydlynu gofal parhaus y cleifion hyn.

Mae'r sector hefyd yn parhau i godi pryderon ynglŷn â chynaliadwyedd y gweithlu meddygol mewn gwasanaethau (ysbyty) acíwt. Mae byrddau iechyd lleol yn adrodd ei bod yn anodd recriwtio i rai arbenigeddau ... Mae'r prinder staff meddygol wedi arwain at ystyried bod rhai gwasanaethau'n anniogel.[28]

Fodd bynnag, mae mwy a mwy o ymgynghorwyr yn dewis ymeithrio o'r broses dderbyn acíwt. Yn 2012, roedd meddygon yn ymarfer mewn dim ond chwech allan o deg ar hunain arbenigedd y RCP yn darparu'r rhan fwyaf o ofal meddygaeth gyffredinol a gofal acíwt heb ei ddethol yng Nghymru.[27] At hynny, mae cyfrifiad diweddaraf yn dangos na fyddai 58.5% o hyfforddeion arbenigedd uwch yng Nghymru yn dewis hyfforddi mewn meddygaeth gyffredinol petaent yn gallu troi amser yn ôl.[9] Canfyddir yn gynyddol bod meddygaeth fewnol gyffredinol yn arbenigedd straen uchel â llwyth gwaith uchel iawn. Yng Nghymru, mae 48.5% y meddygon ymgynghorol yn dweud bod adegau pan maent yn teimlo eu bod yn gweithio o dan bwysau gormodol, â 35.4% yn dweud bod hyn yn digwydd yn aml. Yn fwy pryderus, mae 92.3% o feddygon ymgynghorol yn dweud wrthym eu bod weithiau, yn aml, neu bob amser yn canfod eu hunain yn gwneud gwaith y byddai doctor is wedi'i wneud yn y gorffennol.[9] Mae'r sector hefyd yn parhau i godi pryderon ynglyn â chynaliadwyedd y gweithlu meddygol mewn gwasanaethau (ysbyty) acíwt. Mae byrddau iechyd lleol yn adrodd ei bod yn anodd recriwtio i rai arbenigeddau ... Mae'r prinder staff meddygol wedi arwain at ystyried bod rhai gwasanaethau'n anniogel.[28] Yn 2016, nid oedd y GIG yng Nghymru yn gallu llenwi 39.8% o'r swyddi meddyg ymgynghorol a hysbysebwyd.29 Mae'r methiant hwn i benodi hyd yn oed yn uwch ar gyfer rolau â galw uchel amdanynt sy'n canolbwyntio ar ofalu am bobl hwn a phobl sâl iawn.[30] Er gwaethaf y cynnydd parhaus mewn galw am arbenigwyr mewn meddygaeth yr henoed, gostyngodd nifer y lleoedd hyfforddi ar gyfer yr arbenigedd hwn yn 2015.[30]

Dylai'r llwyth gwaith derbyniadau acíwt gael ei ddosbarthu'n fwy cyfartal rhwng yr holl arbenigeddau. Dylid cydnabod meddygaeth fewnol gyffredinol fel un o'r agweddau pwysicaf a mwyaf heriol mewn gofal acíwt, ac mae'n rhaid gweithredu ar frys i'w drawsnewid yn swydd statws uchel. Bydd nifer fwy o feddygon yn gweithio mewn meddygaeth fewnol gyffredinol yn caniatáu mwy o hyblygrwydd ac yn atal bod llwyth gwaith anhydrin meddygaeth acíwt ar ysgwyddau nifer fach yn unig. Byddai hyn hefyd yn darparu'r gofal cleifion gorau ar gyfer y nifer gynyddol o gleifion â chyflyrau tymor hir lluosog, ac mae'n allweddol i lwyddiant y symud arfaethedig o ofal ysbyty i ofal yn y gymuned.

Aildrefnu'r gweithlu gofal heb ei drefnu

Yn y blynyddoedd diweddar, mae Ysbyty Treforys yn Abertawe wedi profi heriau mawr wrth ddarparu gwasanaethau gofal heb eu trefnu. Roedd doctoriaid yn wynebu cyfradd defnydd gwelyau 100% mewn meddygaeth, cyfran uchel o gleifion sy'n ffit yn feddygol yn defnyddio gwelyau meddygol acíwt a rhwystrau yn y system yn arwain at oedi wrth drosglwyddo gofal. Penderfynodd y tîm meddygol fynd i'r afael â'r problemau hyn trwy aildrefnu eu gweithlu meddygol a gwasanaeth meddygol acíwt gan ddefnyddio egwyddorion gweithlu Ysbyty'r Dyfodol.

Bellach mae'r ysbyty wedi ailstrwythuro ei batrymau gwaith i sicrhau mwy o ymwneud wrth ddrws ffrynt yr ysbyty yn ystod yr wythnos ac ar benwythnosau, â mynediad ar unwaith at yr holl arbenigeddau meddygol, gan gynnwys gwasanaethau i'r oedrannus ac eiddil, a sefydlu gwasanaeth gofal dydd. Mae hyn wedi arwain at well llif cleifion, gwasanaeth cleifion mewnol y mae ymgynghorwyr yn ei ddarparu, a doctor uwch yn adolygu cleifion ar ddyddiau'r wythnos, gan weithio tuag at wasanaeth 7 diwrnod.

Mae ymgynghorwyr Treforys wedi cytuno ar yr egwyddorion canlynol: bydd gan bob claf ymgynghorydd a enwyd, bydd doctoriaid yn cymryd arweiniad clinigol am ddiogelwch, canlyniadau clinigol a phrofiad y claf, bydd gan bob claf gynllun rheoli clinigol manwl a seiliwyd ar barhad gofal. Bydd gan feddygon rôl gynyddol mewn gofal cyffredinol a gofal heb ei drefnu. Bydd meddyg ymgynghorol yn bresennol yn yr ysbyty 12 awr y dydd, 7 diwrnod yr wythnos, ag ail ymgynghorydd yn bresennol ar benwythnosau.

I gyflawni hyn, sefydlwyd timau ward sy'n seiliedig ar arbenigedd. Cafodd yr holl arbenigeddau eu cynllunio ar sail grwp gwaith a gofynnwyd iddynt gyflawni'r safonau hyn â ffocws penodol ar ofal heb ei drefnu â gwaith â chleifion mewnol. Roedd hyn yn golygu bod yn rhaid iddynt rannu'r gwaith rhwng eu hunain ac mae gan y rhan fwyaf rotâu ag un neu ddau ymgynghorydd yn gwneud gwaith â chleifion mewnol yn bennaf am 1 mis ar y tro. Roedd yr ailddylunio angen buddsoddiad sylweddol a chytunodd y bwrdd iechyd i benodi nifer o feddygon ychwanegol i ddarparu meddygaeth gyffredinol â ffocws ar gleifion eiddil ac oedrannus.

Hyd yma mae'r tîm yn Nhreforys yn gallu rhestru nifer o lwyddiannau. Bellach ceir rowndiau ward ymgynghorydd 5 diwrnod yr wythnos ac mae'r safonau penodol a restrwyd uchod wedi cael eu cyflawni i raddau helaeth. Mae meddygaeth henoed yn darparu gwasanaeth mewngymorth i'r uned derbyniadau meddygol acíwt (AMAU). Hefyd mae arbenigwyr strôc, gastroenteroleg a resbiradol yn cynnal ymweliadau adalw dyddiol â'r AMAU. Bydd dau ymgynghorydd ar alw ar benwythnosau, gostyngiad yn hyd yr arhosiad, ac mae nifer yr allgleifion ar wardiau llawfeddygol i lawr i ffigyrau sengl. Mae mynediad at yr uned strôc wedi gwella.

Fodd bynnag, recriwtio meddygol yw'r un her fwyaf rydym yn ei hwynebu. Rydym wedi methu â llenwi pedair swydd ymgynghorydd eleni. O 26 swydd hyfforddi meddygol craidd, roedd 13 heb eu llenwi ym mis Awst 2016. Mae cynnydd yn y dyfodol yn ansicr oni bai y gellir gwella recriwtio meddygol yng Nghymru. ■

Dr David Price
Cyfarwyddwr clinigol meddygaeth, Ysbyty Treforys
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg

Heb ddigon o ddoctoriaid: Beth allwn ni ei wneud yn y tymor byr?

- **Dylai GIG Cymru ddefnyddio dull mwy cydgysylltedig, wedi'u gydlynu'r genedlaethol o ymdrin â recriwtio.**
- **Dylai byrddau iechyd fuddsoddi mewn rolau meddyg cyswllt sy'n gallu rhyddhau amser hyfforddeion ar gyfer addysg.**
- **Dylai byrddau iechyd ail-fuddsoddi arian hyfforddeion heb ei wario mewn rolau newydd, ee cymrodoriaethau clinigol.**
- **Dylid datblygu lleoliadau ar gyfer myfyrwyr a hyfforddeion meddygol ymhellach.**
- **Dylid annog graddedigion i gychwyn mewn ysgolion meddygol, yn enwedig myfyrwyr sy'n hanu o Gymru.**
- **Dylai hyfforddiant meddygol israddedig ac ôl-raddedig ganolbwyntio ar gyflyrau tymor hir.**
- **Dylid ystyried achredu a chefnogaeth â strwythur ar gyfer ysbytai addysgu.**
- **Dylid annog defnyddio technoleg mewn ffordd fwy arloesol, yn enwedig mewn ardaloedd gwledig.**
- **Dylid datblygu meddygaeth wledig, yn enwedig yng Nghanolbarth Cymru, fel uwch arbenigedd meddygol.**
- **Dylid datblygu cyrsiau Tystysgrif Cymhwysedd ar gyfer Cofrestru Arbenigwyr (CESR) â strwythur sy'n cynnwys cymorth a mentora â strwythur ar gyfer doctoriaid arbenigwr staff a chyswllt.**

Dylai bod yn ofynnol gan gyflogwyr bod ymgynghorwyr yn cwblhau DPP mewn meddygaeth fewnol yn ogystal â'u harbenigedd a dylai'r rhan fwyaf o hyfforddeion meddygon hyfforddi'n ddeuol mewn meddygaeth fewnol a'u harbenigedd, gyda chefnogaeth adborth a goruchwyliaeth ymgynghorydd.[30] Hefyd dylai meddygon sy'n gweithio mewn swyddi gradd ganol, heb hyfforddiant, gael eu cefnogi i ddatblygu eu gyrfaoedd a gwella'u sgiliau proffesiynol. Mae'n rhaid i fyrddau iechyd gymryd camau cyflym i flaenoriaethu'r broses dderbyn acíwt a gwasanaeth i'r ward mewn cynlluniau swydd ymgynghorydd, ond bydd angen cynllunio ofalus ar hyn i sicrhau nad yw'n dod ar draul ymrwymiadau arbenigedd. Hefyd mae'n rhaid i fyrddau iechyd gydnabod y risg i'r gwasanaeth o golli'r ymgynghorwyr hynny sy'n agosáu at ymddeol, a gweithredu i gadw'r uwch feddygon hyn a'u gwybodaeth a phrofiad am gyhyd â phosibl, yn enwedig mewn ysbytai mwy anghysbell.

Adeiladu'r sylfaen dystiolaeth

Dylai llywodraeth Cymru, GIG Cymru, Deoniaeth Cymru, y colegau brenhinol a'r prifysgolion gydweithio i fuddsoddi mewn casglu data a fyddai'n darparu sylfaen dystiolaeth gadarn ar gyfer ymgyrchoedd a strategaethau recriwtio meddygol. Mae angen i ni gael gwell dealltwriaeth o'r sbardunau ar gyfer recriwtio a chadw. Ni wnaethpwyd digon o ymchwil hyd yma, ac mae gormod o benderfyniadau wedi'u seilio ar dystiolaeth anecdotaidd yn unig ynglyn â pham na allwn recriwtio doctoriaid i weithio yn GIG Cymru.

Gweithlu GIG iach

Dylai llywodraeth Cymru fuddsoddi yn iechyd a lles ei gweithlu GIG trwy weithredu canllawiau iechyd y cyhoedd ar gyfer cyflogwyr y Sefydliad Cenedlaethol dros Ragoriaeth mewn Iechyd a Gofal (NICE) ar ordewdra, rhoi'r gorau i ysmygu, gweithgarwch corfforol, lles meddyliol a rheoli salwch tymor hir. Mae lles ac ymgysylltu staff yn gysylltiedig â gwell gofal cleifion a gwell profiad y claf. Dylai llywodraeth Cymru ystyried lles ac iechyd staff fel rhan o'i strategaeth hyfforddi a gweithlu meddygol, buddsoddi mewn cynlluniau mentora a hyfforddi, a hyrwyddo rhannu ymarfer da. Hefyd dylai byrddau iechyd gymryd mwy o ddiddordeb mewn lles ymgynghorwyr a hyfforddeion. Yn aml bydd hyfforddeion sy'n symud rhwng gwahanol gyflogwyr bwrdd iechyd yn rheolaidd yn adrodd ar broblemau aml, gan gynnwys rotâu afresymol, dim llawer o rybudd o ddyrannu sifft, patrymau gweithio anhyblyg, gwallau cyflogres a thaliadau cyflog wedi'u methu, ac anhawster wrth gael mynediad at gyfrineiriau a manylion mewngofnodi wrth newid rhwng ysbytai. Mae'r profiadau hyn yn gallu cael effaith negyddol sylweddol ar forâl y gweithlu. Gallai cael un cyflogwr – GIG Cymru – yn hytrach na chyflogwyr bwrdd iechyd ac ymddiriedolaeth ar wahân helpu i sicrhau bod yr holl ddoctoriaid iau'n cael eu trin a'u gwerthfawrogi fel gweithwyr GIG tymor hir drwy gydol eu cylchdroadau hyfforddiant.

Model gweithlu newydd ar gyfer drws ffrynt yr ysbyty

Ysbyty cyffredinol dosbarth yw Ysbyty Brenhinol Morgannwg ag oddeutu 61,400 o dderbyniadau i'r adran achosion brys bob blwyddyn. Mae tua 30% yn cael eu derbyn. Mae'r bwrdd iechyd yn gwasanaethu poblogaeth â chyfraddau uchel iawn o amddifadedd ac mae'n wynebu heriau recriwtio mawr. Roedd 15% yn unig o'r derbyniadau meddygol yn cael ei reoli fel achosion dydd, ac yn aml roedd cleifion meddygol yn cael eu rheoli ar wardiau heb fod yn rhai meddygol. Gwnaethom benderfynu creu un adran feddygol, yn cyfuno gofal meddygol a gofal brys.

Gwnaethom ddiffinio'r sgiliau a'r cymwyseddau sy'n ofynnol ar gyfer pob cam o brofiad y claf, ac yna dylunio'r gweithlu o amgylch y cymwyseddau hyn. Gwnaethom sicrhau bod parafeddygon yn gallu atgyfeirio'n uniongyrchol at feddygaeth, cynyddu nifer y staff ar y rota, a datblygu'r tîm meddygol mewnol. Gwnaethom hefyd aildrefnu'r timau nyrsys a datblygu rôl y cynorthwyydd y tîm meddygol. Mae'r model gweithlu newydd wedi ei gwneud yn haws recriwtio, wedi cynyddu gofal dydd i 25% o achosion ac wedi gwella boddhad cleifion. Mae wedi gostwng yr amser rhwng cyrhaeddiad 999 i adolygiad gan feddyg ymgynghorol, a cheir llai o gleifion meddygol mewn gwelyau heb fod yn feddygol. ■

Dr Ruth Alcolado
Arweinydd clinigol ar gyfer ailfodelu meddygol
Bwrdd Iechyd Prifysgol Cwm Taf

Cefnogi arweinwyr clinigol y dyfodol

Mae gofal da yn y dyfodol yn dibynnu ar hyfforddiant da yn awr. Mae'n rhaid blaenoriaethu hyfforddiant ac addysg feddygol wrth ddylunio gwasanaethau iechyd. Mae cleifion yn haeddu cael gofal gan feddygon arbenigol.

Mae'n rhaid cynyddu nifer yr hyfforddeion a myfyrwyr meddygol israddedig. Mae'n rhaid cefnogi ac annog doctoriaid iau a myfyrwyr meddygol i aros yng Nghymru trwy gynnig llwybrau hyfforddi newydd arloesol, gwell llwyth gwaith, a mwy o gyfleoedd i gymryd rhan mewn rhaglenni arweinyddiaeth glinigol a gwella ansawdd.

Heb ddigon o ddoctoriaid ac wedi'i orymestyn

Nid yw'r DU yn hyfforddi digon o ddoctoriaid i ateb y galw. Ceir llai o fyfyrwyr meddygol yn nawr nag yn 2010,[31] er gwaethaf nifer gynyddol o gleifion. Mae nifer y doctoriaid cymwys sy'n hyfforddi i fod yn arbenigwyr meddygol hefyd wedi gostwng,[29] ac yn y blynyddoedd diwethaf bu anawsterau wrth lenwi niferoedd sylweddol o swyddi hyfforddi arbenigol.[32] Mae prinder y cofrestryddion meddygol yn cynyddu'r pwysau ar ddoctoriaid sy'n hyfforddi sydd eisoes yn bodoli, yn annog CMTs i beidio â symud i'r rolau hyn ac yn cyfaddawdu gofal cleifion.

Ar hyn o bryd mae Cymru yn cael trafferth i recriwtio digon o hyfforddeion i lenwi rotâu ysbyty; roedd 33% o leoedd hyfforddai meddygol craidd heb eu llenwi yn 2016.[7] Mae'n rhaid mynd ati i ymdrin â'r broblem hon; mae'n rhaid i Lywodraeth Cymru a GIG Cymru weithredu i hyrwyddo Cymru fel lle ardderchog i fyw a gweithio fel doctor.

Darganfu cyfrifiad 2015–16 fod 16.7% o hyfforddeion arbenigedd uwch wedi ystyried gadael y proffesiwn meddygol yn llwyr yn y flwyddyn ddiwethaf, a bod 31.7% yn unig yn meddwl eu bod yn dod o hyd i gydbwysedd priodol rhwng hyfforddiant mewn meddygaeth gyffredinol ac yn eu prif arbenigedd.[9] Hyd yn oed yn waeth, dywedodd 11.6% o hyfforddeion arbenigedd uwch wrthym nad ydynt yn mwynhau eu gwaith yn aml, a dywedodd 62.8% fod y swydd yn gwneud iddynt deimlo'n isel weithiau, yn aml neu bob amser.[9]

Mae problemau â recriwtio meddygol yn bygwth bodolaeth llawer o ysbytai a meddygfeydd yng Nghymru. Mae angen i ni hyfforddi mwy o ddoctoriaid a nyrsys yng Nghymru â'r nod o'u cadw i weithio yma.

Meddyg ymgynghorol yng Nghymru

Mae'r argyfwng recriwtio hyfforddeion yn teimlo feltrên sy'n dod tuag atoch ar hyn o bryd ... mae'n anodd cael rheolaeth ysbyty, sy'n gyfrifol am ein gwaith o ddydd i ddydd, i gydnabod hyn.

Meddyg dan hyfforddiant yng Nghymru

Dim mor 'ifanc': Y daith o fyfyriwr meddygol i ymgynghorydd

- **5 mlynedd mewn ysgol feddygol.** Ar ôl i fyfyrwyr meddygol gwblhau eu gradd feddygol israddedig, byddant yn cychwyn ar hyfforddiant meddygol ôl-raddedig.
- **2 flynedd o hyfforddiant sylfaenol.** Dyma gam cyntaf hyfforddiant ôl-raddedig. Cyfeirir atynt fel doctoriaid iau, doctoriaid mewn hyfforddiant neu hyfforddeion, maent yn gweithio ar gylchdroadau ar draws y GIG, gan gynnwys mewn ysbytai a meddygfeydd.
- **2 flynedd o hyfforddiant meddygol craidd (CMT).** Mae hyfforddeion wedi gwneud y dewis i ddod yn feddyg (yn hytrach na meddyg teulu, llawfeddyg neu fath arall o ddoctor). Byddant yn gwneud pedwar i chwech cylchdro mewn gwahanol arbenigeddau meddygol. Mae rhai hyfforddeion meddygol yn dilyn gwahanol lwybr ac yn cychwyn ar goes cyffredin gofal acíwt (ACCS), sy'n cyfuno 3 blynedd o feddygaeth acíwt, gofal critigol, anaestheteg a meddygaeth frys.
- **4 blynedd o hyfforddiant arbenigol (ST).** Bellach mae hyfforddeion wedi penderfynu pa fath o arbenigwr ysbyty maent eisiau bod, yn dewis o oddeutu 30 arbenigedd meddygol gan gynnwys cardioleg a meddygaeth henoed. Byddant yn cymryd rolau fwyfwy uwch, gan gynnwys fel y cofrestrydd meddygol. Ar ddiwedd yr hyfforddiant arbenigol, gall doctoriaid wneud cais am swydd ymgynghorydd. Mae'n werth cofio bod llawer o hyfforddeion yn treulio blynyddoedd ychwanegol gwerthfawr yn gwneud ymchwil academaidd, yn cymryd rhan mewn rhaglenni arweinyddiaeth, neu'n ennill profiad mewn gwledydd eraill. Mae hyn yn cynyddu hyd cyffredinol yr amser hyfforddi. ■

Beth y gallem ei gynnig i ddoctoriaid iau yng Nghymru?

- rhaglenni cefnogi a mentora â strwythur
- mwy o gyfleoedd gwella ansawdd ac arweinyddiaeth glinigol
- mwy o gyfleoedd ymchwil academaidd ac arloesi
- cyfleoedd gradd MSc a MD a addysgir
- mwy o lwybrau dysgu a phatrymau gwaith hyblyg
- grantiau untro i leddfu baich ariannol arholiadau proffesiynol ■

Ar y rheng flaen: Beth mae meddygon dan hyfforddiant yn ei wneud?

Mae doctoriaid mewn hyfforddiant, yn aml yn cael eu galw'n hyfforddeion neu ddoctoriaid iau, yn darparu gofal cleifion mewn amrywiaeth o leoliadau yn ogystal â bodloni amcanion blynyddol i wneud cynnydd â'u hyfforddiant. Mae'r termau hyn yn cwmpasu doctoriaid ag amrywiaeth o sgiliau a phrofiad o'r rheiny sydd wedi graddio o ysgol feddygol yn y flwyddyn ddiwethaf i'r rheiny sydd wedi bod yn ymarfer meddygaeth am fwy na degawd ac sy'n paratoi i gwblhau eu hyfforddiant a dod yn ymgynghorwyr.

Maent yn gyfrifol am asesu a derbyn y rhan fwyaf o gleifion sâl sy'n mynychu ysbyty trwy adrannau brys neu DacAB a'r tu allan i oriau gwaith arferol, yn ogystal ag edrych ar ôl cleifion mewnol ar y ward. Mae diwrnod nodweddiadol yn cynnwys nodi pob claf y mae eu tîm yn gyfrifol amdanynt a sicrhau eu bod yn cael eu gweld a'u hadolygu ar rownd ward; trefnu ac adolygu profion a diagnosteg; cyfathrebu â chleifion, perthnasau a thimau meddygol eraill; a gwneud trefniadau i ryddhau cleifion. Efallai y byddant hefyd yn gweld cleifion sy'n cael eu hatgyfeirio o'r gymuned mewn clinig cleifion allanol i benderfynu ar gymorth a thriniaeth barhaus ac ymgymryd â rhestrau gweithdrefn fel mater o drefn.

Fel arfer nhw yw'r cyntaf i weld claf sy'n sâl neu'n dirywio ac nid oes ganddynt opsiwn i optio allan o waith penwythnos, dros nos neu sifft. Bydd swyddi'n cael eu cylchdroi bob 4 i 6 mis, a bydd swyddi hirach o hyd at 1 flwyddyn yn cael eu cynnig i hyfforddeion uwch. Mae'r rhain yn sicrhau bod hyfforddeion yn cael profiad o amrywiaeth o sgiliau ac amgylcheddau dysgu, a gall hyn fod mewn nifer o wahanol ysbytai neu ardaloedd.

Maent hefyd yn gyfrifol am eu datblygiad proffesiynol eu hunain. Mae'n rhaid iddynt ymgymryd â nifer benodol o weithdrefnau o dan oruchwyliaeth i sicrhau cymhwysedd. Mae'n rhaid i ddoctoriaid mewn hyfforddiant gwblhau arholiadau proffesiynol, ac ar gyfer meddygon dan hyfforddiant mae hyn yn cynnwys y MRCP tair rhan ac arholiadau arbenigol ag elfennau ysgrifenedig ac ymarferol. Hefyd mae'n rhaid iddynt sicrhau bod eu dysgu yn ddiweddar trwy ddarllen cyfnodolion a mynychu cyrsiau a chynadleddau. ■

Dr Richard Gilpin a Dr Charlotte Williams
Meddygon dan hyfforddiant, GIG Cymru

Yn fy marn bersonol, mae hyfforddiant pwrpasol, hyblygrwydd a mentoriaeth ynghyd â chyfleoedd eang i ddatblygu addysg feddygol, arweinyddiaeth neu sgiliau ymchwil o gyfnod cynnar yn allweddol i hyfforddiant ffantastig.

Meddyg dan hyfforddiant yng Nghymru

Table 1 Nifer y swyddi hyfforddai meddygol craidd (CMT) heb eu llenwi yng Nghymru, Awst 2016[7]

Safle	Cyfanswm	Swyddi gwag
Ysbyty Wrecsam	14	5
Ysbyty Glan Clwyd	18	11
Ysbyty Gwynedd	16	6
Ysbyty Bronglais	4	4
Ysbyty Withybush	10	8
Ysbyty Glangwili	7	3
Ysbyty Tywysog Philip	5	3
Ysbyty Morriston	29	13
Ysbyty Singleton	10	1
Ysbyty Princess of Wales	9	5
Ysbyty Brenhinol Morgan-nwg	10	3
Ysbyty'r Tywysog Siarl	13	2
Felindre	4	0
Holme Towers	2	0
Ysbyty Nevill Hall	11	1
Ysbyty Brenhinol Gwent	24	6
Ysbyty Athrofaol Cymru	26	3
Ysbyty Athrofaol Llandochau	6	0
Cyfanswm	**218**	**74**

Llenwi'r bylchau

Yng nghyfrifiad o ymgynghorwyr yng Nghymru, mae 42.9% o'r ymatebwyr yn adrodd bod bylchau mewn rotâu hyfforddeion 'yn aml yn achosi problemau sylweddol o ran diogelwch cleifion' ac yn ôl 45.8% pellach 'yn aml [yn achosi problemau] ond fel arfer ceir datrysiad amgen felly nid yw diogelwch cleifion yn cael ei gyfaddawdu fel arfer'. Dywedodd 11.3% yn unig o'r ymatebwyr wrthym fod bylchau mewn rotâu yn achosi problem yn anaml neu byth[9] (gweler Tabl 1).

Dywedodd fwy na thraean yr hyfforddeion arbenigedd uwch wrthym eu bod yn gweithredu i lawr yn rheolaidd neu'n achlysurol i lenwi bylchau yn y rota hyfforddeion meddygol craidd.9 Dywedodd bron i ddwy ran o dair o'r hyfforddeion arbenigol hyn eu bod yn teimlo eu bod weithiau, yn aml, neu bob amser yn gweithio o dan bwysau gormodol, â 63.2% yn dweud wrthym fod hyn oherwydd nifer annigonol o hyfforddeion.[9]

Dylid cynyddu nifer y swyddi israddedig meddygol a CMT yng Nghymru. Dylai newidiadau i rota ganiatáu hyfforddeion i weithio gyda'r un timau am floc o amser, i wella parhad gofal a gwella hyfforddi a dysgu yn y gwaith. Dylid amserlennu rolau CMT i sicrhau amser clinig ac amser addysgu. Dylai ysbytai ag adborth gwael gan hyfforddeion gynhyrchu cynlluniau sy'n manylu ar sut byddant yn newid ar unwaith neu byddant mewn perygl o golli'r hyfforddeion hynny.

Mae llawer o hyfforddeion mewn anhawster ariannol ac mae hyn yn cyfrannu at apêl gweithio i asiantaeth, gweithio dramor neu newid gyrfa ... rwy'n pryderu'n aml ynglyn â ph'un a byddaf yn gallu fforddio i gwblhau agweddau gorfodol ar fy hyfforddiant – fel y mae llawer o hyfforddeion eraill yn pryderu.

Meddyg dan hyfforddiant yng Nghymru

Efallai y bydd y GIG yng Nghymru'n dymuno cynnig cymorth ariannol â ffioedd gorfodol fel rhan o becyn i recriwtio doctoriaid dan hyfforddiant a'u cadw. Darganfu'r Gymdeithas Hyfforddeion Meddygaeth Brys (Emergency Medicine Trainee Association) mai cost anochel hyfforddiant yw £15,286.[33] Mae hyn yn rhoi baich enfawr ar hyfforddeion, â gwahanol symiau o ddarpariaeth absenoldeb astudio mewn gwahanol ardaloedd. Nid yw Deoniaeth Cymru neu fyrddau iechyd yn cwmpasu arholiadau proffesiynol gorfodol, a gellir eu hychwanegu at ffioedd aelodaeth undebau a chyrff proffesiynol, ffioedd hyfforddi, Cyngor Meddygol Cyffredinol (GMC) a ffioedd indemniad meddygol, mae nifer fach ohonynt yn osgoadwy. Gallai lleddfu'r straen ariannol hwn fynd yn bell i helpu recriwtio a chadw..

