# Agenda - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:
**Ystafell Bwyllgora 4 - Tŷ Hywel**
Dyddiad: Dydd Iau, 16 Chwefror 2017
Rhag-gyfarfod Aelodau: 09.15
Amser: 09.30

I gael rhagor o wybodaeth cysylltwch a:
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## Rhag-gyfarfod anffurfiol (09.15 - 09.30)

## 1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

## 2 Ymchwiliad i recriwtio meddygol - sesiwn dystiolaeth 6 - Coleg Brenhinol Meddygaeth Frys a Choleg Brenhinol y Radiolegwyr

(09.30 - 10.30) (Tudalennau 1 - 48)

Dr Amanda Farrow, Pennaeth yr Ysgol, Coleg Brenhinol Meddygaeth Frys Cymru
Dr Robin Roop, Is-lywydd, Coleg Brenhinol Meddygaeth Frys Cymru
Dr Martin Rolles, Cadeirydd y Pwyllgor Sefydlog Cymreig, Coleg Brenhinol y Radiolegwyr
Dr Toby Wells, Ysgrifennydd, Coleg Brenhinol y Radiolegwyr

## Egwyl (10.30 - 10.40)

## 3 Ymchwiliad i recriwtio meddygol - sesiwn dystiolaeth 7 - Coleg Brenhinol y Seiciatryddion a Choleg Brenhinol Pediatreg ac Iechyd Plant

(10.40 - 11.40) (Tudalennau 49 - 63)

Yr Athro Keith Lloyd, Coleg Brenhinol y Seiciatryddion
Dr M Sakheer Kunnath, Coleg Brenhinol Pediatreg ac Iechyd Plant

## Egwyl (11.40 - 11.45)

## 4 Ymchwiliad i recriwtio meddygol - sesiwn dystiolaeth 8 - Byrddau Iechyd Lleol

(11.45 - 12.45) (Tudalennau 64 - 80)

Yr Athro Peter Barrett-Lee, Cyfarwyddwr Meddygol, Ymddiriedolaeth GIG Felindre
Martin Jones, Cyfarwyddwr Gweithredol y Gweithlu a Datblygu Sefydliadol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr
Dr Evan Moore, Cyfarwyddwr Meddygol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr
Sharon Vickery, Pennaeth Uned Gyflawni a Staffio Meddygol Adnoddau Dynol, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg
Dr Philip Kloer, Cyfarwyddwr Meddygol, Bwrdd Iechyd Prifysgol Hywel Dda

## Cinio (12.45 - 13.30)

## 5 Ymchwiliad i recriwtio meddygol - sesiwn dystiolaeth 9 - Deoniaeth Cymru

(13.30 - 14.30) (Tudalennau 81 - 92)

Yr Athro Peter Donnelly, Deon Ôl-raddedig Dros Dro
Dr Phil Matthews, Dirprwy Gyfarwyddwr Meddygaeth Teulu / Pennaeth yr Ysgol Hyfforddiant Arbenigol ar gyfer Meddygaeth Teulu
Dr Helen Baker, Cyfarwyddwr Cyswllt (Gofal Eilaidd)

## 6 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod ac o'r cyfarfod ar 1 Mawrth 2017

1 Mawrth, er mwyn ystyried:

- Bil Iechyd y Cyhoedd (Cymru) - briffio cyfnod 2
- Ymchwiliad i defnydd o feddyginiaeth wrthseicotig - trafod y cwmpas a'r dull gweithredu ar gyfer yr ymchwiliad
- Ymchwiliad i Ofal Sylfaenol - cynlluniau ar gyfer cyfarfodydd yn y dyfodol
- Adolygiad Seneddol o ddyfodol Iechyd a Gofal Cymdeithasol yng Nghymru

7 Ymchwiliad i recriwtio meddygol - trafod y dystiolaeth

(14.30 - 14.40)

8 Bil Iechyd y Cyhoedd (Cymru) - Trefn Ystyried - cytuno mewn egwyddor cyn trafodion Cyfnod 2

(14.40 - 14.45) (Tudalennau 93 - 98)

Mae cyfyngiadau ar y ddogfen hon

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

**Welsh Assembly Health Social Care and Sport Committee**

**Inquiry into medical recruitment**

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

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

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

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

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

3. This in turn is reflected in an increasing propensity to access health services. Demand from people over 65 years of age, for instance, continues to grow considerably and has resulted in rising numbers of GP appointments both in person and over the

[1] Stats Wales National level population estimates by year, age and UK country

phone. This increase in demand in primary care services inevitably leads to increasing pressures in secondary care services, including A&E departments.

4. The latest results from the GP Patient Survey, for example, show that one in three patients (32.9%) who were unable to get an appointment at their GP surgery out of hours went to Emergency Departments instead.[2] Furthermore, between 2014-15 and 2015-16 attendances at major A&Es in Wales has increased by 11,125 or 1.41%, and this figure is set to grow.

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

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

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

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

| Staff Category | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | % Change since 2010 | % Change since 2013 |
|---|---|---|---|---|---|---|---|---|
| All Grades | 260.19 | 274.29 | 263.42 | 287.28 | 286.03 | 288.08 | 9.68 | 0.28 |
| Consultant | 49.00 | 53.50 | 54.60 | 61.20 | 66.80 | 63.20 | 22.47 | 3.16 |
| Specialty Doctor | 28.30 | 36.45 | 43.20 | 39.30 | 45.60 | 47.85 | 40.86 | 17.87 |
| Staff Grade | 3.10 | 2.10 | 1.00 | 1.00 | 1.00 | 1.00 | -210.00 | 0.00 |
| Associate | 20.7 | 17.5 | 17.5 | 15.8 | 12.5 | 11.5 | -80.18 | -37.94 |

[2] GP Patient Survey, July 2016
[3] Stats Wales Performance against 4 hour waiting times target by major hospital and NHS Wales Informatics Service Monthly Accident and Emergency Report - After April 2013
[4] Stats Wales Medical and dental staff by grade and yea

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Specialist** | 2 | 2 | 0 | 6 | 0 | 0 | | |
| **Foundation House** | 55.0 | 51.0 | 51.0 | 52.0 | 58.0 | 50.0 | -10.00 | -4.00 |
| **Officer 2** | 0 | 0 | 0 | 0 | 0 | 0 | | |
| **Foundation House** | 14.0 | 12.0 | 15.0 | 12.0 | 12.0 | 14.0 | 0.00 | 14.29 |
| **Officer 1** | 0 | 0 | 0 | 0 | 0 | 0 | | |

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

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

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

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

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

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

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

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

[5] Nuffield Trust Fact Check: migration and NHS staff and Stock of doctors by country of first qualification

16. Moreover, the volatile Pound Stirling could make competitive salaries more unattractive in the UK compared to other EU nations, especially given the UK's average salary only ranked 10th out of the 28 EU countries.[6] Since the Brexit vote, the value of the Pound has dropped by c.16% compared to the Dollar and c.6% compared to the Euro. The uncertainty of when the Pound might recover might also play a part in dissuading healthcare professionals from immigrating to the UK.

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

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

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

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

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

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

| 1 A&E Consultant | Estimated number of patients 1 Consultant treats per day |
|---|---|
| Canada[8] | 34 |

[6] Average Salary in European Union 2016
[7] RCEM Essential facts regarding A&E Services in Wales
[8] Canadian Institute for Health Information Emergency Department Visits in 2014-2015 and Canadian Medical Association Emergency Medicine Profile

| | |
|---|---|
| **Wales** | 33 |
| **Italy**[9] | 29 |
| **Australia** | 18 |
| **New Zealand**[10] | 12 |

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

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

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

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

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


[9] NCIB Paediatric em… …cal speciality
[10] ACEM Specialist Emergency Medicine Workforce and Ministry of Health Emergency department use 2014/15
[11] Stats Wales, Performance against 4 hour waiting times target by major hospital
[12] Australian Government, Medical workforce 2012 and Australia's hospitals 2014-15
[13] RCEM Stretched to the limit
[14] Physician / Doctor, Emergency Room (ER) Salary (Canada)
[15] NZ Doctors' Guide

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

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

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

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

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

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

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

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

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

34. Furthermore, emergency medicine consultants are looking at other staffing models which strengthen the workforce and help with resilience and retention of staff. Advanced Nurse Practitioners (ANPs), for example, have recently been introduced in some areas and work as non-medical practitioners to support emergency medicine staff.

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

## Conclusions and Recommendations

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

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

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

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

[18] RCEM Wales STEP Campaign

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

# Written Evidence to Medical Recruitment Inquiry – Clinical Oncology

**Prepared by:** Dr Martin Rolles, Consultant Clinical Oncologist, Swansea
Chair, Standing Welsh Committee of the Royal College of Radiologists

**Introduction**

Clinical Oncologists (CO) treat cancer using the full range of non-surgical options: radiotherapy, and systemic anti-cancer therapies, SACT (chemotherapy, biological and immunological therapies, hormonal therapies.)