Datblygu gweithlu o Gymru

Yn amlwg mae cynyddu niferoedd hyfforddiant yn ddatrysiad tymor hir, fel y mae creu ysgol feddygol yng ngogledd Cymru a pharhau i ddatblygu'r ysgol ôl-raddedig yn Abertawe. Fodd bynnag, mae'r sefyllfa'n argyfyngus. Nid oedd yn bosibl gwneud 39.8% o benodiadau ymgynghorydd yng Nghymru yn 2015.[9] Mewn mwy na hanner yr achosion, roedd hyn oherwydd nid oedd unrhyw ymgeiswyr o gwbl. Yn syml, nid oes digon o ddoctoriaid ar gael.

Mae'n hanfodol bod Cymru'n gwneud mwy o ymdrech i ddenu ei myfyrwyr ei hun i ysgol feddygol yng Nghaerdydd ac Abertawe. Efallai y bydd y myfyrwyr hyn yn fwy tebygol o aros yng Nghymru ar gyfer eu hyfforddiant ôl-raddedig, ac os byddant yn gadael, maent yn fwy tebygol o ddychwelyd adref yn ddiweddarach. Mae 30% yn unig o fyfyrwyr yn ysgolion meddygol Cymru yn hanu o Gymru. Mae hyn yn cymharu â 55% yn yr Alban, 80% yn Lloegr ac 85% yng Ngogledd Iwerddon.[8] Mae hyn yn erbyn gostyngiad pryderus yn nifer y myfyrwyr sy'n hanu o Gymru sy'n gwneud cais i astudio meddygaeth yn y lle cyntaf; yn ôl UCAS, mae'r nifer hon wedi gostwng gan 15% yn y 5 mlynedd ddiwethaf, gostyngiad mwy serth yng Nghymru nag ar draws gweddill y DU.[34] Mae'n rhaid i ysgolion meddygol gynnig mwy o leoedd israddedig i fyfyrwyr sy'n hanu o Gymru er mwyn tyfu a chadw gweithlu o Gymru, a dylent fuddsoddi mewn rhaglenni allgymorth sy'n annog ceisiadau oddi wrth gymunedau gwledig, anghysbell a Chymraeg eu hiaith.

Gall y bylchau rota mewn llawer o ysbytai llai, gwledig yng Nghymru arwain at weithio unig i lawer i ddoctoriaid iau. Maent hefyd yn golygu nad oes digon o amser addysgu ymgynghorydd wyneb-yn-wyneb i rai hyfforddeion. Dylid datblygu llwybrau hyfforddi sy'n arbenigo mewn gofal iechyd gwledig ac anghysbell yng Nghymru a hysbysebu ar draws y DU i annog yr hyfforddeion gorau i wneud cais.

I gydnabod sut bydd gofal iechyd yn newid dros y blynyddoedd i ddod, dylid adeiladu'r swyddi hyfforddiant gwledig hyn o amgylch taith integredig y claf, a'u gwneud yn fwy deniadol trwy gyfleoedd newydd i ennill cymwysterau ôl-raddedig neu brofiad ffurfiol mewn rolau arweinyddiaeth neu wella gwasanaeth. Os gall Cymru arloesi i ddiwallu ei rhaglenni hyfforddiant ei hun, gallai hyn ddenu hyfforddeion o bob rhan o'r DU a allai fod â diddordeb mewn datblygu sgiliau newydd.

Dull cenedlaethol o ymdrin ag arloesi

Unwaith eto, mae'n amser am strategaeth hyfforddiant a gweithlu meddygol genedlaethol. Heb ddull strategol o weithredu, mae cynllunio gweithlu yng Nghymru wedi mynd yn anghyson a digyswllt. Mae'r GIG yng Nghymru angen gweledigaeth ar gyfer y dyfodol, ac mae'n rhaid i'r weledigaeth hon ddarparu ar gyfer cynllunio gweithlu cenedlaethol – mae'n rhaid i nifer y swyddi hyfforddiant, o ysgol feddygol ymlaen, gael ei chynllunio ar draws y system. Mae cyhoeddiad buddsoddiad mewn gofal sylfaenol i'w groesawu, ond mae'n rhaid iddo beidio ag arwain at brinder mewn gofal meddygol arbenigol. Gellir mynd i'r afael â hyn dim ond os oes cynllun cydlynol i gynyddu nifer gyffredinol y lleoedd hyfforddiant ar draws meddygaeth, o ysgol feddygol ymlaen.

Mae'n rhaid i Lywodraeth Cymru a GIG Cymru ganolbwyntio ar fynd i'r afael â heriau recriwtio a hyfforddi, yn enwedig yng ngogledd a gorllewin Cymru. Bellach mae'n rhaid cynllunio niferoedd arbenigedd ac isarbenigedd yn genedlaethol â mewnbwn clinigol uniongyrchol, ac mae'n rhaid cael ymgais o'r newydd i fynd i'r afael â phryderon am gylchdro hyfforddiant: mae cofrestryddion meddygol yn adrodd bod symud rhwng gogledd Cymru a de Cymru yn amhoblogaidd iawn, yn enwedig pan mae hyn yn golygu symud teuluoedd.

Dylid sefydlu cylchdroadau trawsffiniol ag ysbytai yn Lloegr, a dylai bwrdd iechyd gyfathrebu'n fwy effeithiol â'u hyfforddeion: dylai doctoriaid sy'n dechrau ar gylchdroadau wybod eu hamserlen llawer yn gynt nag y maent ar hyn o bryd. Mae angen i Gymru gymryd yr awenau ac arloesi ar faterion fel hyfforddiant eang, meddygaeth arbenigol yn y gymuned a llwybrau hyfforddiant gwledig.

Mae angen mwy o hyfforddeion

Y rhwystr allweddol i recriwtio hyfforddeion gradd iau a chanolig yw llwyth gwaith trwm y rheiny sy'n gweithio mewn arbenigeddau meddygol. Oherwydd poblogaeth sy'n heneiddio a chynnydd mewn cleifion sy'n byw gyda chyflyrau cronig, tymor hir, yn y dyfodol bydd y GIG angen mwy o ddoctoriaid sy'n gymwys mewn meddygaeth gyffredinol – ond ar hyn o bryd nid oes digon o hyfforddeion i ddelio â'r llwyth gwaith sydd eisoes yn bodoli.

Darganfu un arolwg RCP o hyfforddeion meddygol yn y DU y canfyddir bod llwyth gwaith y cofrestrydd meddygol gradd ganolig yn fwy na'u cyfoedion mewn arbenigeddau eraill: dywedodd 59% o ddoctoriaid iau eu bod yn meddwl bod gan gofrestryddion meddygol lwyth gwaith trwm ac roedd 37% yn meddwl bod eu llwyth gwaith yn 'anhydrin', ac roedd 69% o gofrestryddion meddygol yn meddwl bod cydbwysedd gwaith-bywyd cofrestryddion yn wael.[18] Mewn cymhariaeth, dywedodd 2% yn unig o hyfforddeion llawfeddygol - a dim meddygon teulu dan hyfforddiant - eu bod yn meddwl bod llwyth gwaith eu cofrestryddion yn anhydrin.

Mae'r canfyddiadau hyn yn mynd ati i annog doctoriaid iau i beidio â mynd i mewn i arbenigeddau meddygol: mae cyfraddau ymgeisio ar gyfer cynlluniau hyfforddiant sy'n cynnwys meddygaeth gyffredinol yn gostwng.[18] Mae bylchau rheolaidd wedi dechrau ymddangos mewn rhaglenni hyfforddiant meddygol – bylchau y mae'n rhaid eu llenwi gan staff locwm drud. Pan ofynnwyd a fyddai cymhellion ariannol, gwell defnydd o dechnoleg, neu ostyngiad mewn llwyth gwaith yn gwneud doctoriaid iau yn fwy tebygol i ddod yn gofrestryddion meddygol, dywedodd bron pob ymatebydd mai gostwng llwyth gwaith yw'r ffactor pwysicaf.[35] Dyma reswm arall pam na ddylid lleihau nifer yr hyfforddwyr meddygol; bydd rotâu fwyfwy anhydrin yn gwaethygu problemau â recriwtio.

Er ein bod yn hyfforddi mwy o ddoctoriaid nag erioed, oherwydd bod llawer yn dewis gweithio'n hyblyg, neu'n rhan amser ac mae eraill yn gadael y proffesiwn, ceir colled net yn gyffredinol. Nid oes digon o swyddi CMT yn y DU i lenwi'r swyddi hyfforddiant arbenigedd uwch sydd ar gael, diffyg sy'n cael ei waethygu gan nifer fawr o hyfforddeion meddygol craidd yn gadael meddygaeth gyffredinol am arbenigeddau fel meddygaeth teulu neu oncoleg glinigol. Dylai hyfforddeion yng Nghymru gael eu dilyn trwy'r system a dylid gofyn iddynt pam eu bod yn gadael a beth fyddai'n eu darbwyllo i ddychwelyd.

Arweinwyr clinigol yfory

Dylid cynnig mwy o gefnogaeth ar gyfer ymchwil academaidd a llwybrau hyfforddiant addysg, gan gynnwys darparu cyrsiau ôl-raddedig angenrheidiol. Dylai cyfleoedd ymchwil fod ar gael i'r holl hyfforddeion. Dylai Cymru barhau i fuddsoddi mewn rhaglenni hyfforddiant ac arweinyddiaeth glinigol fel cynllun Cymrodoriaeth Hyfforddiant Arweinyddiaeth Glinigol Cymru.

Mae'r RCP yn gweithio gyda Deoniaeth Cymru i benodi tiwtoriaid coleg ym mhob ysbyty yng Nghymru. Mae'r meddygon ymgynghorol hyn yn cefnogi addysg a datblygiad meddygon dan hyfforddiant. Fodd bynnag, datblygiad mwy diweddar yw penodi tiwtoriaid coleg cyswllt, rôl arweinyddiaeth y mae o leiaf un hyfforddai meddygol craidd yn ymgymryd â hi ym mhob ysby ty yng Nghymru. Anogir tiwtoriaid coleg cyswllt i ddatblygu sgiliau i wella gofal cleifion a hyfforddiant meddygol a chynrychioli eu cydweithwyr ar lefel cyfarwyddiaeth. Dyma enghraifft gref o sut mae Deoniaeth Cymru a'r RCP yn cefnogi hyfforddeion yn gynnar yn eu gyrfaoedd i ddechrau paratoi ar gyfer rolau arweinyddiaeth uwch.

Mae gormod o bwysau ar staff y rheng flaen felly mae pobl yn gadael. Ar hyn o bryd mae galw sy'n cynyddu yn gwaethygu hyn – twf yn y boblogaeth, pobl yn heneiddio. Y brif broblem arall yw llai o staff, oherwydd swyddi wag ni allwn eu llenwi. Nid diffyg cyllid mo hyn yn union – nid oes gennym ddigon o bobl yn dod allan o hyfforddiant y gallem eu cyflogi

Meddyg ymgynghorol yng Nghymru

Paratoi myfyrwyr meddygol i weithio ar reng flaen y GIG

Yn ystod 2010, cyhoeddodd Ysgol Meddygaeth Prifysgol Caerdydd adolygiad mawr o'i gwricwlwm. Roedd hyn yn dilyn yr Arolwg Cenedlaethol o Fyfyrwyr a data Rhaglen Sylfaen y DU a ddangosodd bod myfyrwyr Caerdydd yn adrodd ar lefelau is o barodrwydd ar gyfer ymarfer a bod yn gyfarwydd â gweithdrefnau ymarferol. Mewn ymateb, lansiodd Prifysgol Caerdydd y Rhaglen Cysoni, a ddyluniwyd i wella'r pontio rhwng addysg israddedig ac ôl-raddedig i baratoi graddedigion Caerdydd ar gyfer ymarfer yn y GIG modern. Mae myfyrwyr meddygol yn rhan annatod o dimau clinigol o amgylch Cymru ac yn cymryd cyfrifoldeb am ofal cleifion mewn amgylchedd dysgu diogel ac o dan oruchwyliaeth. Mae'r prosiect arloesol hwn yn caniatáu oddeutu 350 o fyfyrwyr israddedig y flwyddyn i brofi byd go iawn doctor iau.

Mae'r tîm wedi gweithio'n agos ag Ysgol Meddygol Prifysgol Abertawe a Deoniaeth Cymru i ddatblygu amserlen o leoliadau clinigol. Trwy baru myfyrwyr meddygol â doctoriaid ôl-raddedig ar gyfer yr isddarlithyddiaeth myfyriwr iau 8 wythnos, rydym yn gallu darparu lleoliad clinigol o dan oruchwyliaeth sy'n canolbwyntio ar ofal uniongyrchol cleifion mewn lleoliadau acíwt. Mae'r myfyrwyr blwyddyn olaf yn cymryd cyfrifoldeb am ofal cleifion mewn amgylched dan oruchwyliaeth. Mae myfyrwyr yn cylchdroi rhwng yr ysbyty a'r gymuned i sicrhau barn gytbwys ar ofal sylfaenol/eilaidd.

Mae myfyrwyr meddygol yn cysgodi eu cydweithwyr ôl-raddedig am 2 fis, ac mae'r myfyrwyr hynny â chynnig swydd yng Nghymru yn cael treulio eu lleoliad olaf – sef isddarlithyddiaeth myfyriwr uwch – yn yr ysbyty lle byddant yn gweithio fel doctoriaid iau ar ôl graddio. Mae hyn yn caniatáu i fyfyrwyr ddod i adnabod cydweithwyr yn eu gweithle yn y dyfodol, ymgyfarwyddo eu hunain â systemau a phrotocolau, a'u paratoi ar gyfer rheng flaen ysbyty prysur y GIG. Mae oddeutu hanner myfyrwyr meddygol Cymru yn aros yng Nghymru ar gyfer eu swydd gyntaf, a chredwn fod y system yn cael effaith grymus ar eu hunanhyder. Mae'r lleoliad olaf hwn yn caniatáu iddynt reoli cleifion yn uniongyrchol o dan oruchwyliaeth timau ysbyty, ac roedd 93% o fyfyrwyr yn credu bod yr addysgu ar leoliad yn dda neu'n dda iawn ac roedd 91% yn credu bod ansawdd yr oruchwyliaeth glinigol yn dda neu'n dda iawn.

Mae'r rhaglen wedi cyflawni'r hyn mae wedi ceisio ei gyflawni ac roedd 80% o raddedigion Prifysgol Caerdydd yn dweud eu bod yn teimlo eu bod wedi cael eu paratoi ar gyfer eu swydd gyntaf mewn ysbyty. Yr her nesaf yw arddangos sut y bydd y gwaith hwn yn gwella gofal, profiad a diogelwch cleifion. Mae'r strwythur newydd yn sicrhau bod myfyrwyr yn barod ar gyfer eu gyrfa ym meddygaeth, ac yn arddangos ymrwymiad GIG Cymru i hyfforddi'r genhedlaeth nesaf o ddoctoriaid. ■

Dr Stephen Riley
Cyfarwyddwr y Rhaglen C21
Ysgol Meddygaeth Prifysgol Caerdydd

Rhoi llais i hyfforddeion

Ym mis Awst 2016, penododd dau fwrdd iechyd yng Nghymru brif gofrestrydd, doctor dan hyfforddiant sy'n gweithredu mewn rôl gyswllt rhwng hyfforddeion meddygol ac uwch reolwyr clinigol. Mae gan y swydd datblygu arweinyddiaeth rôl allweddol i'w chwarae wrth gefnogi hyfforddeion, rhaglenni addysg feddygol a mentrau gwella ansawdd. Mae'r ddwy swydd hyn yn rhan o raglen beilot prif gofrestrydd Ysbyty'r Dyfodol y RCP. Mae'n rhaid cyflwyno'r fenter hon ar draws pob bwrdd iechyd yng Nghymru i annog uwch hyfforddeion i ddatblygu sgiliau arweinyddiaeth ac addysg.

Prif gofrestrydd: Rôl arweinyddiaeth dan hyfforddiant

Fel y prif gofrestrydd cyntaf erioed yng Nghymru, cefais y cyfle i gymryd rhan mewn penderfynu ar lefel cyfarwyddiaeth, gan gynnig barn ac adborth hyfforddeion yn rheolaidd. Roeddwn yn gallu bod yn eiriolwr ar gyfer doctoriaid iau a mynychais gyfarfodydd ar eu rhan i drafod telerau newidiadau i'r rota ar alwad. Roedd hyn yn llwyddiannus iawn a gwnaethom lwyddo i ddod i gyfaddawd y mae pob parti yn hapus ag ef.

Hefyd bûm yn trafod telerau'r taliad a gynigiwyd i ddoctoriaid meddygol sy'n cymryd sifftiau locwm ychwanegol i sicrhau bod cydnabyddiaeth ariannol ar gyfer oriau ychwanegol a phan fydd sifftiau'n newid ar fyr rybudd. Mae hyn wedi cael canmoliaeth oddi wrth y corff doctoriaid iau. Bu sefyllfaoedd lle mae hyfforddeion wedi teimlo eu bod yn cael eu tanseilio gan reolwyr ac yn pryderu am berfformiad eu cyfoedion, ac yn y rôl prif gofrestrydd rwy'n gallu eu cynghori a chymryd eu pryderon ymlaen yn gyfrinachol.

Mae doctoriaid iau mewn sefyllfa unigryw. Maent yn gweld enghreifftiau o ymarfer da a drwg mewn gwahanol ysbytai yn ystod eu cylchdroadau. Trwy'r prif gofrestrydd, roedd doctoriaid iau yn gallu awgrymu newidiadau ar sail ymarferion gwaith eraill, gan gynnwys gwella ansawdd a diwygio gwasanaeth. Yn fy amser fel prif gofrestrydd, gwnaethom wella prosesau trosglwyddo a rhyddhau a datblygu protocolau ysgrifenedig ar lif cleifion. Credaf fod y profiad wedi bod yn arbennig o gadarnhaol i mi, yn ogystal â'r doctoriaid iau eraill a'r gwasanaeth ehangach. ■

Dr Robin Clwyd Martin
Cyn prif gofrestrydd
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Ffordd newydd o weithio

Dylai ysbytai ddarparu gofal arbenigol ymhell y tu hwnt i waliau'r adeilad – mae'r adeilad yn rhan o'r gymuned, yn hytrach na bod ar wahân iddi. Mae'n rhaid i gleifion gael mynediad at y gofal arbenigol sydd ei angen arnynt, pan mae ei angen arnynt.

Mae'r heriau presennol sy'n wynebu GIG Cymru yn golygu y bydd angen i ni ddod o hyd i ffyrdd i leihau derbyniadau i ysbyty a gwella gofal cleifion yn y gymuned. Mae llawer o feddygon eisoes yn gweithio rhwng ysbytai cymunedol ac ysbyty, ond mae gwybodaeth electronig a systemau cyfathrebu yn hanfodol. I sicrhau gwasanaeth diogel, mae angen i ni wneud yn siwr bod cyfleusterau cymunedol yn addas i'r diben, a bod gan y gweithlu'r sgiliau gofynnol. Mae angen cael cydnabyddiaeth wleidyddol ni fydd ad-drefnu gwasanaethau'n arbed amser yn y tymor byr; yn wir, bydd y broses bontio'n gofyn am fuddsoddiad sylweddol.

Dylai byrddau iechyd weithredu model gweithlu Ysbyty'r Dyfodol, â mwy o ofal meddygol arbenigol yn cael ei ddarparu yn y gymuned.[21] Dylai gweithio integredig a deilliannau a rennir â phartneriaid gofal cymdeithasol ac iechyd fod y norm; dylai meddygon a thimau meddygol dreulio rhan o'u hamser yn gweithio yn y gymuned er mwyn darparu mwy o ofal arbenigol yng nghartref y claf, neu'n agos ato.

Byd cydweithredu rhwng gwahanol rannau o weithlu'r GIG yn helpu gwasanaethau i ddod yn gynaliadwy ar gyfer y dyfodol. Dylai rôl yr ysbyty fod yn ganolfan technoleg ac arbenigedd clinigol ar gyfer y boblogaeth leol, yn enwedig ar gyfer diagnosteg a thriniaeth. Dylid canolbwyntio ar ddatblygu ffyrdd o weithio sy'n galluogi cleifion i adael ysbyty yn ddiogel cyn gynted ag y bydd eu hanghenion clinigol yn caniatáu.

Yn wyneb galw cynyddol am ofal iechyd ynghyd â phrinder staff mewn rhai arbenigeddau ar draws y DU, rydym wedi tueddu galw'n syml am fwy o bobl i gael eu hyfforddi mewn proffesiynau a rolau traddodiadol. Fodd bynnag ... nid yw twf parhaus y gweithlu cyffredinol ar sail modelau darpariaeth gwasanaeth sydd eisoes yn bodoli yn gynaliadwy.[5]

Gweithio mewn partneriaeth i wella gofal i bobl hyn

Yn Ysbyty Brenhinol Gwent yng Nghasnewydd, mae prosiect diweddar wedi datblygu gwaith integredig newydd rhwng y bwrdd iechyd, yr awdurdod lleol a'r trydydd sector. Efallai bod gan lawer o bobl hwn sy'n cael eu derbyn i ysbyty mewn angen gofal meddygol brys broblemau cymdeithasol, yn hytrach na meddygol, sy'n cyfrannu at eu sefyllfa. Gellir atal hyn trwy wella 'gwydnwch cymdeithasol' pobl hwn - hynny yw, gallu pobl hwn i aros yn ddiogel ac yn annibynnol yn eu cartrefi eu hunain.

Nod y prosiect yw ceisio cadw pobl hwn yn ddiogel ac yn annibynnol yn eu cartrefi eu hunain a lleihau derbyniadau i ysbyty. Mae hwyluswyr gofal hyfforddedig yn trafod â phobl hwn pa ymyraethau syml sy'n gallu gwella eu gwydnwch, ac yn cynhyrchu Cynllun Cadw'n Iach. Mae'r bobl hwn yn cael eu nodi gan ddefnyddio haenu risg – algorithm cyfrifiadurol sy'n nodi pa mor debygol yw y bydd rhywun yn mynychu ysbyty dros y flwyddyn nesaf. Mae'r rheiny mewn risg uchel yn cael cynnig y Cynllun Cadw'n Iach. Gallai'r ymyraethau mae'r Cynllun yn manylu arnynt gynnwys ymyraethau fel cymhorthion symudedd a gwiriadau budd-dal. Mae'r hwylusydd gofal hefyd yn trafod cymorth i ofalwyr a gwydnwch argyfwng, felly mae cofnod ysgrifenedig yn cael ei gadw i'r unigolyn hwn, ei deulu a gweithwyr iechyd proffesiynol.

Dyma enghraifft ardderchog o sut dylai gweithlu'r dyfodol newid i ddarparu gofal holistaidd fel rhan o dîm integredig, â chlinigwyr yn gweithio'n agos ag awdurdodau lleol a'r trydydd sector. Dylai modelau gofal yn y dyfodol ddibynnu'n fwy ar nodi cleifion yn rhagweithiol ar sail risg yn hytrach na systemau ar sail atgyfeiriadau. Dylai gweithlu'r dyfodol ddefnyddio algorithmau ystadegol i nodi pobl a fyddai'n cael budd o ymyrraeth yn hytrach nag aros am ddirywiad yn eu hiechyd i sbarduno atgyfeiriad. Yn olaf, bydd gwasanaethau'n cael eu cyd-gynhyrchu â chleifion. Mae'n rhaid i bobl sy'n defnyddio gwasanaeth fod yn bartneriaid cyfartal wrth gynllunio'r gwasanaeth hwnnw. Yn y prosiect hwn, cafodd fformat a dyluniad y Cynllun Cadw'n Iach ei ddatblygu gan ddefnyddio gwybodaeth fewnol, arbenigedd a phrofiad y bobl hwn a'u teuluoedd.

Hyd yma mae'r prosiect wedi cysylltu â mwy nag 800 o bobl hwn, a'i nod yw cysylltu â 4,000 i gyd dros y 2 flynedd nesaf. ■

Dr Richard Gilpin a Dr Charlotte Williams
Meddygon dan hyfforddiant, GIG Cymru

Heb ddigon o arian ac wedi'i orymestyn

Bydd angen datblygu ffyrdd newydd o weithio. Bydd hyn angen buddsoddiad. Bellach mae angen dull system gyfan o ymdrin ag effaith gofal heb ei drefnu ar draws gofal sylfaenol, cymunedol, eilaidd a chymdeithasol. Mae'r GIG heb ddigon o arian, heb ddigon o ddoctoriaid ac wedi'i orymestyn. Yn ein hysbytai, rydym yn gweld effaith toriadau i ofal cymdeithasol, â phobl agored i niwed yn cael eu bownsio o amgylch system ddarniog yn rhy aml. Mae angen i ni symud i ffwrdd o wasanaethau sy'n cael eu cynllunio mewn seilos ac yn edrych ar un rhan fach o driniaeth claf, i gynllunio di-dor ar draws iechyd a gofal. Mae angen i ni roi'r amser a'r lle i arloesi i glinigwyr y rheng flaen a'u partneriaid mewn gofal cymdeithasol, a'r rhyddid a'r gefnogaeth i gamu y tu hwnt i waliau eu sefydliad.

Dylai Cymru arwain y ffordd trwy ddatblygu modelau gweithlu integredig newydd mewn cymunedau gwledig. Dylai hyfforddiant ac addysg feddygol darparu'r arbenigedd i ddoctoriaid reoli cleifion hwn ag anghenion cymhleth, gan gynnwys eiddilwch a dementia, ac arwain a chydlynu 'gofal cyfan' cleifion yn yr ysbyty ac yn y gymuned. Mae llawer o feddygon eisoes yn gweithio rhwng clinigau yn y gymuned a'r ysbyty; dylai'r GIG yng Nghymru adeiladu ar y pocedi hyn o ymarfer da a dilyn dull a gynlluniwyd o ymdrin â sefydlu gofal arbenigol yn y gymuned. Mae'r Comisiwn ar Gyffredinoli wedi nodi bod 'gan gyffredinoli rôl fwy eithaf i'w chwarae mewn cymunedau anghysbell a chymunedau â phoblogaeth wasgaredig [yn y DU]'.[16]

Amser i arwain y ffordd

Dylid datblygu rôl y meddyg cymunedol. Dylai Cymru hyrwyddo ei hun fel lle i ddatblygu sgiliau arbenigol iawn mewn meddygaeth wledig a chymunedol. At hynny, mae daearyddiaeth yn bwysig i hyfforddeion, a gwyddom yr hoffai'r rhan fwyaf o hyfforddeion ennill swydd ymgynghorydd lle maent wedi ymgymryd â hyfforddiant arbenigol. Gallai hyn roi hwb i geisiadau i swyddi ymgynghorydd yng Nghymru ym mlynyddoedd y dyfodol. Mae gwaith Grwp Cydweithredol Gofal Iechyd y Canolbarth yn cynnig potensial enfawr yn y maes hwn a bydd y RCP yn parhau i fynd ati i ymgysylltu â'i waith. Mae gan Gymru gyfle go iawn i arwain y ffordd o ran dylunio gwasanaeth iechyd cymunedol arloesol.

Dyluniwyd y gweithlu presennol i ddarparu gwasanaethau i fodelau a phatrymau gofal hanesyddol. Mae'r ffordd yr ydym yn darparu gofal wedi esblygu, ac felly mae'n rhaid i'r gweithlu wneud.[6]

Cefnogi rolau clinigol eraill

Mae gofal rhagorol i gleifion yn dibynnu ar weithio mewn tîm cydlynol, trefnus ag adnoddau da a dylai'r GIG ddatblygu a sefydlu rolau clinigol eraill mewn gweithlu ysbyty'r dyfodol yng Nghymru. Dylid annog doctoriaid gradd staff ac arbenigol cyswllt mewn ysbytai yng Nghymru, a'u cefnogi yn nilyniant eu gyrfaoedd.

Mae lefelau staffio priodol ar draws y tîm yn hanfodol ac yn galluogi ysbytai i ddarparu gofal mwy effeithiol, effeithlon sy'n canolbwyntio ar gleifion. Dylid mynd i'r afael â phrinder nyrsys, a dylid hyrwyddo modelau arloesol o staffio sy'n cynnwys gweithwyr proffesiynol perthynol i iechyd fel therapyddion galwedigaethol a ffisiotherapyddion. Dylid datblygu rolau'r uwch ymarferydd nyrsio a'r meddyg cyswllt fel aelodau craidd y tîm clinigol. Gan weithio ochr wrth ochr â doctoriaid, gall meddygon cyswllt ddarparu cefnogaeth hanfodol, yn enwedig mewn gofal eilaidd, fel cofnodi hanes cleifion neu archebu a dehongli profion diagnostig.

Fodd bynnag, ni ddylai unrhyw gynnydd mewn niferoedd staffio ar gyfer y swyddi hyn fod ar draul ehangiad ymgynghorwyr, ac ni ellir cael unrhyw ostyngiad yn y gyllideb addysg feddygol yng Nghymru. Mae gwneud y niferoedd trwy recriwtio graddau heb fod yn hyfforddi neu weithwyr gofal iechyd proffesiynol eraill yn unig i lenwi bylchau mewn rotâu yn ateb tymor byr i broblem amlweddog, llawer mwy. Os tynnir y rhaniad ariannol rhwng addysg feddygol ac addysg heb fod yn feddygol, ceir risg sylweddol y bydd ariannu ar gyfer pynciau cost uwch yn cael ei ailgyfeirio i hyfforddiant ac addysg ar gyfer proffesiynau gofal iechyd eraill. Er y gallai hyfforddiant meddygol fod yn ddrud, mae'n fuddsoddiad tymor hir mewn diogelwch cleifion a gofal ansawdd uchel.

Defnyddio technoleg i wella profiad y claf

Dylai byrddau iechyd groesawu arloesi er mwyn gwella cyfathrebu â chleifion a rhwng gweithiwr gofal iechyd proffesiynol ac i wella ansawdd gofal a phrofiad y claf. Mae disgwyliad cynyddol i bobl ryngweithio â gwasanaethau iechyd gan ddefnyddio technoleg bersonol fel ffonau deallus a llechi; lle bo hynny'n briodol, dylai cleifion a chlinigwyr fod yn gallu defnyddio teleiechyd a thelefeddygaeth, yn enwedig mewn ardaloedd anghysbell a gwledig.

Mae angen i delefeddygaeth ddod yn rhan fwy annatod o ymarfer bob dydd. Mae'n rhaid i glinigwyr barhau i herio gwrthwynebiad i newid. Mae safle datblygu Ysbyty'r Dyfodol RCP yng Ngogledd Cymru, CARTREF, yn brosiect telefeddygaeth sy'n ceisio gwella mynediad at ofal i gleifion eiddil yng Nghymru wledig. Mae'r prosiect yn caniatáu cleifion i gael apwyntiadau ysbyty dilynol trwy glinigau

Darparu gofal diabetes arbenigol yn y gymuned

Mae rheoli cyflwr cronig fel diabetes math 2 angen mewnbwn tîm amlddisgyblaethol ar draws gofal sylfaenol ac eilaidd. Mae modelau gofal hanesyddol ar gyfer diabetes wedi gwahanu elfennau gofal sylfaenol a gofal eilaidd ac wedi arwain at ddarnio gofal, dyblygu llwyth gwaith ac aros yn hir am gyngor arbenigwyr uwch.

Yng Nghaerdydd, lle ceir ychydig dros 23,000 o bobl i gyd wedi cofrestru â diabetes, rydym wedi symud tuag at wasanaeth diabetes mwy di-dor. Gwnaethom ddechrau ag astudiaeth beilot fach a dechrau gweithredu'r model gofal cyfan yn 2010. Mae ymgynghorydd diabetes wedi'i neilltuo i bob un o'r 69 meddygfa yn y bwrdd iechyd sy'n ymweld â'r practis dwywaith y flwyddyn i adolygu nodiadau achos, lledaenu canllawiau ymarfer gorau a chael dialog wyneb yn wyneb â meddygon teulu a'u nyrs practis.

Ceir ymgynghorwyr diabetes sy'n gyfwerth ag wyth amser llawn a dau ymgynghorydd diabetes academaidd. Mae pob ymgynghorydd yn mentora 6-8 o bractisau gan ddibynnu ar faint y rhestr. Yn ogystal, gall meddygon teulu ofyn am gyngor oddi wrth eu hymgynghorydd sy'n cefnogi trwy system electronig (yn debyg i e-bost ond ag archwiliad cadarn) ag uchafswm amser ymateb 5 diwrnod ar gyfer ymholiadau o ran meddyginiaeth a rheolaeth. Bydd ceisiadau am gyngor yn cael eu cyfeirio'n awtomatig at yr ymgynghorydd priodol. Mae hyn yn sicrhau bod gan feddygon teulu fynediad at gyngor uwch amserol a datblygu perthynas â'u hymgynghorydd heb i'r claf gorfod aros i gael ei weld mewn clinig cleifion allanol. Mae atgyfeiriadau cleifion allanol gofal eilaidd yn cael eu brysbennu'n electronig i'r ymgynghorydd priodol trwy Borth Cyfathrebu Clinigol Cymru (WCCG). Gall yr ymgynghorydd gymeradwyo a threfnu'r atgyfeiriad i glinig neu ofyn am wybodaeth ychwanegol. Mae'r ail opsiwn yn agor dialog a allai ddatrys yr ymholiad. Yn ogystal, rydym wedi datblygu canllawiau presgripsiynu diabetes math 2 lleol sy'n tywys dewis triniaeth ac yn dwyn sylw at wahaniaethau cost rhwng dosbarthiadau o driniaeth. Bwriedir i'r canllawiau gefnogi presgripsiynu gofal sylfaenol a dwyn sylw at bresgripsiynu mwy cost effeithiol lle bo hynny'n bosibl.

Dros y 2 flynedd gyntaf o weithredu, gostyngodd atgyfeiriadau newydd i glinigau gofal eilaidd gan 35%. O ganlyniad, gostyngodd yr amser aros ar gyfer apwyntiadau cleifion allanol o ychydig llai na 6 mis i rhwng 4 a 6 wythnos gan ddibynnu ar y clinig. Darganfu archwiliad o ofal sylfaenol fod mwy o hyder yn gyffredinol wrth reoli diabetes ond yn enwedig wrth gychwyn triniaeth chwistrelladwy heb fod yn inswlin, cyfuno therapïau a thitradiad dos triniaeth trwy'r geg a thrwy chwistrelliad. Darganfu staff y practis bod mynediad electronig at gyngor uwch ymgynghorydd o fewn wythnos waith yn arbennig o ddefnyddiol. Yn aml bydd cyngor a gynigir ar gyfer claf unigol yn cael ei ddefnyddio mewn senarios clinigol eraill sy'n arwain at effaith hyfforddiant sy'n byrlymu. Yn fwy diweddar, rydym wedi arddangos gwell canlyniadau haemoglobin wedi glycadeiddio (HbA1c) mewn cleifion sydd wedi cael eu trafod naill ai yn ystod ymweliadau

fideo ac mae'n golygu bod cleifion a pherthnasau'n gallu gweld arbenigwyr heb deithio. Gall y tîm arddangos cyfraddau boddhad cleifion o 80%. Dyma un enghraifft o blith nifer o delefeddygaeth glinigol arloesol a gweithlu ysbyty'r dyfodol yng Nghymru; mae'n rhaid rhannu ymarfer gorau yn fwy cyson a'i gyflwyno mewn ffordd â strwythur.

Rwy'n gweld meddygon cyswllt fel rhan o'r datrysiad ar gyfer prinder yn y gweithlu meddygol – wrth gwrs ni fyddant yn cymryd lle doctoriaid ond yn sicr i helpu â rhai o'r tasgau sy'n cymryd y rhan fwyaf o'n diwrnod gwaith.

Meddyg ymgynghorol yng Nghymru

neu'n electronig, ac rydym yn gobeithio y bydd hyn yn arwain at ostyngiad o ran HbA1c ar draws gofal cychwynnol oherwydd mwy o hyder a gallu i reoli diabetes. Rydym hefyd wedi gweld presgripsiynau newydd ar gyfer inswlin analog yn cyrraedd man gwastad ac yn dechrau gostwng, wrth i bresgripsiynau inswlin dynol ddechrau codi â'r potensial ar gyfer arbedion cost. Dyma faes yr hoffem ei ddatblygu dros y 2 flynedd nesaf.

Hyd yma, mae'r newidiadau hyn wedi cael eu gwneud mewn amgylchedd cost niwtral trwy ofyn i gydweithwyr gofal sylfaenol ac eilaidd gydweithio mewn gwahanol ffordd. Mae'r model yn parhau i esblygu ac rydym yn recriwtio nyrsys diabetes arbenigol i gefnogi practisau.

Rydym yn gobeithio ariannu'r swyddi'r hyn trwy ddefnydd mwy cost effeithiol o inswlin dynol lle bo hynny'n briodol ac adolygu'r meini prawf stopio ar gyfer meddyginiaethau nad ydynt bellach yn effeithiol. Rydym hefyd yn credu y gallai'r model hwn fod yn ddefnyddiol wrth gefnogi gofal sylfaenol i reoli cyflyrau cronig eraill. Mae ei lwyddiant yn dibynnu ar ddatblygu cysylltiadau agos, cynaliadwy â gofal sylfaenol. Rwy'n ddiolchgar i'm cydweithwyr mewn gofal sylfaenol ac eilaidd am y gwaith caled sydd wedi cyfrannu at sefydlu a chynnal y model hwn o ofal arloesol. ■

Dr Lindsay George
Arweinydd clinigol diabetes, Ysbyty Athrofaol Llandochau
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Y tîm amlddisgyblaethol yn y Gwasanaeth Gwybodaeth Cenedlaethol am Wenwynau

Tîm amlddisgyblaethol yw Gwasanaeth Gwybodaeth Cenedlaethol am Wenwynau (NPIS) yng Nghaerdydd sy'n cynnwys 11 gwyddonydd gwybodaeth am wenwynau sy'n darparu cyngor dros y ffôn i'r GIG, â chefnogaeth pedwar tocsicolegydd a ffarmacolegydd clinigol ymgynghorol a dau gofrestrydd ffarmacoleg clinigol arbenigol.

Yn y DU, bydd dros 140,000 o bobl yn cael eu derbyn i ysbytai bob blwyddyn ar ôl dod i gysylltiad â gwenwynau dan amheuaeth a bydd mwy na 3,000 o bobl yn y DU yn marw o effeithiau gwenwyno. Mae NPIS yn darparu cyngor am reoli'r bobl hyn ledled y DU, ac i Iwerddon dros nos hefyd. Mewn rhai achosion, gellir rhoi sicrwydd ac osgoi derbyn diangen. Mewn rhai eraill, gall cyngor am reoli gwenwynau achub bywyd. Yn rheolaidd mae NPIS (Caerdydd) yn sicrhau'r sgoriau boddhad gwasanaeth uchaf o blith pedair canolfan NPIS y DU. Mae staff hefyd yn cyfrannu at gronfa ddata TOXBASE, sy'n cynnwys mwy na 17,000 o gofnodion cynnyrch. Dyma'r gwasanaeth cyngor ar-lein tocsicoleg rheng flaen yn y GIG a'r llynedd roedd 608,868 sesiwn defnyddiwr TOXBASE ac edrychwyd ar dudalennau unigol cofnodion TOXBASE 1.69 miliwn o weithiau. Trwy gyfnerthu adnoddau arbenigol bu'n bosibl darparu gwasanaeth ansawdd uchel, cost effeithiol, sy'n arbed mwy o amser i'r GIG nag y mae'n costio.

Mae NPIS (Caerdydd) hefyd yn arwain ar Gronfa Ddata Gwybodaeth am Wenwynau'r DU, cronfa ddata unigryw sydd wedi galluogi nodi tueddiadau o ran gwenwyno a chyngor i wella iechyd y cyhoedd ar bopeth o godenni hylif glanedydd i sylweddau seiciatrig newydd. Mae Uned Gwenwynau Cymru yn cynnwys NPIS a ward trin gwenwynau Gwenwyn yn Ysbyty Athrofaol Llandochau. Er bod NPIS (Caerdydd) yn darparu cyngor yn genedlaethol, mae ward Gwenwyn yn darparu gofal o ansawdd uchel i gleifion wedi'u gwenwyno yn lleol yng Nghaerdydd. Mae'n uned chwe-gwely a adeiladwyd yn bwrpasol sy'n cael ei staffio gan nyrsys, gan gynnwys dwy nyrs seiciatrig sy'n gweithio ar y ward, â chefnogaeth tîm o docsicolegwyr a ffarmacolegwyr clinigol, sy'n galluogi dull hollol holistaidd o weithredu. Mae'r uned bwrpasol hon wedi galluogi rheoli cleifion yn fwy effeithlon ac yn gysylltiedig â hyn bu gostyngiad yn yr hyd arhosiad cyfartalog o 34 i 18 awr, er gwaethaf cynnydd mewn galw, fel nad oedd angen unrhyw welyau ychwanegol. Trwy gydweithio'n agos â Gwasanaeth Ambiwlans Cymru, o'r oddeutu 1,200 i 1,800 o gleifion y mae angen eu derbyn bob blwyddyn, mae mwy nag 80% yn cael eu derbyn yn uniongyrchol, gan osgoi mwy na 1,000 o dderbyniadau diangen yn yr adran achosion bys a darparu gofal diogel ac ansawdd uchel.

Mae datblygu pecyn clercio integredig wedi symleiddio derbyniadau wrth wella cadw cofnodion. Cafodd y dull amlddisgyblaethol hwn o weithredu ei gydnabod â dyfarniad cadeirydd a phrif weithredwr yn 2012. Mae'r tîm yn parhau i ddatblygu, ac yn bwriadu cyflwyno triniaeth newydd byrrach ar gyfer gwenwyno paracetamol. ■

Dr John Thompson
Cyfarwyddwr a ffarmacolegydd clinigol ymgynghorol
Gwasanaeth Gwybodaeth Cenedlaethol
am Wenwynau (Caerdydd)

Sut y gall y RCP helpu?

Dylanwadu ar newid yng Nghymru

Mae adroddiad hwn gan y RCP ar y gweithlu meddygol yng Nghymru yn dilyn cyhoeddiad *Ffocws ar y dyfodol*, ein cynllun gweithredu ar gyfer llywodraeth Cymru newydd,[3] a *Mynd i'r afael â'r her*, a manylodd ar y weledigaeth ar gyfer gofal acíwt a model Ysbyty'r Dyfodol yng Nghymru.[2] Trwy ddatblygu ein polisïau, ein gwaith gyda chleifion a'n hymweliadau sgwrsio ag ysbytai, rydym yn gweithio i gyflawni newid go iawn ar draws ysbytai a'r sector iechyd a gofal cymdeithasol ehangach yng Nghymru.

Cyfrifiad o feddygon ymgynghorol a chofrestryddion meddygol yn y DU

Ar ran Ffederasiwn Colegau Brenhinol y Meddygon, mae'r RCP yn cynnal cyfrifiad blynyddol sy'n cael ei anfon i bob meddyg ymgynghorol a chofrestrydd meddygol yn y DU yn yr arbenigeddau meddygol cyffredinol. Yn y cyfrifiad rydym yn gofyn am wybodaeth am gynlluniau swyddi, llwydi gwaith a chyfrifoldebau. Ystyriwn hwn i fod y data ansawdd uchaf sydd gennym ar gael yn y DU mewn perthynas â'r gweithlu meddygol.

Heb ddigon o arian, heb ddigon o ddoctoriaid ac wedi'i orymestyn

Mae bod yn ddoctor yn ddwys, yn werthfawr ac yn heriol. Mae gweithlu sy'n derbyn gofal yn darparu gwell canlyniadau i gleifion. Mae'r RCP wedi ymrwymo i werthfawrogi a chefnogi doctoriaid y GIG. Byddwn yn:

- gweithio gyda'n doctoriaid sy'n aelodau i ddod o hyd i atebion newydd i bwysau gweithlu
- gwthio am weithredu ar draws y llywodraeth a'r GIG
- arddangos y gorau o feddygaeth.

Amdanom ni

Nod Coleg Brenhinol y Meddygon (RCP) yw gwella gofal cleifion a lleihau salwch, yn y DU ac ar draws y byd. Rydym yn canolbwyntio ar y claf ac yn cael ein harwain yn glinigol.

Mae ein 33,000 o aelodau ledled y byd, gan gynnwys 1,200 yng Nghymru, yn gweithio mewn ysbytai ac yn y gymuned ar draws 30 o wahanol arbenigeddau meddygol, yn gwneud diagnosis ac yn trin miliynau o gleifion ag amrywiaeth enfawr o gyflyrau meddygol.

Yn cynnwys cleifion a gofalwyr ar bob cam, mae'r RCP yn gweithio i sicrhau bod meddygon yn cael eu haddysgu a'u hyfforddi i ddarparu gofal o ansawdd uchel. Rydym yn archwilio ac yn achredu gwasanaethau clinigol, ac yn darparu adnoddau i'n haelodau asesu eu gwasanaethau eu hunain. Rydym yn gweithio gyda sefydliadau iechyd eraill i wella ansawdd gofal meddygol, a hyrwyddo ymchwil ac arloesi. Rydym hefyd yn hyrwyddo polisïau ar sail tystiolaeth i lywodraeth i annog ffyrdd o fyw iach a lleihau salwch o achosion ataliadwy. Gan weithio mewn partneriaeth â'n cyfadrannau, cymdeithasau arbenigol a cholegau brenhinol meddygol eraill ar faterion sy'n amrywio o hyfforddiant ac addysg glinigol i bolisi iechyd, rydym yn cyflwyno llais pwerus ac unedig i wella iechyd a gofal iechyd.

Cymryd rhan

Ar wefan RCP, gallwch ddarllen am enghreifftiau sydd eisoes yn bodoli o ymarfer arloesol a gwrando ar ddoctoriaid sy'n siarad am sut maent wedi cyflawni newid yn eu hysbytai. Gallwch hefyd ddarparu gwybodaeth ar gyfer gwaith RCP yng Nghymru trwy anfon eich sylwadau, syniadau ac enghreifftiau o ymarfer da atom.

I helpu i lunio dyfodol gofal meddygol yng Nghymru, ewch i'n gwefan:
www.rcplondon.ac.uk/wales

I ddweud wrthym beth yw'ch barn – neu i ofyn am fwy o wybodaeth – anfonwch neges e-bost atom:
[redacted]

Trydarwch eich cefnogaeth:
@RCPWales
#MedicineisBrilliant
#MeddygaethynWych

Cyfeiriadau

1 Coleg Brenhinol y Meddygon. *Underdoctored. Underfunded. Overstretched. The NHS in 2016*. Llundain: RCP, 2016

2 Coleg Brenhinol y Meddygon. *Mynd i'r afael â'r her: Gwella gofal acíwt, bodloni anghenion cleifion yng Nghymru*. Caerdydd a Llundain: RCP, 2014.

3 Coleg Brenhinol y Meddygon. *Ffocws ar y dyfodol: Ein cynllun gweithredu ar gyfer Llywodraeth nesaf Cymru*. Caerdydd a Llundain: RCP, 2015.

4 Gwasanaethau'r Gweithlu, Addysg a Datblygu GIG Cymru. NHS Wales workforce: Key themes and trends. Ionawr 2015. [Mynediad ar 30 Medi 2016].

5 GIG Cymru. *A planned primary care workforce for Wales*. Llywodraeth Cymru, 2015. [Mynediad ar 30 Medi 2016].

6 Conffederasiwn GIG Cymru. *The NHS Wales workforce briefing paper*. Ionawr 2016. [Mynediad ar 30 Medi 2016].

7 Data Deoniaeth Cymru

8 NHS Education for Scotland. *Domicile of UK undergraduate medical students*. Caeredin: NES, Mawrth 2013. [Mynediad ar 30 Medi 2016].

9 Ffederasiwn Colegau Brenhinol y Meddygon yn y DU. *Census of consultant physicians and higher specialty trainees in the UK 2015–16*. Llundain: RCP, 2016.

10 Costau a ddarparwyd gan Wasanaethau'r Gweithlu, Addysg a Datblygu (WEDS) GIG Cymru

11 Arsyllfa Iechyd Cyhoeddus Cymru. *Demograffeg 2016*, Iechyd Cyhoeddus Cymru, 2016.

12 Ymddiriedolaeth Nuffield. *A decade of austerity in Wales: The funding pressures facing the NHS in Wales to 2025/26*, Llundain: Ymddiriedolaeth Nuffield, 2014.

13 Arolwg Iechyd Cymru 2015: Statws iechyd, salwch, a chyflyrau eraill [Mynediad ar 30 Medi 2016].

14 Arolwg Iechyd Cymru 2015: Prif ganlyniadau cychwynnol [Mynediad ar 30 Medi 2016].

15 Coleg Brenhinol y Meddygon. *Census of consultant physicians and medical registrars in the UK*. Llundain: RCP, 2011

16 Cyngor Meddygol Cyffredinol. *The state of medical education and practice in the UK report: 2013*. Llundain: GMC, 2013.

17 Coleg Brenhinol y Meddygon. Data Pwyllgorau Ymgynghorol ar Benodiadau (AAC) Ionawr–Rhagfyr 2015.

18 Coleg Brenhinol y Meddygon. *Hospitals on the edge? The time for action*. Llundain: RCP, 2012.

19 Cronfa'r Gymanwlad. *Mirror, mirror on the wall: How the US health care system compares internationally*. 2014.

20 Coleg Brenhinol y Meddygon. *Research for all*. Llundain: RCP, 2016.

21 Comisiwn Ysbyty'r Dyfodol. *Future Hospital: Caring for medical patients*. Llundain: RCP, 2013.

22 Arolwg Coleg Brenhinol y Meddygon o hyfforddeion meddygol, Ebrill 2016.

23 Evans M, Phillips C, Roberts R, Salter D. *Adolygiad o Fuddsoddi mewn Addysg i Weithwyr Iechyd Proffesiynol*, 2015.

24 Jenkins D, Phillips C, Cole S, Mansfield M. *NHS Wales workforce review*, February 2016 [Mynediad ar 30 Medi 2016].

25 Cynulliad Cenedlaethol Cymru, *Materion o bwys i'r pumed cynulliad*, 2016. [Mynediad ar 30 Medi 2016].

26 BBC News. Wales NHS nurse shortage 'compromises care', RCN claims. Mai 2014. [Mynediad ar 30 Medi 2016].

27 Coleg Brenhinol y Meddygon. *Census of consultant physicians and medical registrars in the UK, 2012*. Llundain: RCP, 2014

28 Cynulliad Cenedlaethol Cymru, *Materion o bwys i'r pumed cynulliad*, 2016. [Mynediad ar 30 Medi 2016].

29 Ffederasiwn Colegau Brenhinol y Meddygon yn y DU. *Census of consultant physicians and higher specialty trainees in the UK 2014–15: data ac esboniad*. Llundain: RCP, 2016.

30 Greenaway D. *Shape of Training: securing the future of excellent patient care*. Adroddiad terfynol o'r adolygiad annibynnol dan arweiniad Yr Athro David Greenaway. Cyngor Meddygol Cyffredinol 2013.

31 UCAS. *End of Cycle 2015 Data Resources DR3_015_01 Acceptances by Detailed subject group*. [Mynediad ar 30 Medi 2016].

32 Bwrdd Hyfforddi ar y Cyd Colegau Brenhinol y Meddygon. *2015 Annual Specialty Report*. Mawrth 2016.

33 Emergency Medicine Training Association. *Costs of Training Survey Gorffennaf 2016*. [Mynediad ar 30 Medi 2016].

34 UCAS. Deadline Applicant Statistics: Hydref 2015. [Mynediad ar 30 Medi 2016].

35 Coleg Brenhinol y Meddygon. *Hospital workforce: Fit for the future?* Llundain: RCP, 2013.

Meddygon ar y rheng flaen

Y gweithlu meddygol yng Nghymru yn 2016

Yn ddiweddar, rhybuddiodd llywydd Coleg Brenhinol y Meddygon (RCP), yr Athro Jane Dacre, fod GIG heddiw 'heb ddigon o ddoctoriaid, heb ddigon o arian ac wedi'i orymestyn'.[1] Mae'r arsylwadau hyn yr un mor berthnasol i Gymru â gweddill y DU. Er mwyn i GIG Cymru gyflawni ei botensial llawn i wasanaethu pobl Cymru, mae angen digon o adnoddau a gweithlu gofal iechyd ymroddedig, hollol weithredol ac integredig, ynghyd â morâl da a boddhad proffesiynol.

Mae Cymru yn dioddef gan faterion sy'n ymwneud â recriwtio a chadw ymhlith y gweithlu meddygol, ar lefelau uwch ac is. Mae'r materion sydd wrth wraidd y problemau hyn yn amrywiol a chymhleth, ac yn cynnwys daearyddiaeth, canfyddiadau negyddol a diffyg cymhellion i annog doctoriaid i ddilyn gyrfa yng Nghymru. Mae'r RCP yng Nghymru yn credu bod llawer o fentrau y gallem eu mabwysiadu i oresgyn y materion hyn, a dylem eu mabwysiadu.

Coleg Brenhinol y Meddygon (Cymru)
Ty Baltic
Sgwâr Mount Stuart
Caerdydd CF10 5FH

E-bost [redacted]
Dilynwch ni @RCPWales

www.rcplondon.ac.uk/wales

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 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.

Introducing GP Survival (Wales): a summary for evidence session Feb 8th, 2017

GP Survival (Wales) is an online organisation for grassroots GPs.

It is the sister site of GP Survival (England), which currently has a membership of over 6000 individuals.

Approaching 20% of the GP workforce in Wales is now signed up, and this number is ever expanding.

Represented in this space are GP principles and sessionals, GP trainers, GP registrars, and GPs in our Universities, LMCs, LHBs, the RCGP and GPC.

We exist to provide a social media platform for rapid information sharing, and to enhance grassroots engagement on all issues related to primary care politics.

While aligning ourselves with the broad aims of the GPC and RCGP, we occupy a specific niche as an independent voice, and will demand accountability of institutions and politicians. We address matters of public interest via media outlets.

It is noteworthy, and extremely encouraging to our members, that Welsh Government has sought the grassroots view on issues related to workforce. GP Survival (Wales) is honored to provide evidence as a politically neutral organisation.

To this end, we have selected three GP innovators from different geographical areas in Wales. They each bring with them extensive first-hand experience in the recruitment arena.

They will provide invaluable insight into the work that is already being done, and inform how best WG and relevant actors can make real improvement that can be felt at the grassroots level for our workforce now, and on into the future.

MOUNTAIN MEDICINE
BANGOR EMERGENCY DEPT

Written evidence submitted to the
National Assembly for Wales
Inquiry into Medical Recruitment, Feb 2017

Medical Recruitment:
Learning from Bangor ED

Dr Linda Dykes
Consultant in Emergency Medicine
Ysbyty Gwynedd, Bangor

Introduction

Whilst your inquiry today may be mostly focused upon GP recruitment, I wish to share with you the transferable lessons from the Bangor Emergency Department (ED) Clinical Fellow scheme: the most successful Emergency Medicine recruitment scheme in the UK.

Emergency Medicine middle-grade doctors are notoriously difficult to recruit and retain, and rural Wales is notoriously difficult to recruit doctors into. So Ysbyty Gwynedd in Bangor, the western-most Emergency Department (ED) in North Wales, might be expected to have a extremely severe recruitment problem.

And, historically, we did. Indeed, we faced the possibility of going into August 2011 with no middle grade doctors at all. Yet in the intervening six years, we have completely turned around the staffing and recruitment situation.

Bangor ED is now - quite literally - the *only* ED in the UK that has more doctors than posts. We have doctors queueing for posts at all levels (junior, middle-grade and consultant) some of whom are doctors lining up to *return* to Bangor for the next stage of their career.

This has been achieved without recourse to recruitment agencies, golden handshakes, or expensive "doctor hunting safari trips" to India.

It has been achieved by designing posts that doctors actually *want*, treating our doctors *well*, and connecting with potential recruits via their preferred forum (i.e. social media) in a scheme that is 100% clinician-designed and led.

The fundamentals of the strategy underpinning the Clinical Fellow scheme are 100% transferable to other settings in medical recruitment. I hope this summary will be helpful.

This report in the context of the Terms of Reference/scope of your inquiry

This report concentrates on the last three of the five areas of reference for this inquiry, as indicated below. I would, however, be happy to comment upon any of these areas when I give evidence to the Committee in person on Feb 8th 2017.

- ❌ 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 [although with my EM/GP/WAST/Community Care of the Elderly experience I have an interest in this this)
- ❌ The implications of Brexit for the medical workforce.
- ✅ The factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas.
- ✅ 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.

Where we were, and where we are now

Prior to August 2012, the Bangor ED middle-grade doctor tier consisted of only five SAS doctor posts ("staff grades"). They worked a tough rota with 2-in-5 weekends. Night cover was non-resident on-call. Agency locums were used for all annual and study leave, and were also required to top-up cover every weekend, making it an extremely expensive staffing model. Some years, we also had a Wales Deanery Specialty Trainee in ST4-6 (i.e. registrars in their final three years of Emergency Medicine training) but due to failure to fill all the Wales Deanery posts, we were often left without. Hence, as the combined effects of "Modernising Medical Careers" and UK visa/ immigration policy kicked in, like most UK Emergency Departments, we were left with a dearth of middle grades.

By early 2011, we had only one substantive staff grade left (and he was trying to secure a place on radiology training and wanting to leave) and few aced going into August 2011 with no substantive middle-grade doctors at all. This, of course, threatened the supervision we were able to give our *junior* doctors (mainly provided by deanery-approved training posts) placing the viability of the entire ED at risk.

Hence, in late 2011 I proposed and launched the **Bangor ED Clinical Fellow Scheme**. By the 2012/13 recruitment year it had both increased our cover *and* saved more than £250k compared to continuing reliance on agency locums for 4 out of 5 middle-grade posts.

Since then, our middle-grade recruitment has steadily increased, with the number of high quality candidates now at - or surpassing - the (much-increased) number of available posts. This is despite a background trend of major recruitment and retention problems in UK Emergency Medicine, with the well-documented failure in patient flow producing ED/system gridlock and "crowding", an extremely stressful and unpleasant working environment for staff. The speciality has been "haemorrhaging" trainees across the whole UK.