Cancer treatments have improved significantly since the millennium. The overall workload has increased, as has the complexity and the need for specialisation. Radiotherapy is used in 40% of curative cancer treatments, and is a fundamental part of palliative cancer treatments.

The number of incident cancer cases in Wales is consistently increasing by about 1.5% per year[1]. Conservative assumptions are that there will be a 4% annual growth in radiotherapy demand up to 2021, followed by a 2% annual growth up to 2031. There will be a concurrent annual increase in SACT demand of 5% up to 2021, followed by a 2% annual growth up to 2031[2].

SACT is also provided by Medical Oncologists, who are not trained to give radiotherapy. There is significant overlap in SACT provision between clinical oncology and medical oncology.

Radiotherapy in Wales is provided by 3 regional cancer centres: in Rhyl (North Wales Cancer Treatment Centre, NWCTC, Glan Clwyd Hospital), Swansea (South West Wales Cancer Centre, SWWCC, Singleton Hospital), and Cardiff (Velindre Cancer Centre, VCC). Whilst Clinical Oncologists do clinics in peripheral hospitals, they are ultimately based in one of the 3 centres because of the need to supervise radiotherapy treatments.

Specialist Registrar training is carried out in all 3 centres. In South Wales, trainees rotate between Swansea and Cardiff. North Wales trainees are linked to the Mersey Deanery. The Welsh training schemes are highly regarded and popular, and applications are oversubscribed. The training of a Specialist Registrar up to consultant level nominally takes 5 years, full time. In Wales the average duration of training is now more than 8 years because of maternity leave, less than full time working, postgraduate research degrees and clinical fellowships.

**The 2015 RCR Clinical Oncology Census**[3]

The average 2015 UK figure for WTE consultant Clinical Oncologists is 11.9 per million per radiotherapy centre. Wales as a whole is above average at 13.3 though there is significant regional variation. Velindre Cancer Centre is staffed above the UK average, but the two other smaller Welsh centres are below the national average.

| | **WTE consultant Clinical Oncologists** | **Catchment population** | **WTE CO consultants per million population** |
|---|---|---|---|
| NWCTC | 8.0 | 699,794 | 11.4 |
| SWWCC | 9.5 | 899,735 | 10.6 |
| VCC | 23.6 | 1,499,556 | 15.7 |
| *All Wales* | | | *13.3* |
| *UK* | | | *11.9* |

22% of CO consultants working in Wales are International Medical Graduates.

The UK average per centre for Clinical Oncologists *plus* Medical Oncologists pmp is 19. The Wales average is the same.

It should be noted that although the full amount of PAs contracted is recorded in the census, these figures for WTE are capped at 10 Programmed Activities (Pas, sessions.) Around the UK, 50% of consultants work 11PAs or more and these are therefore not reflected in this figure. It also excludes research and additional responsibility PAs.

Consultant numbers pmp is a useful basic comparator but it has clear limitations. Overall size of the department, and geographic considerations are also critical particularly for rural North and South West Wales.

Smaller departments lose out on efficiencies of scale. They have difficulties with specialisation, cross-cover, on-call rotas, non-clinical activities such as service development and research. The impact of staff leaving is proportionately greater: in September 2016 North Wales was down to 6 working CO consultants due to staff leaving.

The South West Wales and North Wales centres both service a geographically dispersed catchment. Clinics are provided at local District General Hospitals. Patient-centred treatment, provided close to home where possible, is a priority. 76% of Welsh CO consultants travel to more than one site on a daily basis (UK average 42%.) Travelling time to distant peripheral units is an issue when there is limited consultant resource, and a requirement to supervise radiotherapy at base.

Retirement

**Percentage (and headcount) of the current consultant workforce expected to retire in the next 10 and 15 years**

| | Next 10 years: 2015–25 | | Next 15 years: 2015–30 | |
|---|---|---|---|---|
| | Age 64 | Age 60 | Age 64 | Age 60 |
| Wales | 24% (11) | 37% (17) | 39% (18) | 63% (29) |
| **UK – overall** | **21% (175)** | **33% (275)** | **36% (301)** | **55% (456)** |

These figures do not reflect the fact that there are increasing numbers of post-retirement consultants still working (2/10 CO consultants at the SWWCC.) These consultants perform a vital service, but do not generally take part in the on-call rota, and can leave at short notice.

In addition, very senior consultants, often with general skills and expertise, are frequently impossible to replace like-with-like. The modern needs for specialisation mean that a replacement job plan may require 2 or more new posts.

Unfilled posts

The 2015 RCR census lists 21 consultant vacancies in the UK, including 3 in Wales. 9 of these vacancies had failed to appoint. This is likely to be an underestimate: chronically unfilled posts may not be re-advertised. Employment of post-retirement consultants allows for deferral of new posts. The census also highlights the fact that this is a UK-wide issue, and that Wales has to compete nationally. In a seller's market, where all UK regions and hospitals compete for the best appointments, less wealthy peripheral areas with hard-pressed units will always be at a disadvantage compared to large prestigious centres.

The issue is complicated by increased national scarcity in some of the less popular cancer specialties such as gynaecological brachytherapy.

As an example, in Autumn 2016 SWWCC advertised for 3 new CO consultants, and did not receive any shortlistable applications.

**Conclusions**

There is an imbalance in the Clinical Oncology consultant workforce across Wales. North Wales and South West Wales are understaffed both in absolute and relative terms, and this threatens the sustainability and development of first class cancer services to the Welsh population.

The consultant CO staffing pmp at VCC is a reasonable target for both North Wales and South West Wales and revenue should be provided to achieve and sustain this. This figure is above the UK average, but considering the extra demands of geography and the need to grow 2 small centres to sustainable size, this is justifiable.

Recruitment will be problematic for the foreseeable future. There is a national and international market for good candidates, and Wales has to compete: this is difficult especially outside the Southeast[4]. There will be a national shortage of newly qualified consultants in the face of increasing demands, and retirement of senior consultants. There is no quick solution to this: long term strategy and realism are needed.

- Welsh training numbers should increase: given current demand, Wales would be able to fill extra training posts. Wales trainees are more likely to stay in Wales long term, although this is never guaranteed. Flexibility to increase numbers is hampered by a perennial question of who in Wales should pay for extra trainees. A priority should be for Welsh Government and the Wales Deanery to sort this out.
- Wales has to promote itself as a place to practice first class medicine, and as a place to live.
- Recruitment has to look outside the UK.
- Although consultants are unavoidable, there is a significant opportunity to expand the skill-set and working practice of specialist nurses, therapists, treatment radiographers, and pharmacists to take on and develop some of the doctors' traditional roles. There is also an incentive to use IT for remote working. To a significant extent Wales has already innovated in this respect out of necessity, for example with radiographer-led breast cancer radiotherapy planning; nurse-led Chemotherapy Day Units in peripheral District General Hospitals facilitated by networked electronic chemotherapy prescribing; videoclinics.

**References**


1. Welsh Cancer Intelligence and Surveillance Unit Official Statistics 2014 data 3 February 2016 http://www.wcisu.wales.nhs.uk/cancer-in-wales-1
2. Transforming cancer services in South East Wales programme business case DRAFT Version 0.53 7 December 2016, Velindre NHS Trust.
3. Clinical Oncology UK workforce census 2015, the Royal College of Radiologists https://www.rcr.ac.uk/clinical-oncology/service-delivery/rcr-workforce-census
4. Wales is not an Island, Academy of Medical Royal Colleges Wales http://www.aomrc.org.uk/amrcw/professional-opinion/



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The Royal College of Radiologists (RCR) is the Professional body for Clinical Radiologists and Clinical Oncologists in the UK.
The Standing Welsh Committee (SWC) represents the RCR in Wales.

# Written Evidence to Medical Recruitment Inquiry – Clinical Radiology

## Introduction

The continued increase in demand for complex imaging, including CT and MRI scans, has far outstripped the service capacity. The mismatch in demand and capacity is exacerbated by the difficulties in recruiting to consultant radiologist vacancies. The shortfall has resulted in reporting backlogs, causing delays in the diagnosis of cancer and other serious conditions and impairing high quality healthcare. The backlog in reporting has also lead to a reliance on private outsourcing companies which is expensive and unsustainable. The current three-year contract for outsourcing in Wales is approximately £5.8 million, and this is likely to increase - the 2015 RCR annual census showed a 51% increase in outsourcing across the UK (from £51milliion in 2014, to £88milion in 2015).