Bucking this national trend, we now have 13 Clinical Fellow posts, plus two 100%-HB funded posts allocated to Wales Deanery trainees (one for an ST3 and one for an ST4-6) and most/all are usually filled. This does not equate to 15 Whole Time Equivalents (WTEs) - fully one third of our current middle-grade tier have taken advantage of the options to be less than full time (LTFT), take a break mid year (either as traditional unpaid leave or by annualising their hours), or both.

Our advertising for Aug 17-Aug18 posts has, for the first time, been conducted entirely by social media and following interviews last week, our middle grade tier is secure until August 2018 at least.

What are Clinical Fellows?

The Bangor ED posts were specifically designed for trainees wishing to take a "year out" of training posts following completion of the three-year Acute Care Common Stem (ACCS) programme and prior to applying for Higher Speciality Training. The headline feature of the posts is the "20% playtime" - 2 sessions a week (plus an admin session) working in pre-hospital emergency medicine (in partnership with WAST), Medical Education, or Management/ Quality Improvement, or a bespoke mixture.

ACCS trainees may have a parent specialty of either EM, Acute Medicine (AM) or anaesthetics, and all have followed a prescribed training programme consisting of 6 months of EM, AM, anaesthetics and Intensive Care, plus one further year of training in their parent speciality.

Our posts were, therefore, designed to dovetail with deanery training posts, but are not educationally approved for training themselves.

Since our posts were designed, most EM trainees are now on "run through" training (i.e. they no longer needing to re-apply for training posts after completion of ACCS) and come to us with the permission of their host deanery on "Out Of Programme Experience" (OOPE).

How this was achieved: the Bangor 6-step recruitment strategy

Our position as the UK's most successful Emergency Department in terms of recruitment and staffing has not been reached by chance, and did not occur as a result of following traditional NHS HR recruitment practices. A combination of extremely hard work, the willingness of our management teams to allow clinicians take ownership of the problem and "get on with solving it" with minimal interference, and - crucially - a knack for understanding the motivations of the doctors who are our potential recruits have all been required. These following six steps summarise the approach I devised and we have successfully utilised. I believe the principles outlined here are applicable to all medical recruitment scenarios.

Step One: Take a good hard look at what you are offering

In a tough recruitment market, mediocre jobs will get nowhere

At the start of 2011, we took a dispassionate view of our existing staff grade posts and it wasn't too difficult to see why we had lost 4 out of 5, with the last man standing preparing to go. The posts were, to put to bluntly, dreadful.

The rota was horrific, the work intensity high, the pastoral and professional-development support zero (apart from the 10 days of funded study leave), and the status of the doctors was poor. The posts were 100% service provision, regarded by all as work-horses.

Acknowledging that no amount of being "near Snowdonia" or "friendly department" makes up for fundamentally bad posts was the Eureka moment that set us on the road to finding a successful solution .

Before this, we had been convinced that "all we needed was a better advert" and, as is so often seen, we resorted to full-page colour adverts in the BMJ extolling the scenery. What few applicants we did have could certainly be described as "scraping the barrel".

Who are the Bangor ED Clinical Fellows?

Real life examples at a reunion

Nick Brazel, post-ACCS anaesthetics. Came to us from East Midlands. Aug 2014-Aug 2015. Returned to anaesthetic training afterwards.

Andy Muirhead-Smith, post-ACCS anaesthetics in London. In Bangor Feb 2014-Aug 2015 Still working in BCUHB

Rio Talbot , Cardiff graduate. CF Aug 2012-Aug 2013 after ACCS in London. Then EM higher training in Wales. Interviewing for Bangor consultant post later this month

Linda Dykes Clinical Fellow programme director

Dafydd Williams. From Anglesey, first language Welsh. Trained in England, moved home Aug 2014-Aug 2015 for CF post. Now Wales' ICM trainee.

Rich Griffiths. From Sheffield. Clinical Fellow Aug 2012-Aug 2013. Returned to Bangor for final six months of EM training. Currently locum consultant in Bangor ED, interviewing for substantive post later this month

Step Two: What are the "push" and "pull" factors for your target recruits?

What makes your target recruits tick?

We initially designed our Clinical Fellow posts by asking our star ACCS trainee "what would make you take a year out and work here before going into ST4?" - which is how we ended up offering a post with front-line ambulance sessions in partnership with Welsh Ambulance.

We have since refined our approach, and realised that in order to successfully recruit, you must have an in-depth understanding of what factors are likely to be acting as "push" and "pull" factors on your target market.

For Bangor ED Clinical Fellow posts, this wasn't difficult to deduce. Generally, EM trainees are finishing ACCS are experiencing significant burnout: many are thinking of leaving. The promise of a civilised rota (ideally, the best they have every worked) and time away from the "hot-zone" of the ED shop floor is appealing. The "playtime" - especially Pre-Hospital EM *in work time and* without having to wait until completion of ST4 (4th year of specialist training) and throwing oneself into sub-speciality training - is a key attraction.

Our typical recruits are around 30 years old, mostly single or in a relationship, with only a few being married. Hardly any of them have yet had children. They are still used to the concept of moving around the country for work - their roots are not too deep and some can still move their possessions in a hired self-drive van.

Most are from England. In our experience they are universally angry with the current Westminster government, loathe Jeremy Hunt, feel let down by the BMA, resent the contract imposition in England and (unsurprising in those choosing to take a post offering a "year out") often cynical and disengaged with the training system.

They are almost all Generation Y. Hence, they are less likely to be motivated by money, and more likely to be motivated by posts offering support, coaching, a better work-life balance, a feeling of "belonging to something that matters" and excellent pastoral support.

By knowing our target recruits, we can target our advertising - see Appendix 2.

Doctors and recruits (and their life-stages)

The "push" and "pull" factors are different at different stages of a medical career and life stages. Some "push" and "pull" factors are professional, but domestic circumstances are vital (and yet too often forgotten).

The most mobile doctors are those in the **first few years after qualification** - by five years in, as per our Fellows, partners/spouses (and their jobs) may be starting to restrict their mobility. The last chance for easy relocation (single and divorced doctors excepted) is **before any kids go to school.**

By the time they are in their late 30s and 40s, many doctors are **parents of school-age kids:** few will be prepared to move across the country without other significant push/pull factors.

However, as **kids get older & leave school**, some doctors may have itchy feet after many years in one place, and financial incentives may be more attractive (older Generation X and younger Baby Boomer doctors often face a double-squeeze of university costs for kids and potential care-home fees for their own parents).

Later-career doctors would be a prime target for many GP posts, with plenty of experience yet no longer tied by the kids (however, elderly parents may influence relocation decisions) and any **last-few-years-before-retirement** doctors may be attracted by pensionable perks if they are still under protected final salary pension arrangements.

- *See Appendix 1 (a rural GP recruitment proposal) for a discussion regarding influence of Welsh language and education policies on decisions to move.*

Step Three: Fix everything you can in the posts you offer

… and be scrupulously honest about what you cannot fix

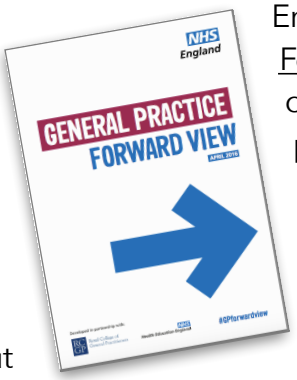
Everyone is wary about job adverts that promise the world, and yet do not deliver the package in full.

This is so endemic in medicine it is a running joke: when I was appointed to Bangor in early 2005 I was promised the rebuild of the ED would be commencing within months, and here we are nearly 12 years later and it still has not happened.

When it comes to designing any post for **junior doctors**, it really isn't difficult to work out what your recruits want sorted out - if it was mentioned in the English Junior Doctors dispute, it is a problem that needs fixing.

Into this category comes rotas (e.g. fixed annual leave allocations, being unable to take time off for important things like family - or one's own - wedding), paltry study leave budgets, covering rota gaps, and not knowing rotations or rotas till the last minute.

Designing posts for **consultants** or **GPs** have some things in common with junior doctors, but others are specific to specialty and post.



England's 2016 "General Practice Forward View" (GPFV) contains a comprehensive analysis and set of proposed solutions to the problems facing Primary Care. Wales will need to meet or surpass the commitments made in England's GPFV if we hope to attract qualified (and trainee) GPs from across the border.

That said, we have advantages in Wales too, and should not be afraid to point these out. Despite the shared problems with underfunding of health and social care with England, we are free of the scourge of CCGs, internal competition, and STPs. We are also free of Jeremy Hunt, a fact that we fully exploit in our "guerrilla" social-media recruitment campaigns (see Appendix 2). For doctors in England bruised and demoralised by battles within the CCG system, the simplicity of NHS Wales structure is a potential bonus. Like scenery, it's not enough to sell a post in isolation, but it could certainly help clinch a deal.

Step Four: Work out your USP (but *don't* copy)

What is it about your job that is unique?

Whilst it is tempting to attempt to carbon-copy formats that have worked well elsewhere, successful jobs are a product of their environment, the workplace culture and the people running them and cannot be replicated exactly.

Several schemes have attempted to copy the Bangor ED Clinical Fellow posts and failed, as they were unable to offer a replicate the full package we offer with the posts, only the headline "playtime" - which isn't enough.

New posts, especially novel ones, benefit from a USP and it is worth taking the time to work out what the should be.

The next page demonstrates the features of our Clinical Fellow posts, in a format we used to advertise the posts.

Autumn 2016 Bangor ED Clinical Fellow advert incorporating the key features of Steps 1-4

Applications for the Bangor Clinical Fellow posts OPEN NOW on NHS Jobs: 050-ED-CF-11-16

MENU

A La carte menu for the perfect year out after ACCS ST/CT3 (any specialty)

STARTER

Included in all packages

- Fantastic quality of life
- Snowdonia on the doorstep
- Fabulous beaches on Anglesey
- Amazing surfing on the Llyn Peninsula
- Hill-walking, mountain-biking, rock-climbing & wonderful road cycling
- Sailing, kite-surfing, horse-riding
- Affordable house rental prices
- Flexible, annualised rota (LTFT very easily arranged)

MAIN COURSE

Emergency Medicine the way it should be

- Rural EM in a friendly, small ED
- Well staffed with loads of middle grades: no #mindtherotagap here
- Enthusiastic Educational Supervisors who have time to look after you
- Structured activity programme to enhance your CV
- Full range of cases (very little bypasses) including STEMIs, strokes, and major trauma

DESSERT

A day a week (two sessions) of playtime, plus a paid-but-not-timetabled SPA session

The icing on the cake of your year out: combining fantastic opportunities and burnout prevention

Pre-Hospital Emergency Medicine

- Shifts with Welsh Ambulance (ambulances and RRVs) plus Helimed
- Gain a unique appreciation of SAR: we are the mountain medicine experts!

Medical Education

- Teaching practice with medical students, paramedic students, MSc students and junior colleagues
- Help develop our simulation programme
- PGCertMedEd fully funded for 12-month posts starting Aug/September

Management/Quality Improvement

- Dreading trying to populate your management portfolio whilst battling with FRCEM & the demands of ST4-6?
- Enjoy the luxury of 2 sessions a week (plus your SPA session) of tailor-made, supported activities and projects

MOUNTAIN MEDICINE
BANGOR EMERGENCY DEPT

www.mountainmedicine.co.uk

Step Five: Build up your brand

Who are you and what do you stand for?

One of the four key roots of employee engagement is that "everyone wants to belong to something bigger then they are". It is also true that most people like to belong to something they perceive as successful. Hence, in Bangor ED we have worked very hard to establish our "brand".

We do not advertise ourselves as the ED in "Ysbyty Gwynedd, Betsi Cadwaladr University Health Board". For most of our target recruits, this means nothing (we have only ever recruited one Clinical Fellow from inside of Wales, though several have subsequently chosen to remain in Wales for higher training) and we may as well be advertising a job in Timbuktu. For those who *are* already aware of BCUHB, a struggling health board in special measures is hardly an attraction - and for a junior doctor, a health board is too big a unit to imagine feeling the impact of one's personal contribution (the 4th "root of engagement")

Non-geographical health board names are significant handicap when it comes to recruitment, and, given the scarcity of Welsh-speaking doctors, we also need to ensure our advertising does not project the impression that speaking Welsh is essential to work as a doctor in Bangor. Hence, we stick to "Bangor ED" or "Snowdonia's ER".

We also use "Mountain Medicine Bangor", our longstanding research and teaching collaborative project with local Mountain Rescue Teams and SAR helicopter partners. We are also known as "Mountain Medicine Bangor" (Facebook group, Twitter handle) and we use the project logo (right) to reinforce our visual identity.

Many of the Bangor ED consultants and Middle Grades - past & present - assist with building the "Team Bangor ED" brand via social media and in person.

(right)

Summary of the efforts Team Bangor ED go to in order to build, and maintain, the "brand".

Most of this is discretionary effort, completely unfunded by the NHS, costing considerable amounts of our own time - and money.

However, the reward for the team is that we can now recruit, and take pride in running what is arguably one of the best small DGH EDs in the UK.

Links:

www.mountainmedicine.co.uk (our unofficial ED website)

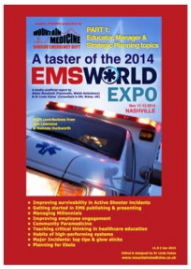
www.scribd.com/BangorED (our unofficial filesharing site)

We attend conferences in polo shirts featuring the ED Mountain Medicine logo. We pay for these ourselves.

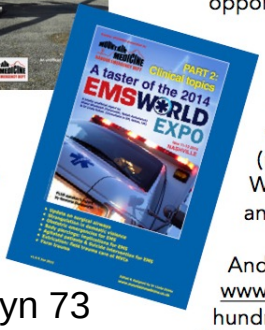
We also **produce and print flyers and leaflet the toilets at some conferences**. We pay for these ourselves, too.

We are active on Twitter, both on individual accounts (followers range from around 250 to over 3500) and with the @YGEDBangor account (653 followers)

We produce conference reports after going on Study Leave. There are further used to promote the ED and we try to release them at times when we are recruiting to make use of a free advertising opportunity.



We **organise CPD events**: these provide speaking opportunities for our Fellows, and reflect very well on our ED when we promote then via Social Media.



These get between 1000-3000 views on our file-sharing website www.scribd.com/BangorED (needs non-NHS computer to view). We also upload our conference posters and other educational material there.

We **accept speaking engagements**: Linda and Rob both speak at national events in the UK, and Linda is regularly invited abroad, too. If we can't attend we delegate any Mountain Medicine speaking invitations to our HSTs and Fellows who've been involved with the scheme.

And finally, **we run our unofficial website**, www.mountainmedicine.co.uk which gets hundreds of hits a week. We maintain and pay for this ourselves.

Step Six: Advertise your wares

Attractive adverts come last, not first!

There seems to be an almost universal belief held by clinicians, managers and politicians that the scenic, recreational and cultural delights of Wales are all that is required to attract doctors to move here, and so all we need are slick and sexy adverts pointing out how lovely it is to work close to mountains/beach/Cardiff.

Sadly, this is complete nonsense, as should be evident from the fact that Wales is short of doctors, still struggling to recruit, to the extent that you are having to hold this government-level inquiry into it.

Advertising is important - see how we do it in Bangor ED in Appendix 2 - but is is the final icing on the cake when tackling a recruiting problem. In Emergency Medicine, General Practice and many other shortage specialities, our potential recruits are "customers", who can walk into a job wherever they like. No business in their right mind would spend their entire budget on an advertising campaign when they know the "product" is sub-standard, and yet this is what continues to occur in the NHS in Wales. Too many of our posts are the equivalent of a 1980s Skoda - basic, old fashioned, outdated, unfashionable and undesirable.

Skoda did not reach it's current market position and award-winning cars merely by sexing up its adverts. It had to completely re-engineer its products, whilst also providing superlative customer service from dealers, in order to overcome the handicaps of its past.

Treating your recruits well

Never underestimate the importance of treating your doctors well. Quite apart from improving one's own job satisfaction, in these days of social media, a kind or harsh word to a trainee could well be relayed across the UK medical community in minutes, particularly in very connected specialities like EM who have many doctors actively using Twitter.

"Feeling like a VIP in Bangor, rather than a useful though ultimately inconsequential person in xxxx deanery"

Pre-2011, although I worked alongside my staff grade colleagues, I knew nothing about them. I didn't know their backgrounds, hopes or dreams. I had no idea of their marital status or kids or hobbies. I didn't know what their learning goals were because I never asked. Looking back, I am ashamed of how poorly we treated them.

In contrast, with my Clinical Fellows today, I know what makes them tick. I know if they have a parent undergoing cancer treatment, an exam looming, or a career dilemma. I know if they worry about running a trauma call. Our educational supervision meetings are usually 2-3 hours for a first meeting and 1.5-2 thereafter (*cf.* average for a new deanery trainee of 30 minutes) usually in a cafe, over food. We know this effort is noted and appreciated by our Clinical Fellows, and is in particular contrast to their feeling of disillusionment in their (usually English) training posts. It is also what makes them recommend our posts to their friends and junior colleagues, even though we are falling behind our competitors in terms of the proportion of "playtime" in our Clinical Fellow job plans.

A word about recruitment practices and HR support

It shouldn't feel like wading through treacle

This eclectic mix of observations are purely from a personal perspective. Like the rest of this paper, they reflect my personal opinions and are not necessarily those of the rest of the ED team.

1. Timescales of unfilled deanery posts being released to health boards for local recruitment

- National problem

The timing of release of unfilled Deanery junior-tier posts (F2, GPST, ACCS-ST1/2) for local recruitment is extremely unhelpful, occurring as it does only weeks before commencement of posts. This results in need to hire agency locums at short notice at extortionate expense, when a few months earlier we have had to send away multiple young doctors wishing to work in Bangor ED for an "F3" year as we've had no posts released back to us at that time. These willing applicants have long gone by the time the Deanery release posts back to us.

2. GPs returning to the UK

- National problem

There have now been two UK-trained GPs wishing to work in North Wales (both of whom had been working in similar primary care environments, one in New Zealand and another in Holland) who have been completely let down by Wales' apparent inability to handle returners to the Performers List in a coherent and responsive way. One gave up and returned to NZ; the other we managed to find a 12-month Speciality Doctor in Care Home medicine post for.

The English GPFV document carries specific provision for returners to GP including decently-funded placements.

Wales must address this as a matter of urgency or risk never being able to recruit returners to practice, who will just leak to England instead.

An experienced GP, even if requiring an element of supervision/conversion to UK practice, is unlikely to be a "net generator of extra workload" to host primary care settings.

3. Delays creating consultant posts for shortage specialties when candidates come forward

- Problem noted in BCUHB, but may be widespread

Consultants in Emergency Medicine are scarce and good ones need to be secured whenever the opportunity presents itself.

In years gone by, regardless of the financial position, if good candidates arose then posts would be created with a "make hay whilst the sun shines" philosophy. However, in BCUHB today, it has taken almost a year to create two new posts for Bangor ED (even in the face of looming retirements on the same tier) primarily due to concerns about budgetary constraints in the current financial pressures.

This is short-termism at its worst, and having worked so hard to fix EM recruitment in Bangor it is also soul-destroying to see our efforts near-sabotaged because the organisation is so desperate to meet short-term financial constraints that it seems willing to sacrifice long-term financial prudence.

The government needs to indicate clearly to Health Boards that recruitment of high-quality consultants, especially in shortage specialties, is an acceptable reason to overspend, especially when there would be foreseeable agency locum usage on the horizon otherwise.

A word about recruitment practices and HR support

4. Policies for overseas doctors commencing posts

- Problem noted in BCUHB, but may be widespread

With the recent arrival of a Dutch doctor completely new to the UK, we have just been made aware that current BCUHB policies compel overseas doctors (and UK doctors returning from abroad) to turn up at work for their paperwork and occupational health assessments/blood tests, *but they are not then added to payroll until these results are back*. In the intervening time, without a payroll number, they are also unable to access on-line mandatory training.

Clearly this is not acceptable: a doctor's first day at work is when they should expect to be paid from and it looks amateurish and exploitative to suggest otherwise: not a good recruitment tool in these days of social media. It would also be a far better use (of days that would otherwise be wasted) for doctors to be able to undertake their mandatory training in this time window before their occupational health blood results are back.

This may be a local policy, but I also understand that for doctors who require their TB status to be ascertained as part of the visa-obtaining process, our local Health Board policy is to re-check this, subjecting these doctors to another delay of several days.

We were also unaware of some of the logistical difficulties faced by doctors new to the UK . For example, UK car insurance companies require UK-registered credit cards be used for payment (I had to pay for my new Dutch doctor's car insurance).

Whilst Bangor ED has very few doctors completely new to the UK, colleagues in other health boards and specialties have made much more use of overseas doctors coming to Wales for their first NHS post. Adequate supporting packages and fair pay-from-day-of-starting-work policies should be required from Welsh Health Boards.

A poor "customer experience" from the point of view of the new recruit will very likely result in adverse gossip on social media, hampering further recruitment.

Appendix One

In Appendix One, I present a four-page proposal as a suggested solution to the dual challenge of recruitment to rural General Practice now, and the need to encourage Welsh-speaking medical students to pick general practice (and in particular rural General Practice) in the future.

Recruitment of rural GPs in mainly Welsh-speaking areas of Wales: an integrated proposal

Dr Linda Dykes, Consultant in EM, Ysbyty Gwynedd and GP - Jan 2017 v1.1

Introduction

Like everywhere else in the UK, Wales is struggling to recruit sufficient GPs to meet the healthcare needs of an ageing population and soaring demand. However, the overall difficulty recruiting GPs is compounded in our rural areas: recruitment of doctors to rural settings is a worldwide problem.

These challenges are further compounded by Wales' need to optimise access to Welsh-speaking HCPs, particularly in areas (e.g. the Llŷn Peninsula, Carmarthenshire) where elderly residents may not be balanced bilinguals, and consultations conducted in English may impact upon the safety and quality of care.

"Do what you've always done and you'll get what you've always gotten..." - Bolger

Quite rightly, the need to increase the number of Welsh-speaking students going to medical school has been recognised.

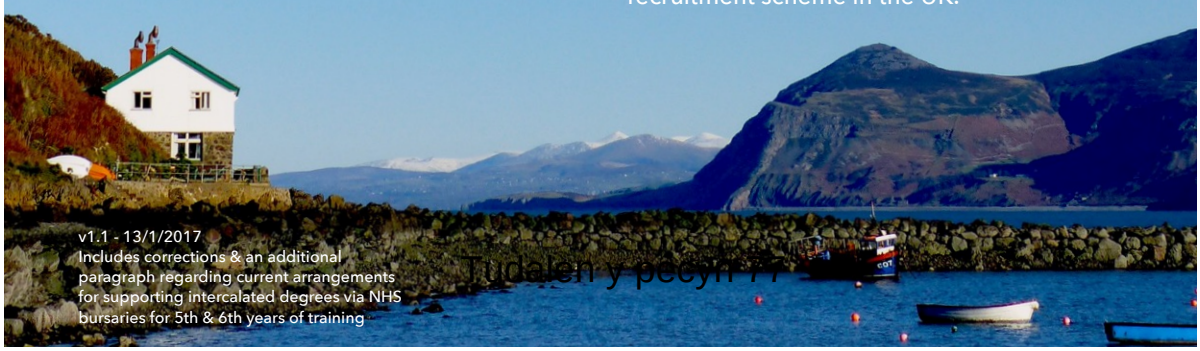
But it takes more than decade to train a GP from scratch, and we are desperately short of GPs *now*. Furthermore, only about half of UK medical graduates choose to enter General Practice.

We know that settled choices regarding eventual specialty are often made early in medical school, and we know that early exposure to rural practice settings increases the chance of Healthcare Practitioner students later working in a rural area.

This proposal suggests a combined solution, which would simultaneously address:

- tackling the serious challenge of GP recruitment to rural areas
- the need to provide optimal exposure to rural practice early in medical school
- support provision of bilingual primary care

The suggestions in this document incorporate the evidence regarding medical students' specialty choices and rural healthcare recruitment, plus the experience I have gained running both a hugely popular medical student programme in Ysbyty Gwynedd Emergency Department and the most successful Emergency Medicine doctor recruitment scheme in the UK.



v1.1 - 13/1/2017
Includes corrections & an additional paragraph regarding current arrangements for supporting intercalated degrees via NHS bursaries for 5th & 6th years of training

Step 1a: Recruit your GP

There are two likely sources of GPs for this scheme:
- already working in Wales who fancy a move
- those considering a complete lifestyle change

Identifying target recruits in the latter group requires pragmatism. Many (if not most) GPs have children. English-speaking families with school-age children are rarely prepared to consider relocating to an area where all the local schools are Welsh-medium*. Hence, the targets would be those with children under 4/5 years of age, or who don't currently have children, or whose children have left school.

Spouse/partner profession is also important. Doctors married to teachers or social workers are unlikely to consider relocation to an area where their spouse/ partner will be unable to gain employment within commutable distance**. However, many doctors are married to other doctors: dual-GP couples would be ideal.

Given that "lifestyle change" is the most likely factor "pushing" someone to contemplate a move to rural practice, post design must include features appealing to GPs feeling unfulfilled or burned-out in their current urban posts. It is also important to recognise that younger recruits (up to their mid-30s) are "Generation Y" and have different motivating factors and behavioural characteristics to older Generation X and Baby Boomer doctors.

Posts should be developed with features such as:

- Flexible job plans with features such as annualised hours and generous funded study leave
- Experienced rural GP mentor/support available
- Sabbatical options after several years' service
- Encourage portfolio careers: offer options within the HBs (e.g. within Enhanced Care schemes)
- Funded Medical Education training (e.g. PGCertMedEd)
- Choice of salaried or partnership options, but with partnerships underwritten by HB (e.g. freedom from "last man standing" financial obligations) & incentivised with indemnity costs covered etc
- Excellent relocation expenses package

** the RAF address this issue by offering support for private/ boarding school fees to all personnel at RAF Valley. This is an option that may require consideration (perhaps for the situation of sixth-form children). Young children immersed in a Welsh-speaking environment do quickly become bilingual - schools in some areas have extra support for such children - but there is no point in pretending that this option is palatable to most English-speaking parents: they are much more likely to decide to opt for another rural part of the UK where it is no consideration (right)*

*** In private industry requiring work abroad, spousal support packages are sometimes offered*

**** Traditional five-year course assumed; suitable equivalent for four-year Graduate-Entry programmes*

Step 1b: Recruit your medical student

The primary goal is to provide an experience of rural healthcare that is the "highlight of medical school", in the hope that this will translate into intention to become a GP, preferably in a rural area, after graduation.

A fully-funded intercalated BSc in Rural Healthcare for students who have completed their third year*** at medical school, combined with a placement to a rural practice or practices for a whole academic year - with good-quality accommodation and a car provided - should prove a *highly* attractive proposition for Welsh-speaking medical students studying at *any* UK university.

The Welsh-speaking Medical Students are then assets. Deployed to a GP surgery to be "buddied" with a non-Welsh speaking GP, or Welsh learner, the student can be utilised as a language tutor, translator, and health-care assistant… all whilst learning medicine. Students used in this way should receive a HCA salary.

Obviously, we would be foolish to limit our long-term efforts to recruit Welsh-speaking doctors to those who have opted to undertake their medical degree in Wales.

Caveat: stunning scenery is not enough

Whilst our amazing scenic and outdoor leisure areas such as Snowdonia, the Llyn and Pembrokeshire are great assets to those who live and visit, it would be folly to think that fabulous scenery alone will motivate doctors to relocate to rural parts of Wales. This is patently not true!

From the perspective of recruiting, GPs wishing to have a lifestyle change to "go rural" have their pick of rural areas of the UK, e.g. Cornwall, Peak District, Lake District, and Scotland. None of these areas have to overcome the twin challenge of language issues from the perspective of childrens' schooling *plus* poor spousal employment prospects (which are worse probably only in the more remote parts of Scotland).

It is only by developing posts *better* than anywhere else in the UK that we can possibly hope to make the idea of moving to rural Wales more attractive than our competitors. This does *not* necessarily mean "Golden Handshakes", but by investing in the areas identified by GPs and doctors in general as their "wish lists", plus making the daunting idea of relocating as hassle-free as possible (e.g. providing accommodation - good quality family homes that could be rented as holiday cottages when not occupied by doctors - or perhaps even providing business set-up grants to spouses**).

Step 2: Does the GP wish to learn Welsh?

It is said to take approximately 1000 hours, using modern language educational techniques and conversational practice, to become sufficiently proficient in a new language for everyday conversation (not technical-level communication). This enables us to quantify the financial cost of training a doctor to learn Welsh.

With rural GP posts already relatively undesirable in the current UK market, it would be unwise to *insist* that willingness to learn Welsh is a pre-requisite for the posts, and patently ridiculous to suggest that applicants should undertake to do so in their own time. We could, however, *incentivise* learning Welsh:

- Offer to send the doctor - in paid work time - on an intensive Welsh-language course. This will of course require locum backfill, which increases the cost substantially (see page 4)
- Introduce step-wise pay premia to reflect Welsh language competency, in *addition* to an already-competitive salary. Speaking Welsh is a skill that doctors moving from elsewhere in the UK are likely to perceive as "only required for the job" (although they may well soon realise that speaking Welsh is of great benefit socially in the rural Welsh communities). See also "The Hiraeth Strategy", right.
- Funded intensive Welsh courses should be offered, in addition to standard study leave, *at any point during the rural GP's stay in Welsh-speaking parts of Wales*.