Clinical Radiology has the largest projected consultant shortfall in Wales of any major medical specialty (-39%) according to 2015 figures from the Centre of Workforce Intelligence.

Wales has other key concerns

- 7% of Consultant Radiologist posts vacant in Wales in 2015 and this position has worsened
- This is an underestimate as many places have stopped advertising vacancies after many years of unfilled posts. For example the last successful appointment of a UK trained radiologist in Llanelli was 22 years ago
- Wales has the worst workforce demographics in the UK with 12% of NHS Wales Radiologists >60 years old, and >40% >50 years old
- Radiology supply–demand shortfall is a probable underestimation with anticipated exponential increase in complex imaging demand over the next decade
- Wales currently is challenged in attracting radiologists from outside Wales and exports 2 out of every 5 trainees to posts in England or outside the UK

There is a major international shortage of radiologists, but the problem in Wales is exacerbated by poor geographical distribution, with similar number or radiologists per capita in the South East of Wales to the rest of the UK, but fewer in more rural areas.

In a seller's market, where all UK regions and hospitals compete for the best appointments, less wealthy peripheral areas with hard-pressed units will always be at a disadvantage compared to large prestigious centres.

## Solutions

Wales has two successful medical schools which attract students from across the UK, and internationally. People who train in Wales may want to settle down locally, though that is not a given. An increase in Welsh medical undergraduate numbers is likely to increase overall numbers of doctors in Wales, but it is not safe to plan specialist services on assumptions of what a first year medical student might want to do 10 or more years later. A better bet is to increase the numbers of juniors, and specialist trainees in Wales and to foster them so that they want to stay. Flexibility to increase numbers is hampered by a perennial question of who in Wales should pay for extra trainees. A priority should be for Welsh Government and the Wales Deanery to sort this out.

Specifically for Radiology, solutions include overseas recruitment, retaining Radiologists after retirement, increasing skills mix, outsourcing reporting and increasing training capacity.

Overseas recruitment is a challenge and very difficult to achieve the scale required. The Migration Advisory Committee 'partial review of shortage occupations' has already listed Radiology as one of only three medical specialties in shortage.

Reliance on personnel who have retired and the continued adoption of extra work by the current workforce is not sustainable in the long term. Skills mix, with increased Radiographer reporting, will help but requires a high degree of Radiologist mentorship which is difficult to achieve with current service demand.

Outsourcing is expensive but is less satisfactory with reduced clinician-radiologist discussions and repeated workload with requests for local review of outsourced scan reports; outsourcing companies' sustainability is questionable with reliance on the dwindling UK radiologist workforce.

All of the above will help address the workforce crisis, but the only sustainable solution is to increase radiologist training capacity and numbers. To this end a business case has been submitted to Welsh Government for a National Radiology Academy. This emulates models in England which have successfully implemented modern training, and increased output with high levels of local retention. The Academy model allows an increase in training capacity while limiting impact on service provision due to economies of scale, with increased trainee to trainer ration compared to the traditional apprenticeship model. It will also support the development of radiographers, sonographers and other imaging professionals.

Recruitment to registrar training posts in radiology is not a problem, with posts oversubscribed by between 6 and 9 times in recent years. This year a new exam was introduced to reduce the number of candidates being interviewed as the numbers have been too great. Radiology remains a popular and competitive specialty.

If the academy proposal is accepted, it is hoped it will also help the uneven distribution of radiology consultants. The current training scheme is based in Cardiff, so registrars tend to live in the South East and stay there for consultant posts. The academy will be sited further west, hopefully in Pencoed near Bridgend, so registrars may choose to live further west. When there are sufficient trainees, the South Wales scheme may also partially split into an East and West based rotation, allowing some trainees to spend more of their time further west with more experience of hospitals further west. Academies in England have shown a 'trickle down' effect, where the increased number of consultants produced first fill posts near the academy, and then to centers progressively further away.

A radiology academy should also provide excellent training, and if trainees enjoy their time in Wales they are more likely to stay, and to spread the word that it is good to work in Wales, attracting others.

## Conclusion

We therefore request your support for the National Imaging Academy business case which is currently being scrutinized by Welsh Government, and importantly also for the increased number of radiology trainees required to fill it, as this offers the best long term sustainable solution to the radiology workforce crisis.

The requirement for increased trainees is a particular concern, with uncertainty around this due to the formation of the new Health Education Wales body who will presumably determine training numbers in future.

Prepared by Dr T Wells, Consultant Radiologist Swansea,
Secretary Standing Welsh Committee of the Royal College of Radiologists
Using RCR data, the National Imaging Academy Business Case and work by Dr M Rolles

## Appendix:

### 2015 Royal College of Radiologists Census Data

### 1. Workforce

**Headcount of consultants**

| | 2010 headcount | 2014 headcount | 2015 headcount | % change 2014–15 | % change 2010–15 |
|---|---|---|---|---|---|
| Wales | 147 | 150 | 160 | 7% | 9% |
| UK | 2,869 | 3,239 | 3,318 | 2% | 16% |

**Whole-time equivalent consultants**

| | 2010 WTEs | 2014 WTEs | 2015 WTEs | % change 2014–15 | % change 2010–15 |
|---|---|---|---|---|---|
| Wales | 140 | 143 | 147 | 3% | 5% |
| UK | 2,714 | 3,048 | 3,125 | 3% | 15% |

**WTE consultant radiologists per 100,000 people**

| | Population | WTE per 100,000 | % change 2014–15 | % change 2010–15 |
|---|---|---|---|---|
| Wales | 3,092,036 | 4.8 | 4% | 2% |
| UK | 64,596,752 | 4.8 | 0% | 9% |

### 2. Consultant radiologists – details

***Gender***

**Percentage (and headcount) of female and male consultants, 2015**

| | Female | Male |
|---|---|---|
| Wales | 36% (58) | 64% (102) |
| UK | 35% (1,163) | 65% (2,155) |

***Age***

**Percentage (and headcount) of consultants in each age group, Wales 2015**

| Age group | Wales | UK |
|---|---|---|
| 30–39 | 14% (23) | 20% (659) |
| 40–49 | 42% (68) | 41% (1,365) |
| 50–59 | 31% (49) | 27% (908) |
| 60 or over | 12% (19) | 7% (246) |
| Not known | <1% (1) | 5% (140) |

*International medical graduates*

**Percentage (and headcount) of international medical graduates in consultant workforce, 2015**

| | Percentage of IMGs in consultant workforce |
|---|---|
| Wales | 23% (37) |
| UK | 28% (921) |

## 3. Unfilled posts

**Unfilled consultant posts, 31 March 2015**

| | Unfilled consultant posts | % of consultant posts unfilled |
|---|---|---|
| Wales | 12 | 7% |
| UK | 324 | 9% |

**Status of unfilled of unfilled consultant posts, 31 March 2015**

| | Wales | UK |
|---|---|---|
| Advertised but failed to appoint | 5 | 166 |
| Advertised but not yet interviewed | 0 | 28 |
| Appointed but not yet taken up | 2 | 45 |
| Funded but not yet advertised | 5 | 64 |
| Funded but not yet appointed | 0 | 21 |
| Total | 12 | 324 |

**Consultant posts vacant for 8 months or longer as of 31 March 2015**

| | Unfilled posts | % of all unfilled posts |
|---|---|---|
| Wales | 5 | 42% |
| UK | 148 | 46% |

**Unfilled consultant posts covered by locums as of 31 March 2015**

| | Unfilled posts covered by locums | % of unfilled posts covered by locums |
|---|---|---|
| Wales | 1 | 8% |
| UK | 96 | 30% |

This is a likely underestimate as many unfilled posts have stopped being advertised, particularly in West Wales.

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

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

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

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

For further information please contact:

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

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

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

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

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

## RCPsych Workforce Census

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

## NHS ten- year plan on workforce

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

## Inquiry questions:

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

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

few resources, services are at risk of collapse. We are calling for Welsh Government to address workforce issues more generally and within their specialties. It must be Welsh Government's priority to develop a workforce plan and training programme to attract the calibre of healthcare professionals to meet these demands as stated in RCPsych in Wales Manifesto 2016.

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

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

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

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

## 2. The implications of Brexit for the medical workforce.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Further comments:**

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

## Key points

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

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

November 2016

MR 08

Ymchwiliad i recriwtio meddygol

Inquiry into medical recruitment

Ymateb gan: Coleg Brenhinol Pediatreg ac Iechyd Plant

Response from: Royal College of Paediatrics and Child Health

# Royal College of Paediatrics and Child Health

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

## 1. Introduction

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

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

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

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

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

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

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

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

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

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

[3] 2011 Census, Office of National Statistics

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

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

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

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

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

2.8 Where children do need to be cared for in a hospital setting we need to ensure that all those delivering urgent care are following consistent guidelines and make sure that all emergency departments have the appropriate skill mix and workforce to deliver safe, effective and efficient care. The RCPCH is currently revising the Intercollegiate Standards for Children and Young People in Emergency Care Settings[8] (last published in

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

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

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

2012) which provide healthcare professionals, providers and service planners with measurable and auditable standards of care applicable to all urgent and emergency care settings.