Offering a month off clinical medicine to do an intensive Welsh language course in paid work time may be a surprisingly attractive "decompression" proposition for a newly-arrived, burned-out doctor seeking a change in lifestyle.

Combined with the reassurance of on-the-spot translation support from a Welsh-speaking medical student, it may well be possible to recruit individuals who are willing to learn Welsh.

The "Hiraeth" Strategy

There are probably more Welsh-speaking doctors *outside* of Wales than *inside*: offering a pay premium to Welsh-speakers **over and above a nationally-competitive salary** may be effective in persuading some to consider answering the hiraeth (yearning for home). Welsh-speaking doctors may be specifically attracted home *because* they want their children to be educated bilingually.

Step 3: Make use of the Medical Student

Unless/until a doctor becomes conversationally proficient in Welsh, other staff will need to support provision of a bilingual service. Welsh-speaking medical students, working with the GP in an "apprentice" model, would provide this facility at the same cost as a HCA (i.e. A4C Band 3) as a maximum, and yet with far greater underpinning medical knowledge, as they would have already completed about half of their pre-registration medical training.

The relationship would be symbiotic: the doctor teaches the student medicine, and the student teaches the doctor Welsh, helping to provide an immersive Welsh-language environment which will in turn speed up the doctor's language acquisition.

Another option: using other HCPs instead of Medical Students

This scheme could also be run using other HCPs (nurse, paramedic, pharmacist or physiotherapists) who are undertaking their Advanced Practitioner training & MSc, during which time they require supervised clinical placements together with time and teaching from a mentor. GPs are ideally suited to this role.

Utilising already-qualified, registered HCPs within the primary care team (instead of a medical student) might be a more flexible addition to the Primary Care Team, and would be faster to set up faster than a new intercalated BSc.

However, It would cost more in pay (i.e. Band 5 or 6, rather than Band 3).

Most importantly, using HCPs instead of medical students would do *nothing* to help encourage medical students into rural primary care, which is likely to be the only way to sustainably tackle rural GP recruitment in Wales.

The ideal solution might well be to utilise **both** - medical students and student Advanced Practitioners.

What would it cost?

Intensive Welsh Courses

- Nant Gwrtheyrn in Pwllheli charge £395 for five-day courses full board, or £255 for daily attendance.
- Completion of their first five levels of course (Pre-entry, Entry, Foundation, Intermediate, Higher 1) would take approx five weeks and cost about £2000
- + locum backfill during the course (c£350/session = £14-18k to backfill five weeks of Welsh course)

Training the medical students to support the learning of Welsh as a foreign language

- I have been unable to find any direct equivalent of the English TEFL (teaching English as a foreign language) courses, which are 4-week long intensive courses.
- Cardiff University offer a 2-year part time National Tutors Qualification which would *not* be suitable - students may need to apply competitively for places on an intercalated BSc and then need a short, swift course to provide them with strategies to assist novice Welsh learners. A bespoke short course may be required.

Paying Medical Students during the intercalated year

- Bangor 3 A4C salary approx £17,000 + on costs: budget as £22,000.
- Use of a vehicle and accommodation (estimate £7000 for 9-month placement) could be included as part of salary package, but the aim is to make the whole rural placement the "highlight of medical school" . This is much more likely if the year is characterised by a well supported placement; enthusiastic GPs; quality accommodation; having more disposable income than the other years of medical school; and not racking up more debt.
- Course Fees of an intercalated BSc plus travel/ subsistence for any associated contact days
- **NB** *intercalated degrees are currently supported by NHS bursaries for courses involving 5th/6th years of training and already carry a cost to the NHS, covering fees and some contribution to living expenses. The current arrangement for intercalated degrees might possibly be enough to attract students to the scheme, especially if combined with decent accommodation and use of a vehicle.*

What would it save?

About £40,000 per post, per year

Reduced locum costs - each post recruited to produces recurring savings in region of £40k+/year

- Vacant GP posts require locum cover - if you can get them - but many remain empty, increasing the pressure on a shrinking number of substantive GPs in the area.
- Locum cover is expensive: based on locum fees of c£350/ session & a typical 8-session GP job plan (cost c£80k including on-costs for substantive post), filling 8 sessions x 44 weeks with a locum would cost about £123k/year.

Saved lives and better healthcare outcomes

- Inequalities in access to primary healthcare are well-recognised as serious problems leading to poorer health outcomes and wellbeing for rural communities.

Summary of anticipated benefits

Supports future GP recruitment to rural areas

A highly attractive intercalated BSc package will encourage students to experience the rural primary care environment early enough in their training to influence their future specialty choice.

Supports provision of healthcare bilingually

Utilising Welsh-speaking medical students in this way would be the most cost-effective way of providing on-the-spot translators *with a clinical background*.

Providing training to participating Welsh-Speaking students in how to support Welsh learners would, in time, help produce a rural NHS workforce capable of nurturing Welsh learners.

Provides a mechanism to improve GP recruitment

Only a tiny minority of doctors will ever be attracted by a move to rural general practice in a remote part of Wales. However, even recruitment of one or two individuals each year would help to alleviate what is currently a problem approaching crisis proportions.

Each post that transitions from locum to substantive filled produces a *recurring* saving of approx £40k/ year… easily half a million pounds in the course of a 10-15 year career in Wales. Part of these savings can be used to support world-class post design. It may also be possible, using the savings, to extend the scheme to all Cardiff/Swansea medical students who wish to participate, whether Welsh-speaking or not.

Appendix Two

Appendix Two contains examples of our unofficial, "Guerilla" adverts/flyers for the Bangor Clinical Fellow posts. Created in my own time without the involvement of HR, these informal, sometimes-provocative and hopefully entertaining adverts are widely shared on social media, and generate many shares and comments *because* they are so different from standard medical adverts.

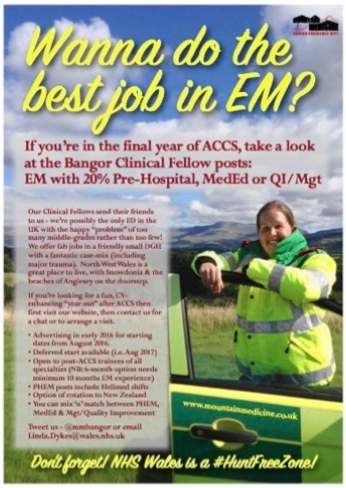
Our recruitment round for 2017/18 has just completed. We attracted a record number of applicants with only social media advertising - more than a dozen flyers over a 12-week campaign - producing a saving of more than £7000 on the customary full-page colour BMJ advert.

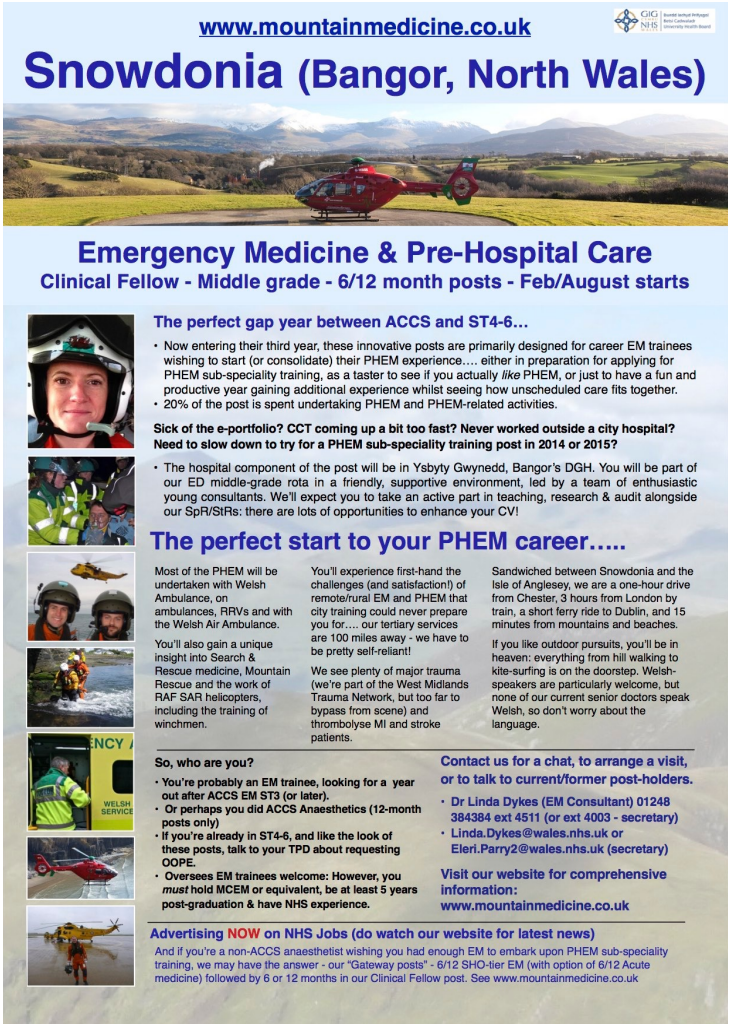
(right)

Selection of unofficial flyers from the 2016/17 recruitment campaign, which emphasised some of the benefits of our Clinical Fellow posts compared to the flash-point topics in the English Junior Doctors dispute during the autumn and winter of 2015/16.

Note in particular the centre-top and bottom-left: by using these "guerilla flyers", we can rapidly respond to the Zeitgeist prevalent amongst our target recruits at the time.

When Lonely Planet recently declared North Wales the 4th best place to visit in the world, we had a new flyer out circulating social media outlets frequented by our target recruits within six hours.





(left)

Early flyer from 2013: the posts at that time were still new and unfamiliar to our target audience.

Today, they are discussed on social media, and doctors we have had no direct contact with recommend them on the Junior Doctors Contract Forum.

(below)

Final flyer of our 2017/18 recruitment campaign: very simple but with the essentials still there.

Signposting to our unofficial website is always included: after each flyer we typically see a spike of about 800 extra hits than normal.

Thought you'd missed your chance to come to our famous post-ACCS Clinical Fellow posts in August? Fantastic jobs with Snowdonia & Anglesey on the doorstep? You're in luck!

Thanks to a couple of deferred starts, one or two opting for LTFT job plans, and creation of additional posts, we can squeeze another one in for a year (plus *possibly* another Aug-Feb) - despite us having more doctors from August than ever before.

Bangor ED

MOUNTAIN MEDICINE
BANGOR EMERGENCY DEPT

Clinical Fellows 2016/17

20% PHEM, MedEd or Mgt/QI

With enthusiastic supervisors, a very friendly department, civilised rota (annualised & LTFT options), playtime of your choice and all the Bangor extras (from pub quiz team to the Mountain Medicine database) then if you're finishing ACCS CT/ST3 (any speciality) why not come to us *this* August? We can't guarantee having many spare places in Aug 2017 - it's half full already from deferred starts.

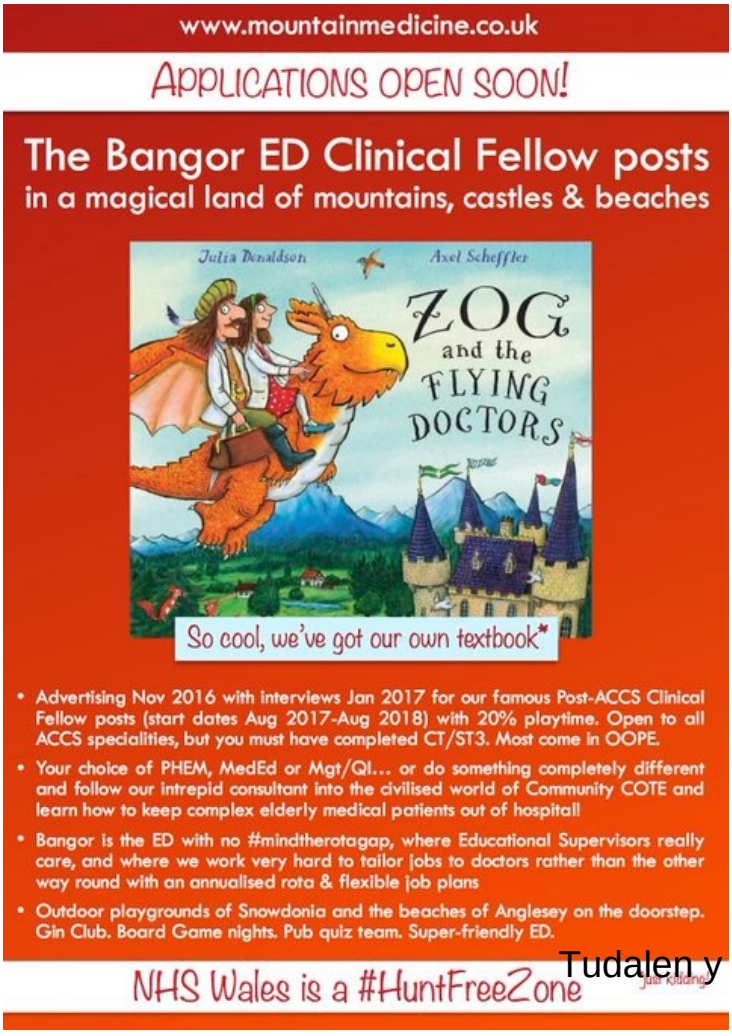
We'd particularly welcome applicants wanting to do MedEd (we'll fund your PGCertMedEd) but could accept another PHEM person!

Contact us: @mmbangor @HelenSalter5 @NoS_EMPhysician

www.mountainmedicine.co.uk

(above)

Catch-up flyer from late Spring 2016 - trying to avoid the "oops we have a space" feeling by emphasising the flexible nature of the posts (e.g. LTFT options) as a reason for having spaces at short notice - which was perfectly true.

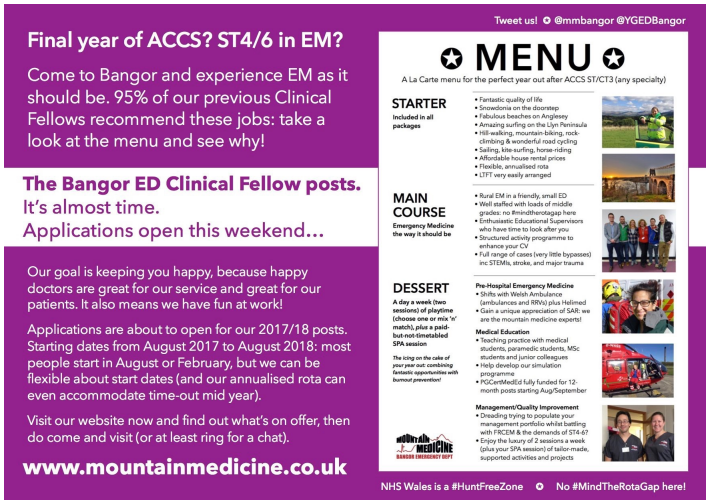


(left)

Early pre-recruitment flyer for 2017/18.

Our adverts for 2017/18 because distinctly more assured and ironically cocky for the current recruitment round. By using flyers such as these as "warm-ups", enquiries are generated and new Twitter followers gained, all of which help to maximise the impact and reach of the later adverts

Medical Recruitment: Learning from Bangor ED



More unofficial flyers from the 2017/18 recruitment campaign.

Above left & right: emphasise that, in contrast to most EDs, our doctors are happy, recommend their posts, and we do not have any problems with rota gaps (the #mindtherotagap hash tag was in wide use at the time).

Right - the most widely viewed flyer of 2017/18 campaign - more than 84,000 views on Twitter.

Below - following the "Zog" warm-up flyer we had toyed with the idea of running a movie-themed campaign, but quickly realised they can alienate potential recruits if they didn't like that movie.

Appendix Three

In Appendix Three, I present for your information page 1-11 (minus appendices which can be supplied upon request) of the Welsh Acute Community Care Scheme (WACCS) proposal document prepared by myself, Welsh Ambulance's Assistant Medical Director and Dr Suman Mitra, a consultant colleague in Ysbyty Gwynedd, in 2015.

We believe this scheme would be of great benefit to Wales, attracting trainees here, supporting Welsh Ambulance, and with likely longer-term benefits for GP recruitment.

We obtained agreement in principle almost two years ago from both Welsh medical schools, the Postgraduate Dean, and WAST. Progress has been slow since, as we have been developing the associated curriculum, and none of us have any time in our job plan for this work.

Thanks to Dr Mitra, the curriculum mapping is now almost complete and we are hopeful that we can start to make progress with WACCS in 2017.

The caveat is the scheme can only progress with the blessing of the Health Boards in order to ensure cover by the Welsh Risk Pool for participating trainees (unless NHS Wales overall were able to construct a national solution). Realistically, the scheme will also require some pump-priming funding support to provide the required administration and consultant time.

10 July 2015

All-Wales Acute Community Care Training Scheme (WACCS): an expanded proposal

Dr Linda Dykes (Consultant EM, Bangor)
Dr Jon Whelan (Assistant Medical Director, WAST)
Dr Suman Mitra (Deputy Training Programme Director, PHEM Wales)

From medical school to PHEM sub-specialty training

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from the project instigator

This document has been revised from our original proposal document, following feedback from stakeholders. It expands the scope of our initial proposals at their suggestion. Both of the Medical Schools in Wales, and the Postgraduate Dean, have indicated their support and offered invaluable and insightful suggestions. In the meantime, the Medical Student Pre-Hospital EM societies at Cardiff & Swansea universities have joined forces.

All the pre-requisite ingredients to make this scheme viable are now in place. It is now time to examine the logistics required to make it a reality. I would welcome feedback on this expanded and revised proposal - l.dykes@btinternet.com or Linda.Dykes@wales.nhs.uk

Dr Linda Dykes
10th July 2015

summary & recommendations

- Many medical students and junior postgraduate trainees are keen to gain experience in Pre-hospital Emergency Medicine (PHEM), but the headline “blue light” jobs are only a small part of the work undertaken by ambulance services.
- In other parts of the UK, undergraduate PHEM programmes (which are optional and selective) are extremely popular: Wales is falling behind the curve
- We propose developing an optional structured all-Wales “Acute Community Care Training Scheme”, that students and trainees could apply to opt into, complementing their existing training and helping to prepare them for later application to PHEM sub-specialty training, and/or as clinicians who are comfortably providing acute care in a community setting.
- We believe the proposed scheme would be advantageous for participating individuals, the two Medical Schools in Wales, Health Boards, Welsh Ambulance Service Trust (WAST), patients, and the Welsh health community in general
- Adverse consequences are likely if such a scheme is not created:
  - ✳ Medical students and junior doctors attracted to PHEM will increasingly shun Wales in favour of regions perceived as more accommodating to those interested in gaining PHEM experience.
  - ✳ As more and more medical students wish to copy their counterparts in England and access shifts with WAST, then unless a formal framework is in place, there is a risk of uncontrolled multiple requests to access observer shifts which will overwhelm the current arrangements for hosting observers
- The proposed scheme would catapult Wales to being a UK leader in providing a structured, developmental curriculum with carefully graded PHEM experience for all levels of trainee from medical student to PHEM sub-specialty training
- The proposed scheme would enable students and junior doctors to actively participate in audit & (potentially) research, crossing the boundaries between pre-hospital, community & in-hospital medicine and raising awareness and understanding of how healthcare provision fits together
- The proposed scheme, once established, has potential to become a platform for the delivery of both undergraduate and postgraduate (probably F1) acute community care.

background

Pre-hospital Emergency Medicine is coming of age. Instead of being a minority pursuit of a tiny handful of doctors, it is now a recognised sub-specialty that is generating huge enthusiasm from medical students & junior doctors.

Several areas of the UK have already embraced medical student involvement in early PHEM training - see page 4 - and there are growing calls for formal exposure to PHEM as a routine part of undergraduate training (Antrum & Ho, 2015).

Whilst some medical schools offer formal schemes in partnership with their local NHS Ambulance Trust, in other areas - including Wales - keen medical students have organised their own PHEM student societies typically concentrating on education events, although most of them are also keen to gain access to pre-hospital experience

At junior doctor level, access to PHEM experience is particularly difficult, as there are logistical and governance barriers to ambulance trusts carrying trainee doctors on shifts in anything other than a purely observer role.

Unfortunately, this makes acquisition of PHEM experience even more difficult for those who could not or did not gain any exposure at undergraduate level and this lack of experience may seriously hamper the chances of these doctors when applying for PHEM sub-specialty training.

The Person Specification for PHEM sub-specialty training lists prior experience as “desirable”, as is possession of the Diploma in Immediate Medical Care... but a pre-requisite of sitting this exam is significant PHEM experience.

Access to PHEM experience is so highly prized by medical students & junior doctors that we believe that developing an all-Wales pre-PHEM training scheme - running from medical student to ST3+ - will help aid recruitment of high quality medical students, and junior doctors, into Wales. It will be the first scheme in the UK to include junior postgraduate trainees as well as medical students.

Conversely, if Wales does *not* develop such a scheme, we will become uncompetitive in the UK market and unable to attract medical students or junior doctors who think they may be interested in PHEM.

Meanwhile, we are struggling to recruit GPs. Medical training, despite efforts to the contrary, is still dominated by hospital placements. Given that we know many medical students make a settled choice of the future specialty quite early in medical school, this remains a worry, and we believe that additional exposure to community-based acute care could help enthuse students to consider general practice for a career... or could enthuse those heading into hospital specialties to find a way to have continued access to community-based sessions via the GMC’s incoming credentialing scheme.

Finally, without a coherent scheme to cater for them, the various medical student PHEM groups that have already sprung up in South Wales are likely to make repeated individual approaches to WAST, which has potential for unfairness in terms of access to this experience, and confusion by paramedics as to the role and remit of medical student and junior doctor involvement.

what there is already (in Wales & beyond)

Undergraduate PHEM schemes elsewhere in the UK:

- The **Barts & Royal London Pre Hospital Programme** - the first formal scheme in the UK - involves the medical school & London Ambulance Service (LAS) as well as the London HEMS clinicians. As well as pre-hospital experience with LAS assets, the scheme features monthly open academic sessions, and PHEM-related Student Selected Components (SSCs). This PCP began as a student-initiated scheme. Participation is (highly) competitive and optional.
- **Barts and the London** also offer an intercalated PHEM BSc option for undergraduates.
- **All London medical schools** include the opportunity for students to undertake shifts with LAS.
- **Oxford medical students** have access to a pre-hospital & trauma extracurricular scheme, and their local ambulance service has provided a car for student volunteer first-responders.
- **Birmingham medical students** have had pre-hospital training and exposure as part of their courses since 1991 and were probably the first in the UK to do so.
- **Other affiliates** of the London schemes (Hull/York, Peninsula, Southampton).

PHEM schemes in Wales: Postgraduate

Ysbyty Gwynedd's Clinical Fellow Programme began in 2011 as a scheme to support recruitment of EM middle-grades. Post-ACCS doctors (i.e. ST4 equivalent) spend 20% of their job plan on PHEM and related activities, including with WAST assets.

PHEM Sub-specialty training for ST5+ trainees in EM & anaesthetics began in Wales in 2012, with two places per year available.

PHEM schemes in Wales: Undergraduate

PEMS (Pre-Hospital & Emergency Medicine Scheme) began as a Cardiff medical student society, run with the support of Dr Katja Empson in UHW. The PEMS scheme, like FPHC Student group, is keen to gain access to WAST shifts, but established activities are assisting interested students access ED placements extra to their normal curricula, and regular teaching sessions on EM and PHEM-related topics. See Appendix 2 (page 12).

Since the production in early 2015 of our original proposal document, the fledgling FPHC group at Swansea medical school has been incorporated into a co-ordinated PEMS structure with Cardiff. The FPHC Wales student lead and the FPHC Wales postgraduate lead [Dr Linda Dykes] intend to propose that the FPHC student lead has a seat on the PEMS committee, but will not seek to duplicate activity.

Some students are accessing PHEM experience by standalone SSCs, but without any co-ordination by WAST or control of content beyond scrutiny by the relevant Medical School.

Swansea medical students do already participate in a limited "ride out" programme.

proposed scheme: outline/components

1. Curriculum

The foundation of the scheme will be an all-Wales PHEM curriculum.

Based upon the syllabus for the DipIMC, the content of Phase 1A of PHEM sub-specialty training, the FPHC's "PHEM Skills Framework", and possibly the FP curriculum, the WACCS curriculum will help participating students and junior doctors to undertake activities to gain useful, practical, cross-transferable skills and clinical knowledge, at the same time as optimising their experience for later application for PHEM sub-specialty training.

2. WAST Placements

Carefully supervised WAST placements in RRVs or Emergency Ambulances will be undertaken with specially selected paramedics - likely to be Advanced Paramedic Practitioners (APPs) or Trainee Advanced Paramedic Practitioners (TAPPs) - who will be fully briefed in the different levels of students and doctors participating in the scheme, and what each is allowed to do. See next page for *provisional* proposals.

3. Participation in Community First Responder Scheme

Medical Students participating in the programme will be required to participate in the WAST CFR scheme wherever they are on placement in Wales.

Qualified doctors will also be encouraged to continue as a CFR.

4. Training sessions/CPD

Participants in the scheme will be required to organise a programme of PHEM-related training sessions, and will be invited to participate in any suitable training opportunities being run by WAST (and hopefully other PHEM providers in Wales, e.g. WAA/EMRTS & Bristow SAR helicopters), such as the North Wales monthly PHEM simulation training.

The intention would be to increase the number of multi-professional CPD opportunities so students & junior doctors can learn, and WAST paramedics attend as CPD.

5. Mentorship

All scheme participants will have a named mentor both within WAST *and* a named supervisor in their participating Health Board, who will help to guide placements, supervise and projects or skill acquisition and decide who is showing satisfactory progress.

6. Assessment

Scheme participants would be assessed regularly, both for acquisition of practical skills and for evidence if participation in the education & CFR elements of the scheme. A failure to demonstrate minimum levels of skill acquisition and/or scheme participation would result in withdrawn access to WAST placements.

WAST placements (provisional)

Trainee	WAST access	Clinical Scope of Practice	Indemnifying organisation	Other activities
Medical Student	Block placement (SSC or elective) + Participation in Community First Responder scheme + Optional shifts with paramedic mentor	Observer-only. Possibility of adding specific skills once competency assessed in pre-hospital environment (e.g. chest compressions in cardiac arrest, 12-lead ECG acquisition)	TBC - ?WAST NB - Hosting SSCs has potential to generate income stream for WAST	Participation in regular teaching sessions (structured around the curriculum), to be organised by student PHEM group affiliated to the pre-PHEM training scheme
F1/F2	Block placement in "Taster weeks" + Optional shifts with paramedic mentor (own time) + Participation in Community First Responder scheme	Paramedic makes all decisions; trainee may assist with practical tasks e.g. cannulation, drawing up drugs, physical examination, "scribing" for the paramedic NB - Postgrad dean has raised possibility of future FP placements within WAST	Employing Health Board	Participation in regular teaching sessions, to be organised by postgraduate trainees in the pre-PHEM training scheme
ACCS trainees CT/ST1-3 **GPST 1-3**	Shifts with paramedic mentor (own time) or other paramedics approved to host doctors participating in the scheme	As F1/2 until trainee has completed at least 4 months in supervised practice seeing unselected patients (i.e. EM or GP) **and** Scheme Educational Supervisor/TPD **and** paramedic mentor believes trainee suitable to undertake clinical decision-making appropriate to "SHO" tier. Paramedic retains right of veto in event of dispute.	Employing Health Board	Participation in regular teaching sessions, to be organised by postgraduate trainees in the pre-PHEM training scheme. Possibility of mentoring TAPP for their MSc modules
ST1-7 (*without* EM or GP experience) *[i.e. no formal training in setting with unselected patients]*	Shifts with paramedic mentor (own time) or other paramedics approved to host doctors participating in the scheme	Paramedic makes all major decisions; trainee may assist with practical tasks e.g. cannulation, drawing up drugs, physical examination, scribing. May only discharge IAW Paramedic Pathfinder.	Employing Health Board	Participation in regular teaching sessions, to be organised by postgraduate trainees in the pre-PHEM training scheme.
Post-ACCS (Bangor Clinical Fellow)	WAST shifts as part of BCUHB-funded job plan. Shifts may be undertaken with any WAST asset but should include all platforms: max 50% Helimed	Doctor likely to lead on many clinical decisions, but paramedic retains right of veto in event of dispute. Allowed APP drugs & external FP10s. Additional competencies (e.g. ketamine analgesia or sedation) may be "earned".	WAST	Leading teaching session programme. Mentor for WAST TAPPs. Running CSGs/ training for paramedics
Post ACCS trainees (ST4-7 in EM, AM, anaes or ICM)	Shifts with any WAST asset in own time	Doctor likely to lead on many clinical decisions, but paramedic retains right of veto in event of dispute. Allowed APP drugs & external FP10s. Additional competencies (e.g. ketamine analgesia or sedation) may be "earned".	WAST	Assists with teaching session programme. Optional - mentor for WAST TAPPs. Optional - running CSGs/training for paramedics

what's in it for WAST?

1. Steady supply of Community First Responders, particularly in Cardiff & Swansea but potentially also elsewhere in Wales

2. More interaction between paramedics and medical students & young doctors, that will eventually translate into more doctors understanding how paramedics train, think and work, and who are comfortable working in community settings

3. Increased access to CPD opportunities for WAST paramedics

4. Easier access to physician mentors for WAST paramedics undertaking MSc programmes, or topping up their vocational qualification to BSc

5. Supporting the transformation of WAST's culture into that of a clinical service first & foremost

6. Avoidance of an uncontrolled proliferation of medical students & junior doctors requesting WAST ride-outs.

what's in it for the Medical Schools?

1. An attractive option to offer potential medical students in a competitive market

2. Demonstrable commitment to promoting multi-professional working & education, plus exposure to community care in the wider sense

3. Assures the quality of student-led initiatives and ensures controlled access to appropriately supervised and structured PHEM placements.

4. Placements providing medical students with first-hand experience of the superb communication skills common to many paramedics: for example, jargon free discussions with patients, persuading & cajoling the unwilling, firm but fair humour with intoxicated patients, and all much close to a worrying or upsetting event than students will ever see in hospital or general practice.

5. For Welsh-speaking medical students, who sometimes report reticence to consult in Welsh (some will cite concerns that they "don't know medical words in Welsh"), the opportunity to work with Welsh speaking WAST crews/patients (especially in NW Wales) and gain confidence in the fact that patients aren't bothered about clinicians using "everyday" Welsh to take a history - they prefer it that way, it builds rapport much more quickly.

what's in it for the Health Boards?

1. Access to PHEM experience is highly prized by trainees, and health boards supporting the scheme via ED consultant participation will be attract trainees

2. As the scheme develops, the use of doctors on WAST assets will result in reductions in ED attendances, admission-avoidance, and more appropriate use of primary care

3. Long term benefits include a cohort of doctors who fully understand the unscheduled care system, and are better able to work across the current artificial boundaries between hospital and the community.

logistical challenges

- All participants in the scheme will be expected to join the Intensive Care Society in order to acquire personal injury & life insurance when working in ambulances. Funding TBC: it may be possible to utilise SIFT money from hosting student SSCs to pay for this cover
- EWTD rest requirements must be respected
- Trainees must have access to supervision/advice (by phone): this would need to be provided by the ED consultants of participating Health Boards where the trainee works. If Health Boards do not wish to participate (and/or ED consultants do not agree to provide cover) then scheme participants (of any grade) will be limited to same level as F1/ F2 doctors where the risk of trainee-related litigation is negligible
- Although Welsh Risk Pool covers claims exceeding £100k, in event of litigation, claims less than this would be borne by the employing Health Board for more junior doctors
- For junior trainees to take an active part in WAST shifts, their employing Health Boards will need to agree to participate in the scheme both in terms of supplying supervision (typically ED consultant on-call, by phone) but also accepting *there could be a litigation risk which might include treating patients in another HB area*: WAST assets in South Wales regularly move between HB areas in the course of a single shift. This is less of an issue in North Wales, but a policy regarding patients treated across the English border will also be required. Should HBs not wish to take on this risk, clinical practice will need to be restricted to that of a medical student, or could be capped at the level suggested for an F1/ F2 doctor (see table, page 7)
- Provision of PPE & how this will be funded
- Provision of Violence & Aggression training for all scheme participants
- Development of assessment tools for use on the scheme
- Willingness of the student-led PEMS societies to participate in organisation of a training programme based around the all-Wales PHEM curriculum (see Appendix) and provision of consultant/ senior trainee supervision of their sessions
- Willingness of EM consultants in providing telephone advice and being part of the governance chain of this scheme - however, some very keen and able trainees would preferentially choose placements in participating departments
- Work required to map levels of scheme participant against the FPHC PHEM provider skills levels
- Work required to expand existing draft pre-PHEM curriculum (currently with activities & skills designed for post-ACCS Clinical fellows) to cover all grades of scheme participants
- Work required to map scheme participation against Foundation Programme curriculum
- Resourcing of time for WAST mentors, HB Educational/scheme supervisors - *NB expected to be minor, as WAST mentors would be undertaking shifts with their mentees and the HB scheme supervisor would often be the trainee's Educational or Clinical Supervisor and hence meeting with them regularly anyway*

the strategic fit

The need for more UK doctors to be "generalists", and less confined to traditional specialty boundaries, is widely recognised, most recently by the Greenaway "Shape of Training" review.

Whilst it is not yet clear how much of "Shape of Training" will be adopted - the recommendations having attracted much negative comment from both specialty Colleges and the BMA - it is abundantly clear that our current "silo" model of hospital versus community/GP medical care is failing to deliver for patients and completely unsustainable given the demographic changes the UK is facing.

Medical students and junior doctors going into many specialties would benefit from a much wider view of health care in the community, and we believe work with the ambulance service would be an excellent way of introducing this.

At present, with few exceptions, the only doctors who routinely see patients in their own homes are GPs, and only GPs and Emergency Physicians see "unselected" patients.

The forthcoming "credentialing" system - currently in preparation with the GMC - may provide a way to break this stranglehold and produce a more flexible workforce with generalist abilities - potentially aded to their specialist training as a "top up".

For example, consider if it were possible for Emergency Physicians, Acute Physicians and Geriatricians (COTE) specialists to undertake "top up" training and credential in Acute Community Medicine - i.e. the component of general practice that isn't chronic disease management. The result would be a cadre of doctors able to seamlessly work between hospital and community, well equipped to support GP with the relentlessly increasing onslaught of complex frail elderly patients - and the ability to create bespoke portfolio careers, promoting sustainability and a creative, vibrant and productive medical workforce.

"Interface Medicine" is a term that we are likely to see the WACCS scheme will be able to promote the concept in Wales.

training opportunities with WAST at medical school & beyond

Following discussions with both Swansea & Cardiff medical schools, and the Wales Postgraduate Dean, it became apparent that our initial proposal had perhaps been less ambitious than it might have been.

Whilst all agreed that a slow, steady launch to the proposed scheme is sensible, they saw future possibilities that we had not. Should these initial proposals prove to be a success, they could pave the way for a new shared relationship between WAST & UG/PG medical training in Wales:

1. Potential to use WAST placements to deliver some core undergraduate content to medical students

2. Potential for a full 4-month Foundation Programme rotation with WAST (probably F1, as 100% deanery funded and never expected to independently discharge patients)

Hosting **medical student placements** has the potential to generate a useful income stream for WAST - around £500 per week per student. Clearly there is potential for a station to host three students and fun an additional shift per day.

Hosting **Foundation Programme** junior trainees - all of whom should have practical skills probably in excess of a newly-qualified paramedic - should mean that WAST would have less requirement for EAs to be crewed by two *paramedics* whilst hosting these doctors, as a lower-banded clinician assisting/driving could be used whilst still maintaining two highly skilled patient attendants.

what happens next?

STAGE ONE - Spring 2015

- WAST to be registered as an Approved Practice Setting with the GMC
- Approach Swansea & Cardiff Medical School and invite their approval for the scheme (highly desirable, not essential) & request admin assistance for running the student phase of the scheme
- Approach Wales Postgraduate Deanery and invite their approval for the scheme - *particularly the use of WAST placements as suitable for FP1/2 "tasters"* & to request admin assistance for running the postgraduate phase of the scheme
- Encourage the existing Welsh undergraduate PHEM groups to unite in order to affiliate with this scheme

STAGE TWO - July-October 2015

- Confirm name of the scheme - Welsh Acute Community Care Scheme or Welsh Interface Medicine Scheme - "WACCS" or "WIMS"?
- Approach Health Board Medical Directors
- Approach EM consultants in each Health Board to determine which would indicate willingness to support the scheme
- Finalise table on page 7 of this report & arrange logistics of booking shifts etc.
- Invite expressions of interest from experienced WAST paramedics
- Complete mapping PHEM curriculum against competencies/levels/assessments
- Plan SSC educational descriptors
- Collate list of potential projects for medical students to undertake on WAST SSCs

STAGE THREE - 2015/16 Academic Year

- Launch in Medical Schools
- Launch postgraduate scheme in BCUHB area initially (no cross-boundary issues with other health boards, supportive consultants on hand & BCUHB Medical Director has already indicated he is fully supportive of the proposed scheme)

STAGE FOUR - when ready: likely 2016/17 or 2017/18 Academic Year

- Roll out to all Health Boards who wish to participate

references

Antrum J & Ho J, Prehospital emergency care: why training should be compulsory for medical undergraduates. EMJ 2015;32:171-172

Websites of other schemes

- London PHP http://prehospitalcareprogramme.org
- Oxford major trauma and PHEM society (student response car) http://studentoxtrauma.org/student-section/student-first-responder-scheme/
- http://pems.doctorsacademy.org/Home/Index
- Affiliates of the Barts & the London PCP scheme http://prehospitalcareprogramme.org/affliates/
- Interesting report from a UCL PCP scheme participant http://www.fphc.co.uk/content/Portals/0/Documents/Pre-hospital%20end%20of%20year%20report%20pdf.pdf

Standalone GP posts for doctors not on the speciality register – a proposal

Dr Sara Bodey – GP in N Wales (Bradley's Practice, Buckley, Flintshire)

January 2017

My background

I am a GP in Flintshire in North Wales (and have been for 12 years), NWLMC Vice Chair, and a GP speciality trainer. I am also an educational supervisor for F2 doctors having experience in General Practice and an undergraduate tutor for the University of Liverpool.

The Workforce Problem

We don't currently have enough GPs regardless of what model of provision primary care is going to follow. And in the next few years many doctors in their 50s are likely to retire (many factors are pushing GPs to retire sooner than they otherwise would, which is another discussion). We are not currently recruiting enough new GPs to replace those leaving or even to fill the gaps already present, as can be seen by the number of practices having to hand back contracts because they cannot recruit.

Where do GPs come from?

Currently there are 4 main ways we can recruit GPs into Wales:

- The standard route is for young doctors to complete a 3-year formal GP training programme and then enter the workforce. A GP training programme consists of three 6 month posts in hospital specialities (for example medicine for the elderly, paediatrics, psychiatry) and then 2 posts in GP training practices, one of 6 months and one of 12 months. During their training, they must pass a written knowledge based exam (the AKT) and in the final year a practical exam that looks for high level consulting skills and decision making (the CSA), they are also continuously assessed by their supervisors and trainers during day to day work. To enter onto a GP speciality training programme doctors must have completed their foundation programme (the first 2 years after graduating, in which they work in a sequence of 4 month posts in different specialities). Some doctors will do other jobs prior to deciding to join a GP

speciality training programme – they may be able to count some of their additional experience towards their GP training but currently only 6 months.

- Recruiting GPs who have already completed UK GP training into Wales from elsewhere in the UK – such doctors can start work straight away
- Recruiting doctors trained in primary care in other countries – these doctors have to go through an assessment process and then do a period of supervised practice before they can work as GPs (the Induction and refresher programme)
- Encourage GPs who are UK trained but who have taken a career break (for whatever reason) to come back into the workforce (currently these doctors would have to go through the induction and refresher process too unless they have been out of the workforce for less than 2 years)

My focus in this discussion will be on the first group with the intention of improving both the numbers and the quality of applicants to GP speciality training by making it possible for young doctors to experience general practice before they must decide which speciality they want to apply for after their foundation programme.

The current situation – a lack of opportunity to try general practice before committing

At present, the only doctors allowed to work in general practice are either those who have completed GP speciality training and are therefore on the GP register, or those on a recognised GP speciality training scheme. The number of places on GP speciality training schemes in Wales is limited to around 130 across the country and hasn't changed since I have been a trainer (it is notable that all other countries in the UK have significantly increased the numbers of GP training posts available). We struggle to fill even this number of places, although last year showed some improvement. My local scheme, Wrexham, nominally has 8 places, and was full last year but the year before only had 2 doctors appointed and the year before that 5. This is in an area that is a real risk in terms of viability of GP service provision at present because of recruitment.

Since the mid-2000s it has also been possible for doctors in the second year of their foundation programme (so called F2 doctors) to undertake supervised posts in general practice. However, the number of these posts available is limited and it is still the case that most young doctors in Wales do not have the opportunity to experience general practice except as a student before they must choose which speciality training programme to apply for. It is not really surprising that a lot will consider specialities that they have experienced during foundation rather than ones they haven't.

Increasing F2 GP experience seems sensible but is restricted by understandable concerns about what would happen to hospital rotas if these doctors were in GP rather than hospital placements.

I train F2 doctors in my practice, and have realised from talking to them that many of them don't know what they want to do after the foundation element of their training is completed, and in fact many opt to not go straight on to speciality training of any sort. This is not just because they are uncertain about which option to choose, it is also because they are often exhausted by the continual assessments they have had to do through medical school and then foundation training.

This year, nearly 50% of F2 doctors did not enter Speciality training after completing their two-year Foundation program. Some went abroad and proportion of them won't come back to the UK. Others chose to locum in different specialities to test the water before deciding to formally commit to a training programme. At present because of the regulations around the performers list (of which more later), they cannot locum in General Practice, but these restrictions don't apply to hospital specialities which they can test out at this point, further reinforcing the pressures to choose a hospital speciality rather than GP.

So, barriers to gaining experience in General Practice exist both during and after Foundation training, and for most, the only way to try it is to commit blindly to the training program; something which we know they do not wish to do. This reinforces an application to GP training as often either being a best guess, or at worst a last option, whereas we want it to be a willing choice from young doctors who really understand what they are signing up to – then they should be more likely to stay for the long haul.

My solution – make it possible for doctors to do standalone posts in General Practice, under supervision, once they have completed their foundation programme

The key here is that it is the young doctors themselves who want this to be possible. They want the option of choosing a post in general practice along the lines of the locum hospital experience they are currently getting after foundation. In fact, this whole concept came from a discussion with a young doctor who had been one of my medical students. A survey I sent out last year to foundation doctors in Wales showed that over 40 doctors (80%) of those who responded would have been interested in doing these posts and contributing to the GP workforce in August 2016 – the link is here: https://www.surveymonkey.com/results/SM-V27ZT38W/

I had a lot of emails from doctors who responded to the survey asking me if it was really going to happen and expressing their enthusiasm for the idea.

I have taken this concept to LMC conference in 2016 where it was passed and therefore is accepted as policy for GPC Wales. It has also been presented at RCGP Wales who had concerns about some aspects around the legislation, but it is going back for a second discussion sometime this year. In addition, I have discussed it at national (UK) LMC conference and it is being seriously considered by national BMA.

Such posts could be for as little as 4 months or as much as a year. They would need a governance structure and appropriate supervision in place but the young doctors often don't want to have them as formal training posts because they have been completing education assessments for many years and want the opportunity to try the speciality without being tied to electronic portfolios of experience and frequent assessments.

There are two other types of doctors who would also benefit from time in General Practice who are not currently able to access it: those who are already committed to a speciality program in a hospital but who are having second thoughts (often this is because they have been pushed into choosing too soon) and would like to try General Practice, and those who are in GP training already but who need more time to pass their exit CSA exam.

This latter group are often overseas trained doctors who struggle to reach the high-level consulting standards required to pass the CSA within the 3-year time limit because they are having to adjust to different cultural and linguistic norms without which it is impossible to perform at the level required. Currently these doctors are offered the opportunity for a final sitting of the exam once the training programme is completed but they cannot stay in general practice (because they are not on the specialist register or on a recognised training programme). Thus, they usually return to hospital practice and sit the exam whilst working in a hospital speciality which means they have less opportunity to fine tune their consulting skills, thus making the exam even harder to pass. If they fail to pass the CSA these doctors are lost to the GP workforce for ever – they are not allowed to reapply.

In short, there are many potential GPs of the future already in Wales who are currently unable to access experience of this speciality at different points in their career. Additionally, a substantial proportion of new graduates are being lost from the health service in Wales completely because of the lack of options available to them at the post-foundation point of their training. Making it possible for these doctors to choose to do standalone posts in GP would potentially increase both the number and I would suggest quality of those applying for GP speciality training. It would also immediately increase the pool of doctors available to work in GP practices.

Potential Benefits

- Increasing the numbers of doctors choosing GP as a career
- Increasing the number of doctors who apply for GP training really knowing what GP involves and therefore staying in the workforce after training is complete
- Offering flexibility after foundation training rather than demanding commitment
- An immediate workforce boost to general practice: 'bums on seats'. In my experience of training F2 doctors is that they can develop into a very useful part of the team and make a significant positive contribution to the practice workload.
- Giving doctors struggling to pass the CSA exam within the time constraints of current GP training the opportunity to stay in a GP work environment whilst they continue to attempt to pass and complete GP training

Potential Pitfalls considered

- Current legislation. The performers list legislation and GMC rules mean this sort of post is currently not allowed. Those doctors allowed to deliver primary medical services must have either completed formal GP training or be on a recognised training programme to do so. It is not immediately clear to me from reading the legislation how F2 posts in GP are actually allowed, particularly in Wales where they aren't mentioned at all! It may be possible to overcome this by recognising these posts as part of a formal programme – although it needs to be noted that the young doctors DON'T want to have to count this sort of experience towards formal training. If not then there is going to need to be legislative change, which will take more time and need to be discussed both at WG and GMC and potentially at a UK government level. However, I do believe that this can, and indeed must, be done.
- Indemnity. Conversations with the main MDOs suggest they would be willing to offer indemnity cover to such posts at a reasonable rate
- Appraisal/revalidation issues. These should be resolvable – the LHB locally already assigns an RO and facilitates appraisal and revalidation for doctors doing locum posts in the hospital at various career stages.
- Safety and supervision issues. There are well defined supervision and job plans available for F2 doctors in General Practice which could be duplicated for these doctors

http://www.northerndeanery.nhs.uk/NorthernDeanery/foundation/Trusts%20/north-tees-updated-for-2015/f2-general-practice)

- Finance. Who will pay for these posts? If the supervision requirements are not overly onerous then it is likely that employing practices may well be willing to fund these posts at least in part – certainly those I have spoken to in North Wales who are currently finding it so difficult to recruit other doctors or indeed nurses have expressed a willingness to do so. There is a case for the LHB or indeed WG being prepared to contribute to the cost of employing the young doctors too, particularly given the positive effects such placements will hopefully have on area wide recruitment. This may be direct to supervising practices as a way of recognising the supervision requirement, or it may be by the provision of some centralised access to training throughout the placement, and training to supervising practices or both. If the post is to be educationally recognised there would be a need for the additional input of the supervising practice to be recompensed via the deanery or WG, and any eportfolio requirements to be resourced – but I do not expect many of the young doctors to want this option.
- Interest from practices. Any concern about using non-GPs can be allayed by experience and adequate support. The scheme should be trialled in current training (ST or F2) practices before being rolled out to non-training practices to identify any problems.
- Avoidance of abuse of the role. There is a risk that this may be viewed by less scrupulous employers, whether GPs, LHB or private providers outside of Wales, as a way of cheaply staffing surgeries. This can be swiftly avoided by the provision of clear reporting pathways for the doctors, and clear requirements for supervision.

I ask Welsh Government to support this concept and work with the GMC and the Performers List to find a solution to the current restrictions on developing such a role in as short a time frame as possible.

I have been a GP for past 15 years and am currently a Partner in a deprived urban practice in Swansea. I have been Director of Admissions for the Swansea Graduate Entry Medicine programme for the past 5 years and am undertaking a Masters degree in research into the recruitment and retention of GPs in Wales.

My response to the enquiry is based primarily on my own research and may not be representative of Swansea University Medical School. It is focused on General Practice in Wales.

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.

As part of my research I have developed a database of all medical students who have been accepted onto the Swansea Graduate Entry Medical Programme(GEM) and tracked them from area of origin and area of domicile through application, medical school and into the workforce. I will present some figures from this research. Appendix A

Also, as part of my research, I carried out a questionnaire survey of current medical students in Swansea, in part to gauge their impression of remaining in Wales and of working in general practice. Appendix B

Finally I have conducted an e-questionnaire that was sent out to all GPs in Wales last May and June as to their impressions of general practice. Appendix C

822 medical students have been accepted onto the GEM course in Swansea. For details relating to the data please see Appendix A. 28% were documented as being Welsh domiciled ie having a Welsh address at the time of application. For those of whom we have secondary school data 25% went to secondary school in Wales with 67% having attended a secondary school in England.

Of the 603 that have graduated, 36 (nearly 6%) are either not registered with the GMC or do not have a current license to practice.

Of those whose current location is known, 20% are undertaking GP training (58% in Wales) and 11% are GPs (52% in Wales). In other words 80 of the 520 doctors either are or are likely to be GPs in Wales. 166 graduates from Swansea went to a Welsh secondary school (27%) and 122 (67%) are still in Wales.

Figures from my e-questionnaire show that 34.2% of GPs mention retirement when questioned what factors may lead to them leaving GP in the next 5 or 10 years, 21.9% describe an intention to retire within 5 years. It also shows that 33.7% have indicated that they are '*highly likely*' to leave General Practice within the next 5 years due to retirement or otherwise. There are approx. 2000 GPs in Wales; if extrapolated, this figure suggests that as many as 400 GPs are considering leaving general practice within the next 5 years and will need to be replaced just to maintain the status quo.

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

Factors affecting recruitment

210 students currently studying in Swansea University across all 4 years of the GEM programme answered a questionnaire survey carried out by a final year medical student(Tom McBride). 39 students (18.6%) went to a Welsh secondary school.

8.6% strongly agreed that they did not want to work in Wales once qualified, with 35% strongly disagreeing with this statement. Only 20% indicated that they were keen to leave Wales to pursue their higher training. Almost 32% indicated that the Junior Doctor contract in England has influenced this choice. By far the most popular reason for staying in Wales is due to the cost of living (78%), with 50% indicating that the supportive clinical environment is a positive factor. The greatest reason for students wanting to leave Wales (61%) is due to having family based outside Wales or friendships/relationships outside of Wales (51%).

20% indicate that they strongly agree with the statement that they are considering GP as a career, with the majority undecided. However, only 8% strongly agree that they would like to remain in Wales to work as a GP. Reasons given for considering GP are, for the majority, the desire to combine a medical career with family life (67%) and the variety that GP offers (59%).The reasons for preferring to specialise is the perception by 60% of respondents that hospital medicine is more interesting/challenging and it allows them to focus on a particular area of interest (57%). For 51%, it is the acute nature of hospital medicine that attracts them. The majority of respondents are undecided as to whether they want to work in Wales as a GP.

There exists opportunity, therefore, to attract the majority of medical students who are undecided as to their choice and location of career to remain in Wales and consider General practice as a career choice. Financial considerations are paramount – leaving university following 2 degrees with large student loans has implications for general practice – students do not want to buy into practices with the huge initial financial outlay. They also want variety and to feel intellectually stimulated by the acute nature of hospital care. There is the perception amongst medical students that general practice is not intellectually stimulating and that anything interesting gets referred to secondary care.

Factors affecting retention

1997 GPs throughout Wales were sent an e-questionnaire survey with 430 responding (22% response rate).

48% were born in Wales with 52% having moved here later. Of those that weren't born in Wales, more than 50% moved here specifically for work, with almost 24% having moved here for university.

54% went to a Welsh secondary school and 44% to a Welsh medical school

GPs currently working in Wales were not more likely to have gone to a Welsh secondary school or to have studied medicine in a Welsh university.

The factors that made our current GP workforce attracted to general practice as a career are similar to those expressed by our current medical students: namely that variety and the ability to combine a career with family life are the most important factors.

GPs were asked if they had ever worked outside Wales, how long it was before they returned to Wales – 41% returned to Wales within 5 years

From the data it is also clear that >75% of GPs have either never worked outside of Wales or had returned to Wales within 5 years. Factors causing them to return were far and away the fact that it was their home, or that they had family living here.

Of concern is the fact that 51% of respondents have considered leaving Wales with 34 % most likely to leave within the next 5 years.

Of those that are contemplating leaving the profession within the next 5 years – 29% cite retirement as the main reason with excessive workload cited by 24% of respondents. For a small number, they have already "had enough" and have resigned. Reasons cited for leaving the profession include the pressure of deferred work from secondary care and the perceived lack of worth:

> *"The negativity of the press and GP bashing from all sides"*
>
> *"GPs are over-worked and under-valued. More and more pressure being passed on to GPs without the added support needed."*
>
> *"I have handed in my notice and am leaving the NHS"*
>
> *"GP has become the cesspit and dumping ground of the NHS"*

In addition GPs are concerned for their own mental health and well-being and fear being burnt out and exhausted.

> *"Each day seems to be getting harder, and my ability and endurance is becoming less.. I don't know why this is, it should be a good job".*
>
> *"Excessive demand and workload. (I) fear I can't do the job as well as it needs to be done"*
>
> *"I cannot continue to subject myself to the adverse effects of the job. My wife and family deserve a father, not an empty shell".*

So why is this happening? For GPs, who themselves admit that the job should be pleasurable and varied, the lack of morale is multi-factorial. Concerns over litigation, lack of support from political masters, lack of resources and relentless demand are all factors that are playing a part in the impending recruitment and retention crisis.

> *"Concerns over litigation and lack of understanding from public and politicians of the pressure that this causes GPs".*
>
> *"Relentless demand-led workload (in) recent years-I still feel I am helping patients but not bearable were it not for seeing light at end of tunnel (retirement) getting nearer".*

> *"Increasing workload and unrealistic expectations on what primary care can achieve with very limited resources"*

However, the lack of morale and increasing exhaustion are not echoed throughout all the responses. For some, General practice still provides the career that attracted them in the first place.

By far the majority of GPs (61%) would still recommend a career in General Practice to students.

Of the GPs that said they would not recommend a career as a GP, the reasons given were that they felt overwhelmed by the work-load and stress, under-resourced, undermined and under-valued. For some, the admission of the fact that they would not recommend GP as a career was tinged with guilt:

> *"I feel awful writing this. I teach undergraduates … and am passionate about general practice and primary care. I love it and think we are of great value to the health service. Unfortunately the politics and cuts that are ongoing with the plans to combine practices into supercentres will take away all that I value most and the part of the job that keeps me going, my close relationship with my patients"*

For those that would continue to recommend GP, a quarter of these respondents have responded with caveats, citing significant workload and stress and would want to ensure that students were fully appraised of the current situation, whilst expressing cautious optimism that the current situation must surely improve. For the remainder, general practice offers positive affirmation of the reasons why they originally chose this career – an extremely rewarding job that is varied, allows autonomy and is immensely satisfying.

46.5% of GPs would not consider leaving general practice in the next 5 years but this does not tell the whole picture. 30% of the respondents who responded "NO" to this question clarified that this is because they are close to retirement anyway, so will be staying out of necessity rather than active choice. Only 32% of respondents would actively choose to remain in general practice over the next 5 years and in actual fact for only 6.7% this is because they love General Practice and enjoy the work. For the vast majority, the reasons for staying in General Practice are because they feel trapped and unable to do anything else. This paints a depressing picture of life as a GP.

> *"Even though I enjoy my work it is stressful and sometimes a thankless job. There are jobs out there that can help people, have interaction with people that do not have the stresses of General Practice."*

> *"I would love to be able to consider something else…like palliative care. I feel I have a wealth of experience but couldn't bear the prospect of the whole re-training thing. There should be ways to switch between specialties to re-vitalise the profession – dual qualification should be an option"*

It is clear then that recruitment difficulties co-existing with retention issues are creating a "perfect storm" with respect to General Practice in Wales. GPs are demoralised, demotivated and burnt out. Demand for services by patients, coupled with increasing sub-specialisation in secondary care means that GPs, who were previously autonomous, specialists in community care feel that have become de-skilled and micro-managed. There is the perception amongst trainees that anything interesting, challenging and intellectually stimulating is referred to secondary care.

In order to inspire medical students to consider a career in General Practice, it needs to be innovative, exciting and challenging with considerable intellectual stimulation; in addition, students need to be exposed to such an arena throughout their training. Evidence shows that the environment in which medical students are taught has an effect on their final career choice (Stagg et al, 2012). Students are also more likely to choose branches of medicine where they have seen successful role models with whom they can identify(Hin Hin Ko et al, 2015). Within Swansea University 71 weeks of the curriculum is spent in secondary care, with just 12 weeks in Primary Care. The majority of teachers on the programme are secondary care clinicians.

The Health Professional Education Investment Review, completed in March 2015, recommends that "the emphasis on hospital-based training and development needs to be adjusted to embrace community settings". In response to this, and taking into account the evidence presented above, there is a pressing need not only to attract students to consider general practice as a career but also to retain the existing workforce.

Within Swansea, I have proposed the development of a Primary Care Academy which sees GPs as Consultants in Community Care guiding patient care through a more integrated team of professionals including nurses, physiotherapists, pharmacists, physician's associates, district nurses, health visitors etc. with truly inter-professional working and learning.

Inter-professional working will mean that patients are directed towards the most appropriate professional at the point of contact, freeing up GPs to deal with more relevant issues and utilising their knowledge and skills more effectively. Freeing up GPs time from those aspects of practice that are more appropriate for other professionals will result in GPs seeing a more appropriate, challenging and intellectually stimulating workload. This would result in increased autonomy, improved job satisfaction and better time efficiency.