## 3. The implications of Brexit for the medical workforce.

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

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

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

3.4 We welcome the announcement made by Jeremy Hunt in England earlier this year to introduce 1,500 new medical training places to make the NHS 'self-sufficient' by 2020. However, it is not clear what this means for

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

Wales. We are not clear as to whether this action will be in partnership with the Welsh Government and that the NHS across the whole of the UK will be 'self-sufficient' . It should be noted that it takes at least seven years to train new students to enter practice so many will not be in place until 2023/24 at the earliest and 1,500 new places is unlikely to fill the current vacancy rates across the medical profession as a whole.

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

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

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

4.2 The Welsh Government has announced the creation of an arm's length organisation, provisionally called Health Education Wales (HEW) to oversee strategic workforce planning, workforce design and education commissioning for NHS Wales. We hope that this will be accompanied by a

clear strategic vision for the recruitment and retention of the medical workforce in Wales and a strategy to realise this.

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

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

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

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

4.7 “Often the adverts say you will be based at one hospital but you may be expected to travel all over the Health Board if necessary (or words to that effect). As travel times in rural areas are not as simple as judging it on the mileage this again is a factor.”

4.8 “Emphasis on training – for all medical groups.”

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

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

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

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

5.1 RCPCH does not manage recruitment campaigns. Positions are advertised through the Oriel website centrally. RCPCH staff and members do, however, frequently attend careers fairs. These are primarily organised locally, sometimes by hospitals. We are not aware of a central strategy or campaign to organise this work, either in Wales or at a UK level.

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

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

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

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

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

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

## Introduction

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

2. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money.

We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

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

## Key points

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

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

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

organisations. The document considers the ten key areas to ensure a sustainable health and social care workforce in the future, including having a long-term vision for health and social care in Wales.