90% of interactions of patients with the NHS occur in primary care and it makes sense for learning to take place at this primary interface between patients and the health service. Medical students will develop an understanding of the patient journey and learn about the relevant specialties in an iterative way. Expansion of the Academy sees the education of Physician's associates and community nurses as well as FY1s, FY2s and VTS trainees. In due course, training in other specialities could also occur in primary care academies including physiotherapists, osteopaths, health visitors, podiatrists, phlebotomists and all those other professionals who support people in the community.

This approach, "based on teams, which make the most of the skills of this wide range of professionals, will be the core operational model of the future" (Welsh Government, 2014).

Rather than the development of another medical school in North Wales, Academies could be developed throughout Wales, recruiting locally and making use of local GP educational supervisors and trainers to deliver teaching through a primary care lens. Instead of their learning being based in Swansea University with placements in local trusts as well as the current GP placements, students could be selected onto the programme from their local areas within Wales and teaching delivered within the community in those areas by qualified, experienced GPs. Support from other primary care staff is paramount in order to be able to deliver this model.

Hin Hin Ko M, Tim K. Lee P, Yvette Leung M, Bruce Fleming M, Elena Vikis M, Eric M. Yoshida M, FRCPC. Factors influencing career choices made by medical students, residents, and practising physicians. BCMJ. 2007;49:482-489 Articles.

Stagg P, Prideaux D, Greenhill J, Sweet L. (2012). Are medical students influenced by preceptors in making career choices, and if so how? A systematic review. Rural and Remote Health (Internet) 2012; 12: 1832. Available:http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=1832

Welsh Government (2014). A planned Primary Care workforce for Wales. Approach and development actions to be taken in support of the plan for a primary care service in Wales up to 2018. Retrieved on 22 June 2016 from: http://gov.wales/docs/dhss/publications/151106plannedprimarycareen.pdf

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

Currently recruitment is not a priority for medical schools in Wales. With approximately 1000 applications for 70 places in Swansea there has never been any incentive for universities to be concerned about recruitment for medical school places. Equality and diversity legislation means that Welsh universities cannot "ring-fence" places for students who are Welsh domiciled (unlike Scotland).

In 2016, Cardiff and Swansea Universities joined forces to identify areas of collaboration and 'admissions' was seen as an area where this would be beneficial. As part of this collaboration, it has become clear that there is a pressing need for a joined up approach to medical school recruitment.

Currently graduate students in Wales who are considering medicine have to choose between two medical schools. With a limited choice of 4 medical schools from which to pick, it does not make sense for Swansea and Cardiff to compete for graduate entrants. I propose that Cardiff University drops its graduate entry track, allowing the dedicated course at Swansea to pick up these students. Swansea and Cardiff can then work collaboratively to identify students at an early age and work towards encouraging them to apply to medical school in Wales.

Numerous individuals, with the best of intentions, duplicate work and deliver inaccurate and/or out of date information about medical school entry. The RCGP, the BMA, the MSC, all offer advice and glossy documents about medical school entry, work experience, entry requirements etc. Reaching Wider and the Mullany Fund work with children from widening access schools to encourage them to consider university and in some cases a medical/allied medical career. Combining this not insubstantial resource in Wales may have the result of ensuring that there is valid, reliable information that is up to date and accurate. Money saved from the resource duplication could ensure that there is a single, reliable information source.

In order to do this, the following strategic objectives have been identified from the Selecting for Excellence Executive sub-group.

1. To develop a programme of widening access activity that includes introductory, developmental and consolidation activities, to plant the seed for a future career in medicine and support the sense that medical school is "for people like me".

2 To use the skills, expertise, knowledge and resources to help organise the activities and develop promotional materials.

3. To encourage engagement with schools from across Wales, concentrating on those areas that are under-represented in medical school and university.

4. To develop supportive processes to encourage school students' understanding and confidence in their ability and suitability for a career in the health service and transition to university.

5 To incorporate evaluation as an integral part of the programme to ensure a continual cycle of quality improvement.

Last year Cardiff and Swansea ran a widening access work experience pilot project where aspiring medical students in year 11 and 12 across Wales were offered a 3 day work experience placement with GPs in Wales, with the intention of inspiring and enthusing these students to consider a career

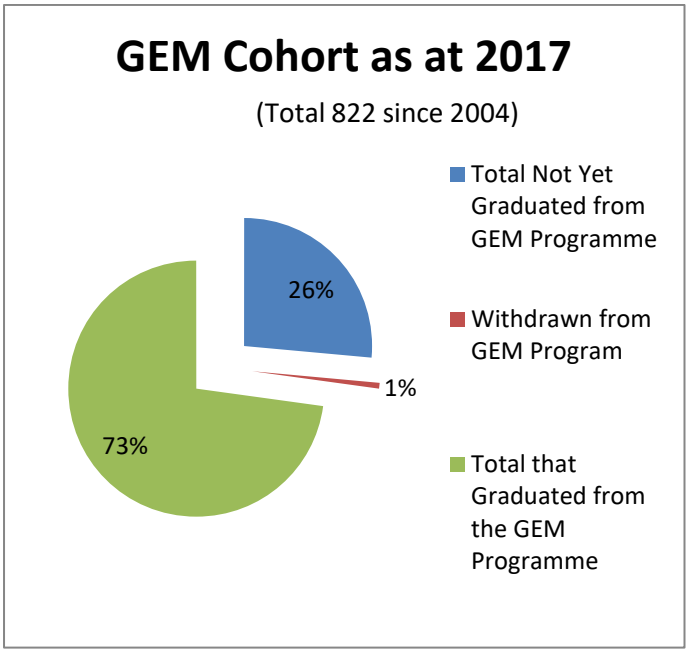
in medicine and with particular emphasis on general practice. The project was a success with increased collaboration between Cardiff and Swansea Admissions teams and the identification of school students who are now more enthused about medicine in general and general practice in particular. Expansion of this project, with a dedicated recruitment team to administer outreach to hard to reach schools, and to widen application to other health care professions would be beneficial to recruitment.

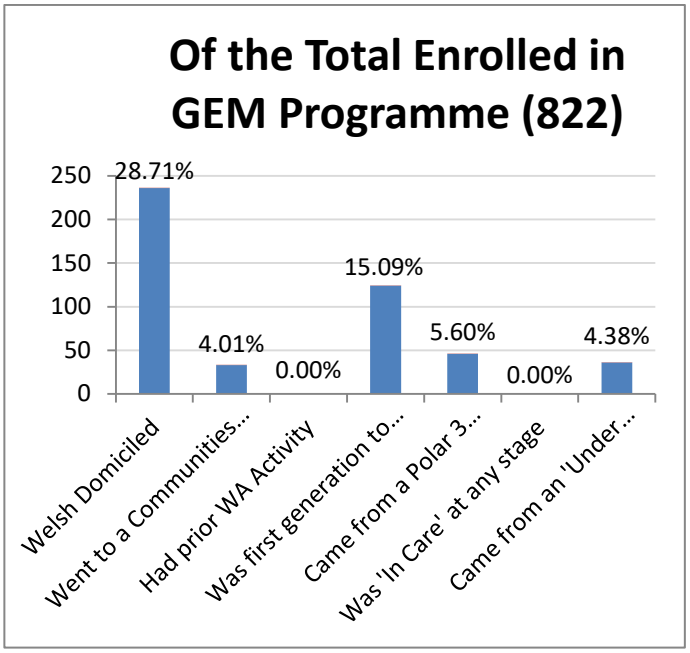
Appendix A: Origins and Destinations of GEM Students - Data

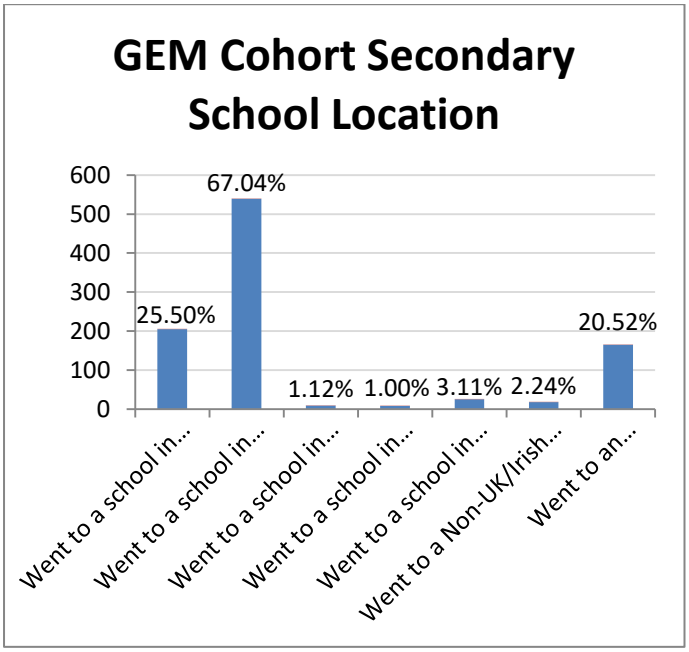
	Qty	%
Total Enrolled in GEM since inception	**822**	**100.00%**
Welsh Domiciled	236	28.71%
Went to a Communities First School	33	4.01%
Had prior WA Activity	0	0.00%
Was first generation to go to Uni	124	15.09%
Came from a Polar 3 location	46	5.60%
Was 'In Care' at any stage	0	0.00%
Came from an 'Under performing school'	36	4.38%
Total Enrolled for whom we have secondary school data	**804**	**97.81%**
Went to a school in Wales	205	25.50%
Went to a school in England	539	67.04%
Went to a school in Scotland	9	1.12%
Went to a school in Northern Ireland	8	1.00%
Went to a school in Ireland	25	3.11%
Went to a Non-UK/Irish School	18	2.24%
Went to an Independent School	165	20.52%
Total Not Yet Graduated from GEM Programme	**219**	**26.64%**
Withdrawn from GEM Program	**6**	**0.73%**
Total that Graduated from the GEM Programme	**603**	**73.36%**
Have done some PG training in Wales	327	54.23%
Not registered with GMC	4	0.66%
Relinquished registration	13	2.16%
Registered with no license	19	3.15%
Practising but current Role is Unknown	79	13.10%
Practising but current Location is Unknown	83	13.76%

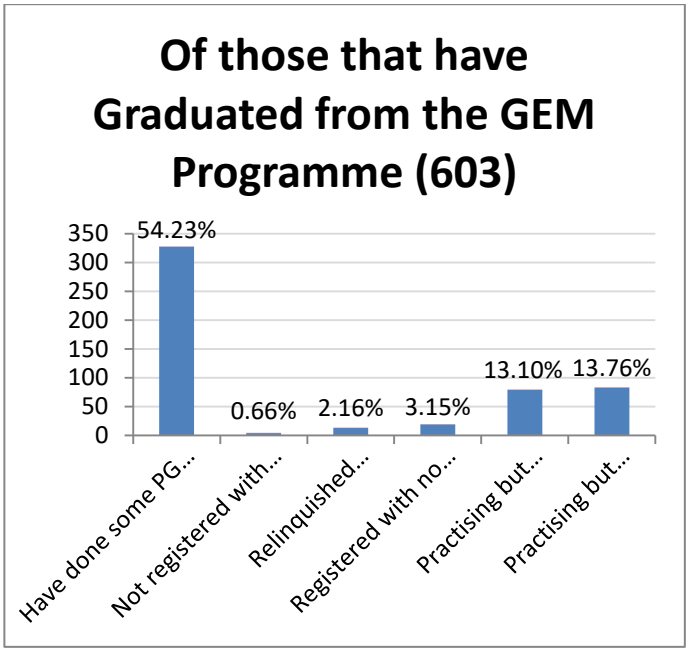
			No.In Wales	% in Wales	No.Outside Wales	% Outside Wales
Of those Currently Practising with a known location	**520**	**86.24%**	262	50.38%	258	49.62%
Currently in Foundation training	188	31.18%	94	50.00%	94	50.00%
Eligible to have entered GP training (Alumni)	**459**	**76.12%**	143	31.15%	316	68.85%
Those who are undertaking GP training	93	20.26%	54	58.06%	39	41.94%
Those who are GPs	50	10.89%	26	52.00%	24	48.00%
Graduated and Welsh Domiciled	189	31.34%	125	66.14%	64	33.86%
Graduated and Welsh Secondary School	166	27.53%	112	67.47%	54	32.53%

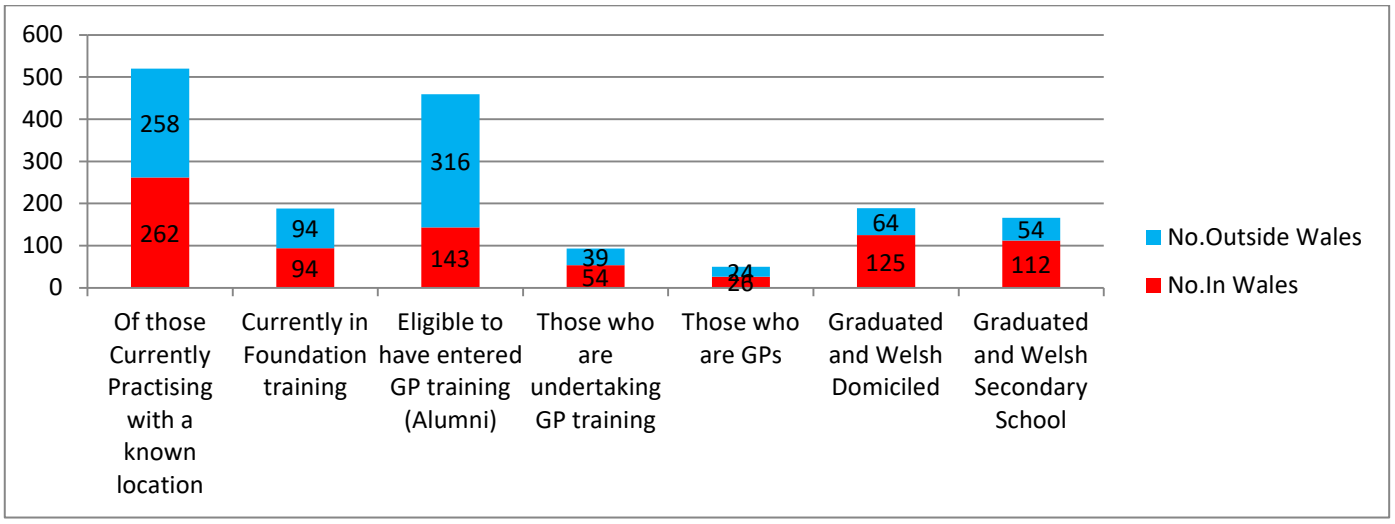
Origins and Destinations of GEM Students - Graphs







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26
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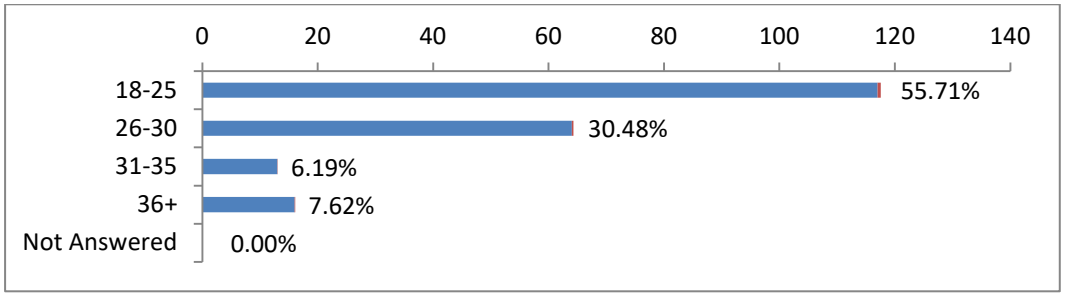
125
54
112
Of those Currently Practising with a known location
Currently in Foundation training
Eligible to have entered GP training (Alumni)
Those who are undertaking GP training
Those who are GPs
Graduated and Welsh Domiciled
Graduated and Welsh Secondary School
No.Outside Wales
No.In Wales

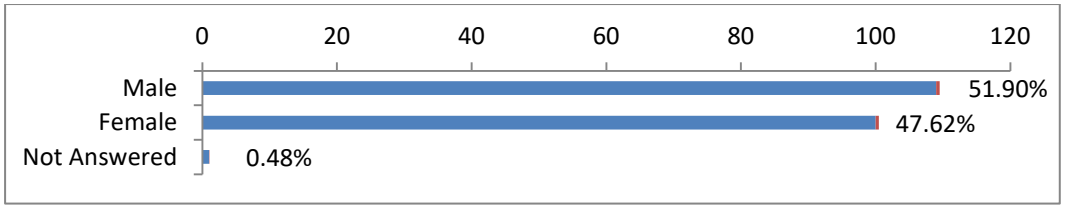
Appendix B: Swansea Student Survey

Total Responses **210**

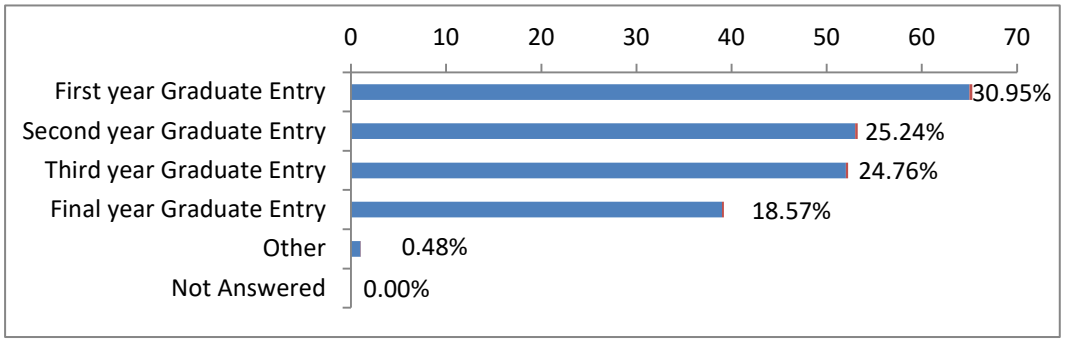
Age	Responses	%
18-25	117	55.71%
26-30	64	30.48%
31-35	13	6.19%
36+	16	7.62%
Not Answered	0	0.00%



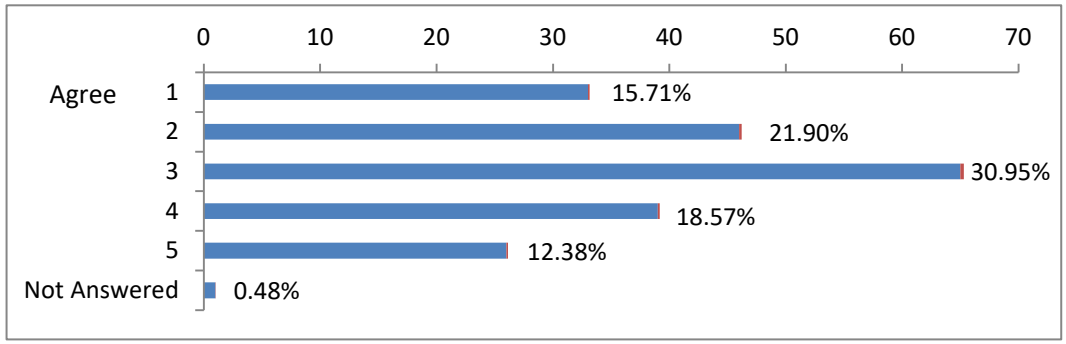
Gender	Responses	%
Male	109	51.90%
Female	100	47.62%
Not Answered	1	0.48%



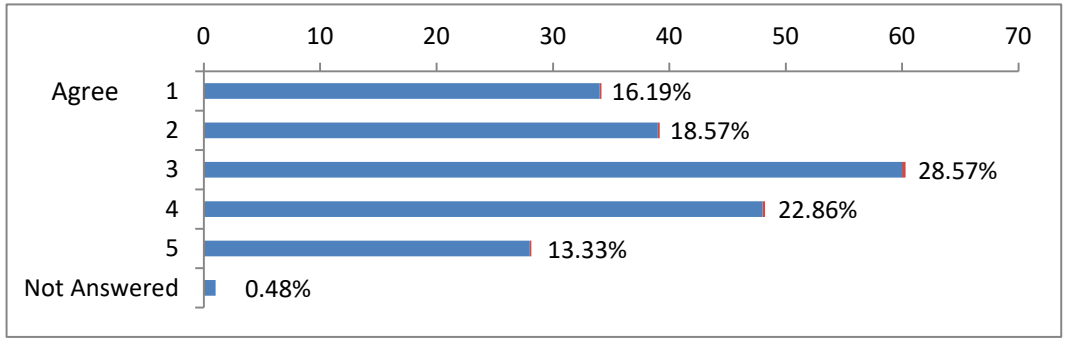
Year of Study	Responses	%
First year Graduate Entry	65	30.95%
Second year Graduate Entry	53	25.24%
Third year Graduate Entry	52	24.76%
Final year Graduate Entry	39	18.57%
Other	1	0.48%
Not Answered	0	0.00%



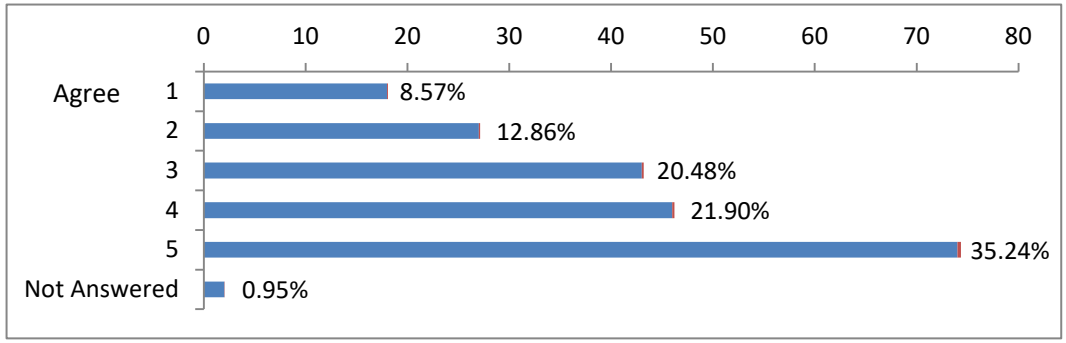
Junior in Wales, Speciality Elsewhere	Responses	%
1	33	15.71%
2	46	21.90%
3	65	30.95%
4	39	18.57%
5	26	12.38%
Not Answered	1	0.48%



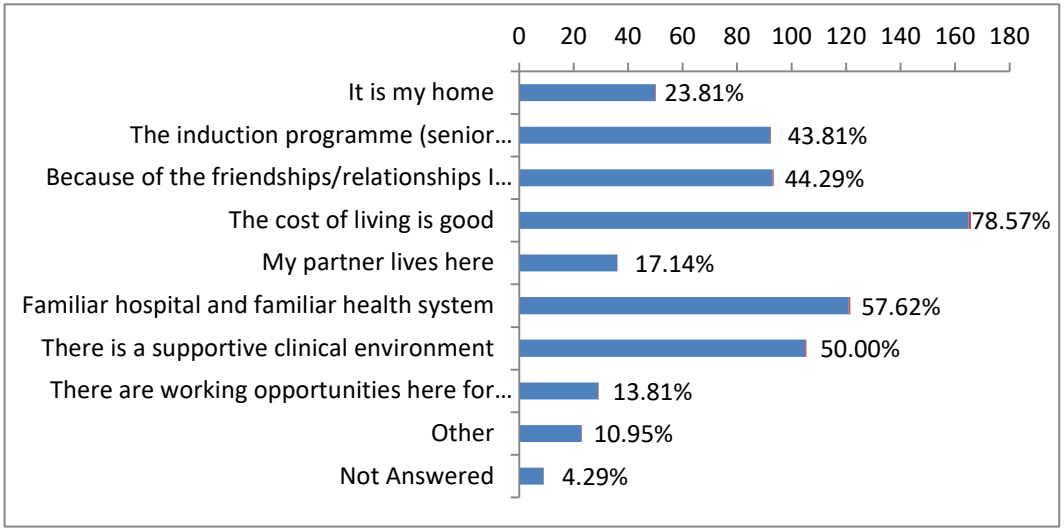
Junior in Wales, Speciality in Wales	Responses	%
	34	16.19%
	39	18.57%
	60	28.57%
	48	22.86%
	28	13.33%
Not Answered	1	0.48%



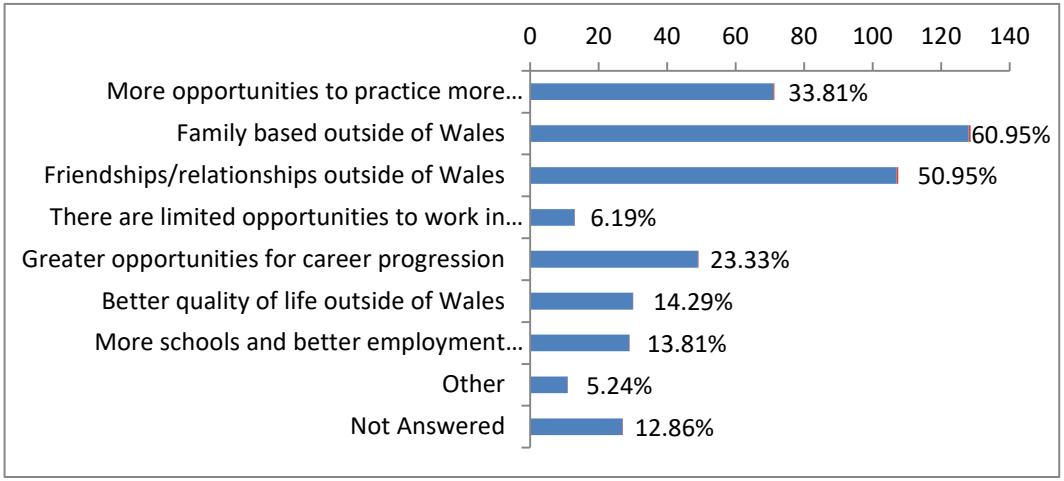
Do not wish to work in Wales	Responses	%
1	18	8.57%
2	27	12.86%
3	43	20.48%
4	46	21.90%
5	74	35.24%
Not Answered	2	0.95%



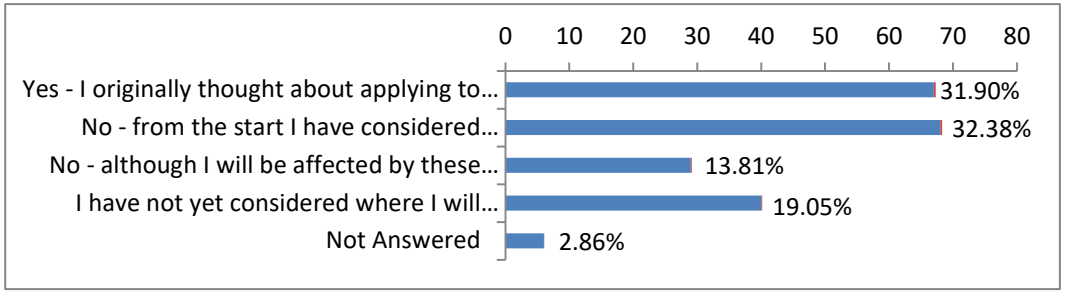
Pros and Cons of Working in Wales	Responses	%
It is my home	50	23.81%
The induction programme (senior assistantship)	92	43.81%
Because of the friendships/relationships I have made	93	44.29%
The cost of living is good	165	78.57%
My partner lives here	36	17.14%
Familiar hospital and familiar health system	121	57.62%
There is a supportive clinical environment	105	50.00%
There are working opportunities here for my partner	29	13.81%
Other	23	10.95%
Not Answered	9	4.29%



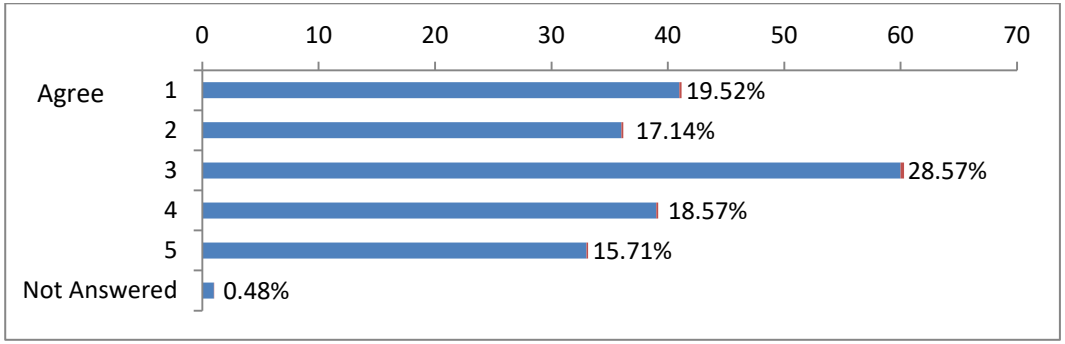
Factors not to want to work in Wales	Responses	%
More opportunities to practice more specialised medicine outside of Wales	71	33.81%
Family based outside of Wales	128	60.95%
Friendships/relationships outside of Wales	107	50.95%
There are limited opportunities to work in my desired location in Wales	13	6.19%
Greater opportunities for career progression	49	23.33%
Better quality of life outside of Wales	30	14.29%
More schools and better employment opportunities outside of Wales	29	13.81%
Other	11	5.24%
Not Answered	27	12.86%



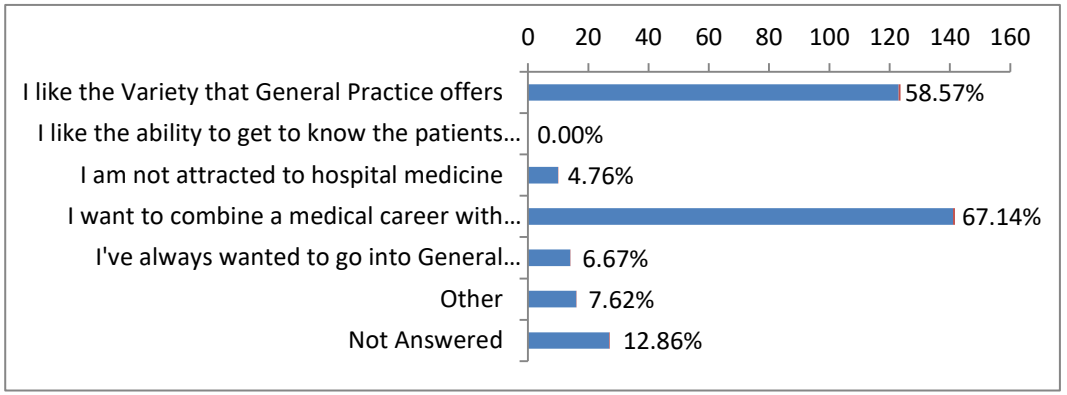
Have changes to Junior contract affected your choice	Responses	%
Yes - I originally thought about applying to another deanery however, these changes have made me consider Wales as my primary option	67	31.90%
No - from the start I have considered applying to Wales therefore, these	68	32.38%
No - although I will be affected by these changes I still intend to work in England therefore, I will apply outside Wales	29	13.81%
I have not yet considered where I will apply for my foundation post	40	19.05%
Not Answered	6	2.86%



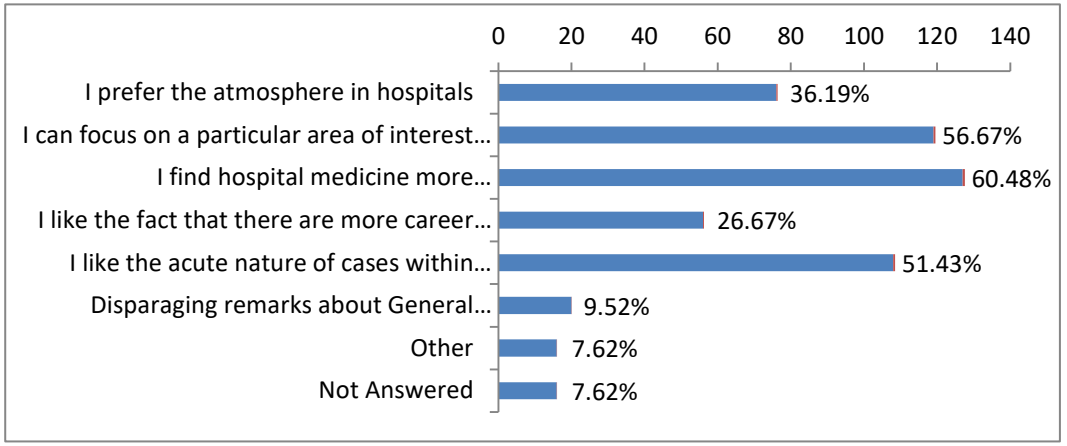
I am considering GP as a career	Responses	%
1	41	19.52%
2	36	17.14%
3	60	28.57%
4	39	18.57%
5	33	15.71%
Not Answered	1	0.48%



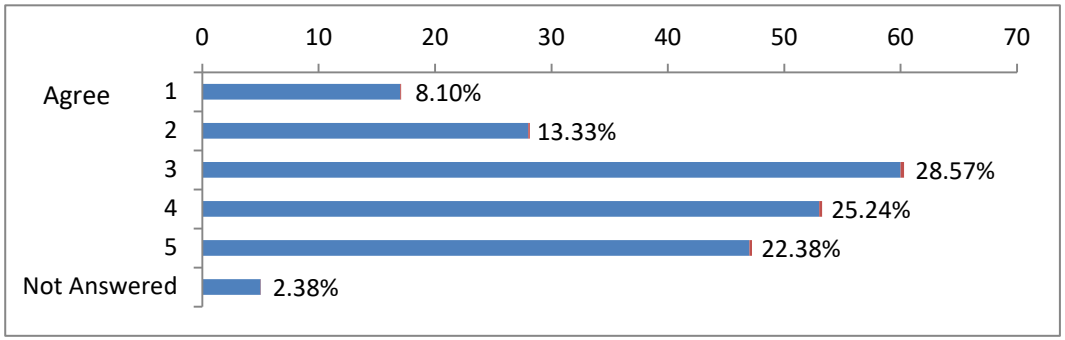
Aspects that have made you consider a career in GP	Responses	%
I like the Variety that General Practice offers	123	58.57%
I like the ability to get to know the patients and their needs	0	0.00%
I am not attracted to hospital medicine	10	4.76%
I want to combine a medical career with family life	141	67.14%
I've always wanted to go into General Practice	14	6.67%
Other	16	7.62%
Not Answered	27	12.86%



Aspects that have discouraged you from considering a career in GP	Responses	%
I prefer the atmosphere in hospitals	76	36.19%
I can focus on a particular area of interest if I specialise	119	56.67%
I find hospital medicine more interesting/challenging	127	60.48%
I like the fact that there are more career pathways offered by hospital medicine	56	26.67%
I like the acute nature of cases within hospital medicine	108	51.43%
Disparaging remarks about General Practice from secondary care clinicians	20	9.52%
Other	16	7.62%
Not Answered	16	7.62%



I would like to work in Wales as a GP	Responses	%
1	17	8.10%
2	28	13.33%
3	60	28.57%
4	53	25.24%
5	47	22.38%
Not Answered	5	2.38%



Appendix C: All Wales GP Survey - Data

Gender	Respondents	%
Male	212	49.3%
Female	218	50.7%
Total	430	100.0%

Age	Respondents	%
<30	6	1.4%
30-44	165	38.4%
45-54	156	36.3%
55-64	98	22.8%
>64	2	0.5%
Unknown	3	0.7%
Total	430	100.0%

Born in Wales	Respondents	%
Yes	206	47.9%
No	224	52.1%
Total	430	100.0%

Welsh 2' School	Respondents	%
Yes	235	54.7%
No	195	45.3%
Total	430	100.0%

Welsh Med School	Respondents	%
Yes	188	43.7%
No	242	56.3%
Total	430	100.0%

Sessions Per Week	Respondents	%
1-2	9	2.1%
2-4	56	13.0%
5-6	135	31.4%
7-8	163	37.9%
9-10	67	15.6%
Total	430	100.0%

Retirement	Respondents	%
Mentions Retirement	147	34.2%
Does not mention Retirement	283	65.8%
Mentions Retirement in 5 yrs	94	21.9%
Under 50 & Mentions Retirement in 5 yrs	9	2.1%
Mentions Retirement in 10 yrs	82	19.1%
Under 40 & Mentions Retirement in 5 yrs	1	0.2%

When did you move to Wales?	Respondents	%
As a young child	4	1.9%
During primary school	15	7.2%
During secondary school	3	1.4%
For university	50	23.9%
For work	106	50.7%
For partner's work	3	1.4%
Marriage	5	2.4%
Live in England, work in Wales	4	1.9%
	190	

Considered leaving Wales?	Respondents	%
Yes	219	50.9%
No	211	49.1%
Total	430	100.0%

Leave GP within 5 years	Respondents	%
1(most likely)	145	33.7%
2	66	15.3%
3	73	17.0%
4	39	9.1%
5(least likely)	107	24.9%
Total	430	100.0%

Leave GP within 10 years	Respondents	%
1(most likely)	83	19.3%
	46	10.7%
	60	14.0%
	45	10.5%
(least likely)	196	45.6%
Total	430	100.0%

Recommend a GP Career	Respondents	%
Yes	264	61.4%
No	166	38.6%
Total	430	100.0%

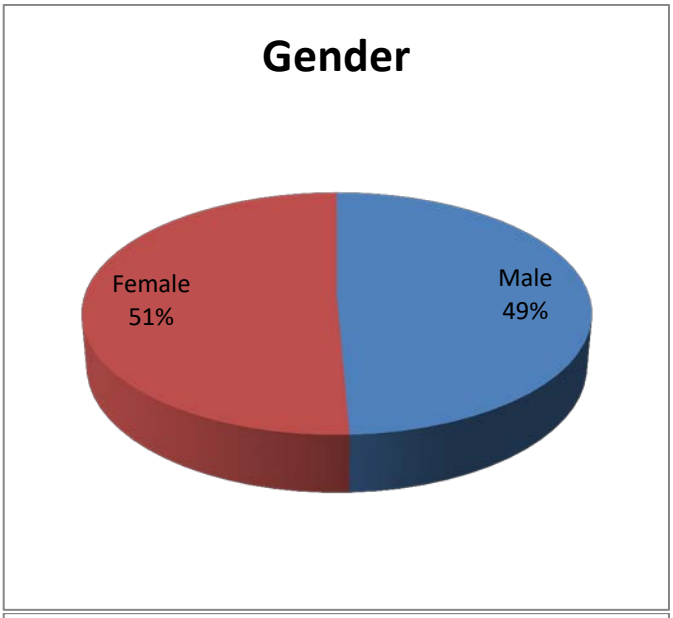
Distance from Secondary School	Respondents	%
Unknown	55	12.8%
0 to 25 miles	134	31.2%
25 to 50 miles	47	10.9%
50 to 75 miles	31	7.2%
75 to 100 miles	23	5.3%
100+ miles	140	32.6%
	430	100.0%

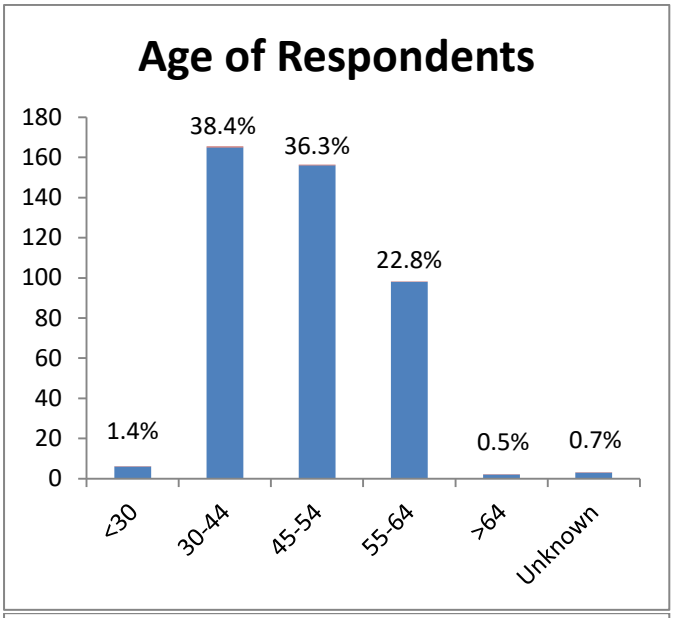
Distance from Welsh Secondary School	Respondents	%
0 to 25 miles	124	56.9%
25 to 50 miles	38	17.4%
50 to 75 miles	20	9.2%
75 to 100 miles	10	4.6%
100+ miles	26	11.9%
	218	100.0%

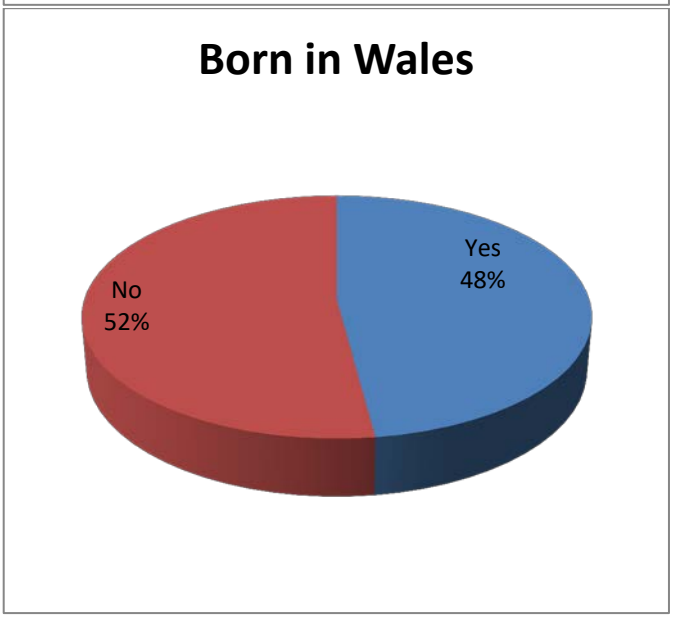
Distance from Welsh Secondary School	Respondents	%
0 to 10 miles	64	44.4%
10 to 20 miles	44	30.6%
20 to 30 miles	25	17.4%
30 to 40 miles	11	7.6%
40 to 50 miles	18	12.5%
	144	100.0%

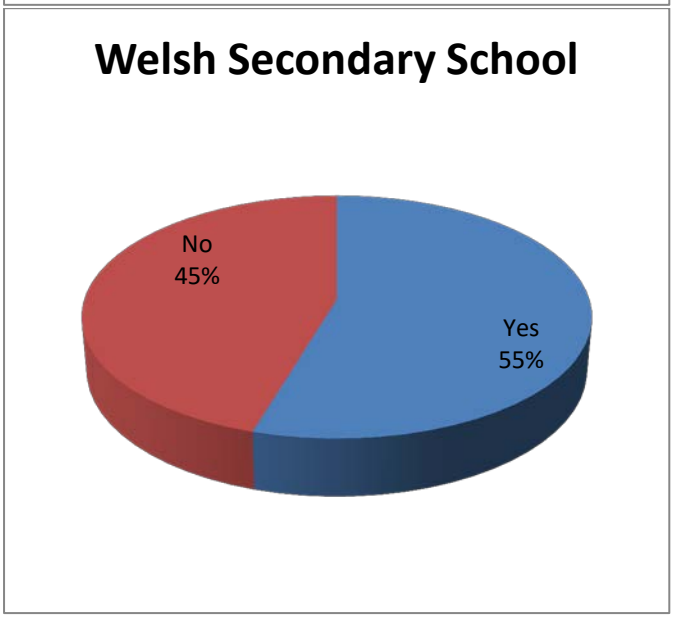
Factors for Practicing in Wales	Respondents	%
It is my home	213	49.5%
My partner/family lives here	182	42.3%
Familiar hospital and familiar health system	64	14.9%
Different political system and approach to health	33	7.7%
To care for dependents	15	3.5%
Other	123	28.6%

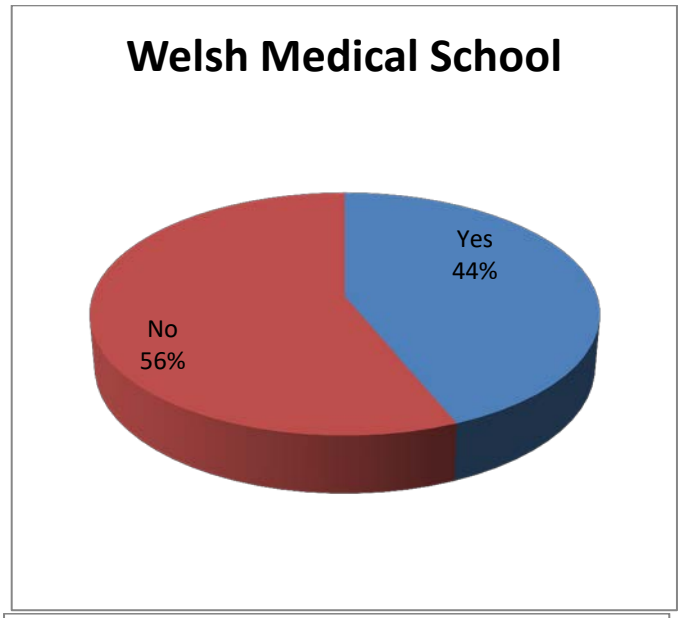
All Wales GP Survey - Graphs

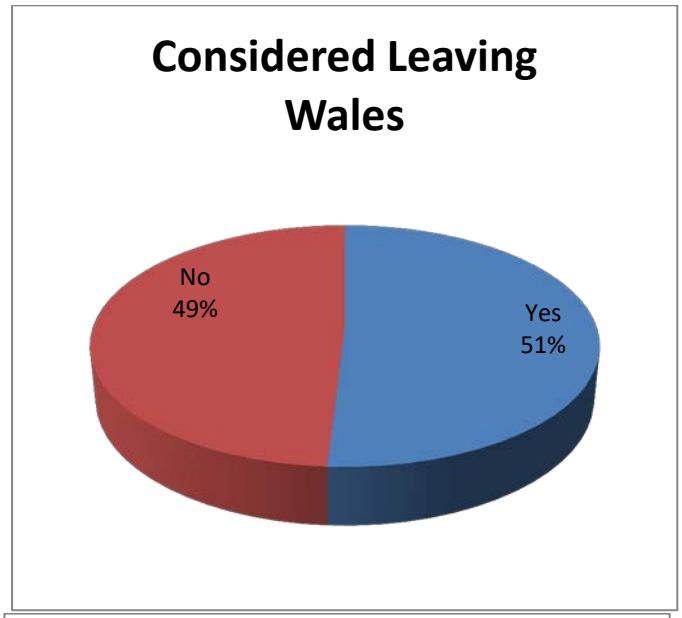


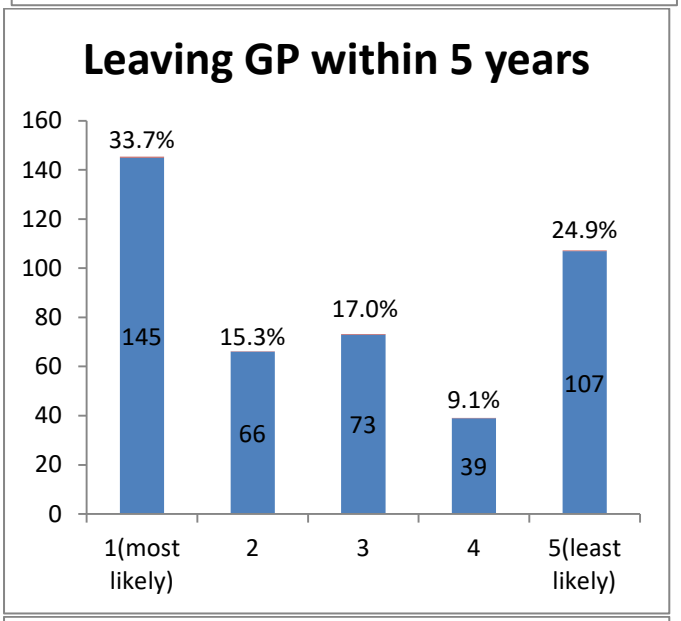


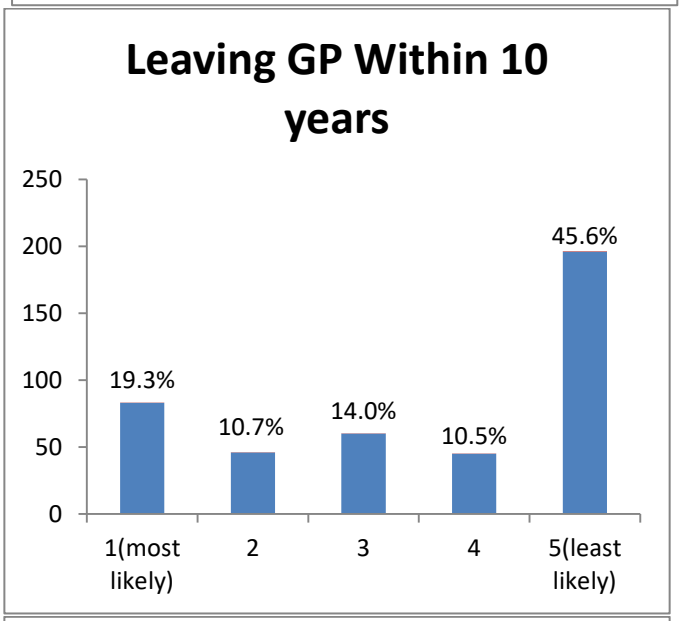




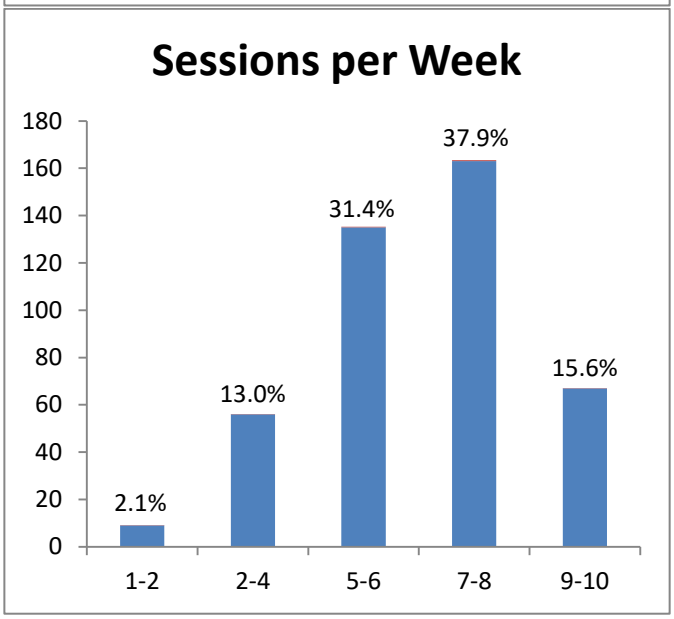

Welsh Medical School
Yes
44%
No
56%

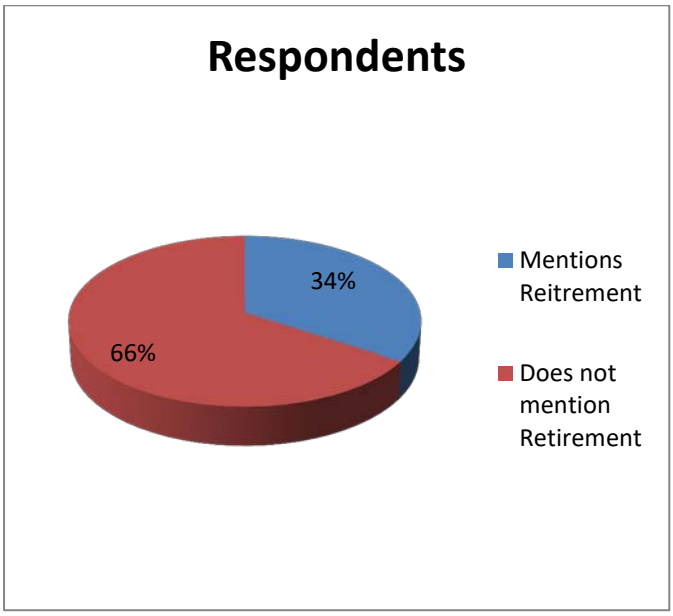

Considered Leaving Wales
No
49%
Yes
51%

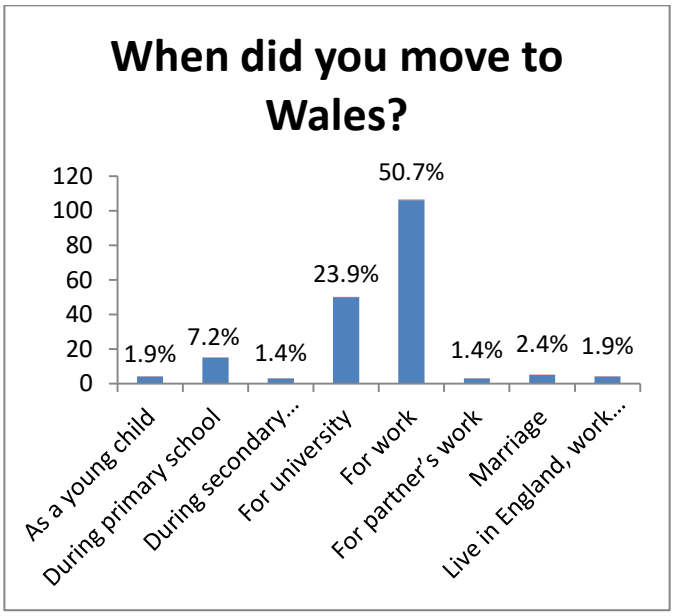

Leaving GP within 5 years
160
140
120
100
80
60
40
20
0
33.7%
145
15.3%
66
17.0%
73
9.1%
39
24.9%
107
1(most likely)
2
3
4
5(least likely)


Leaving GP Within 10 years
250
200
150
100
50
0
19.3%
10.7%
14.0%
10.5%
45.6%
1(most likely)
2
3
4
5(least likely)


Recommend a GP Career
No
39%
Yes
61%


Sessions per Week
180
160
140
120
100
80
60
40
20
0
2.1%
13.0%
31.4%
37.9%
15.6%
1-2
2-4
5-6
7-8
9-10


Respondents
34%
66%
Mentions Reitrement
Does not mention Retirement


When did you move to Wales?
120
100
80
60
40
20
0
1.9%
7.2%
1.4%
23.9%
50.7%
1.4%
2.4%
1.9%
As a young child
During primary school
During secondary...
For university
For work
For partner's work
Marriage
Live in England, work...

Rebecca Evans AC/AM
Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol
Minister for Social Services and Public Health

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-L/RE/0023/17

Dr Dai Lloyd AC
Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Cynulliad Cenedlaethol Cymru
Tŷ Hywel,
Bae Caerdydd
Caerdydd
CF99 1NA

31 Ionawr 2017

Annwyl Dai,

Bil Iechyd y Cyhoedd (Cymru)

Diolch ichi am eich llythyr dyddiedig 24 Ionawr, ac am anfon copïau o'r dystiolaeth ychwanegol sydd wedi dod i law'r Pwyllgor gan Goleg Brenhinol y Meddygon a Chomisiynydd Plant Cymru.

Ystyriwyd yn fanwl ba derfyn oedran fyddai fwyaf priodol ar gyfer rhoi twll mewn rhan bersonol o'r corff, a hynny bob cam o'r ffordd wrth ddatblygu'r Bil. Hefyd, archwiliwyd y mater hwn yn drylwyr yn ystod y gwaith craffu a wnaed gan y Cynulliad blaenorol.

Wrth ddod i'r penderfyniad i bennu 16 oed fel terfyn oedran, rhoddwyd ystyriaeth i ystod eang o ffactorau, gan gynnwys sylwadau rhanddeiliaid a'r dystiolaeth a gyflwynwyd mewn ymateb i ymgyngoriadau Llywodraeth Cymru. Edrychwyd ar fathau eraill o weithgareddau y mae terfynau oedran 16 a 18 arnynt, a hefyd yr ystod lawn o ofynion ar gyfer diogelu plant a phobl ifanc a ddarperir o dan Gonfensiwn y Cenhedloedd Unedig ar Hawliau'r Plentyn (CCUHP). Yn benodol, nod ein dull gweithredu oedd amddiffyn plant a phobl ifanc rhag niwed, heb amharu'n anghymesur ar eu hawliau i fynegi eu hunain a gwneud penderfyniadau am eu bywydau eu hunain.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Correspondence.Rebecca.Evans@gov.wales
Gohebiaeth.Rebecca.Evans@llyw.cymru

Yn sgil ymchwiliad y Pwyllgor i'r Bil, mae nifer o randdeiliaid wedi ei gwneud yn glir eu bod o blaid codi'r terfyn oedran arfaethedig ar gyfer rhoi twll mewn rhan bersonol o'r corff i 18 oed, a hynny am amryw o wahanol resymau. Rwyf hefyd wedi nodi bod Comisiynydd Plant Cymru, yn ei llythyr diweddaraf at y Pwyllgor, wedi galw ar yw aelodau i ystyried ymhellach yr wybodaeth a'r dystiolaeth sydd ar gael yn y maes hwn. Rwyf felly wedi rhoi cyfarwyddyd i fy swyddogion edrych ar y dystiolaeth eto, yn enwedig y dystiolaeth fwy diweddar.

Oherwydd y gwaith cymhleth a manwl sy'n gysylltiedig â'r mater hwn, bydd hynny'n cymryd nifer o wythnosau. Rwy'n bwriadu ystyried y casgliadau y daw'r Pwyllgor iddynt ar y mater hwn, lle mae angen cynnal cydbwysedd gofalus rhwng gofynion pob ochr, fel rhan o'i adolygiad cam un, gan gyflwyno safbwynt Llywodraeth Cymru pan fydd dadl ar egwyddorion cyffredinol y Bil yn y Cynulliad Cenedlaethol.

Edrychaf ymlaen at gael adroddiad y Pwyllgor ar egwyddorion cyffredinol y Bil maes o law.

Cofion cynnes,

Rebecca

Rebecca Evans AC / AM
Y Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol
Minister for Social Services and Public Health

Mae cyfyngiadau ar y ddogfen hon