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

## Background

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

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

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

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

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

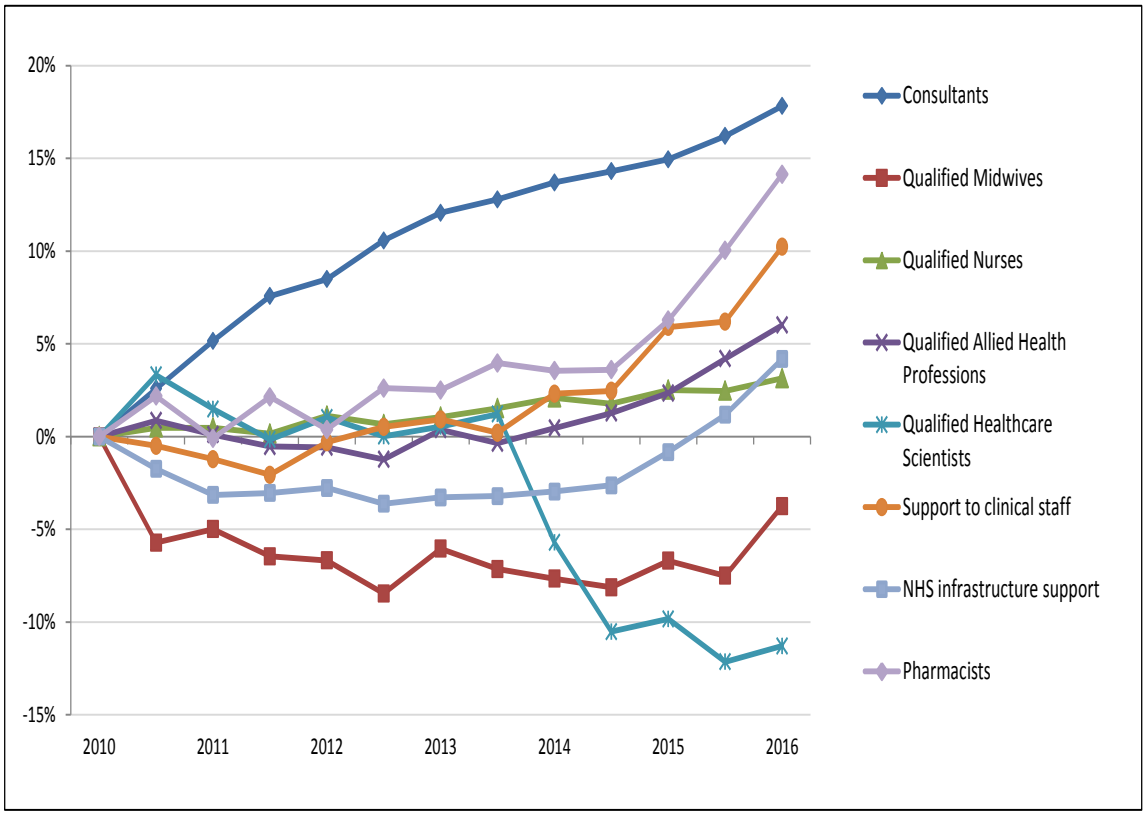
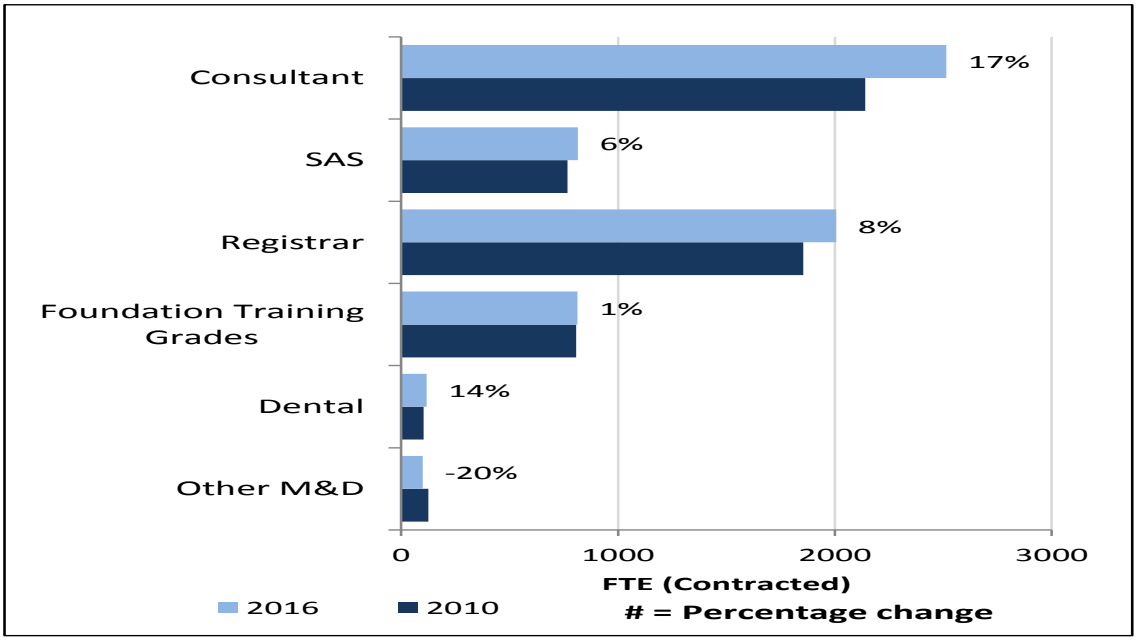



Chart 2: FTE comparison and % variance between 2010-2016 for Medical & Dental grades




## Health Board Vacancies and Recruitment Pressures.

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

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

## Specialty Pressures

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

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

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

- All Wales/ UK recruitment campaigns;

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

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

## Questions

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

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

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

18. The CfWI modelling was based on:

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

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

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

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

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

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

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

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

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

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

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

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

## Q2. The implications of Brexit for the medical workforce.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47. Factors that influence the retention and recruitment of doctors are:

- Geographical locations and small numbers on a rota sometimes resulting in a lack of peer support and limited options for cross cover;
- Out of hours arrangements are not attractive to junior doctors due to a feeling of isolation;

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

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

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

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

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

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

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

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

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

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

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

## Conclusion

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

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

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-06-17 Papur 7 / Paper 7

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

Ymateb Deoniaeth Cymru i Ymchwiliad Recriwtio Meddygol Iechyd a Gofal Cymdeithasol

## Y Cefndir

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

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

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

hyfforddeion a benodir a rhagor o gyfraniad gan yr hyfforddwyr oherwydd nad yw pobl yn gallu camu ymlaen drwy'r rhaglenni mor gyflym ag y byddai rhywun yn ei ddisgwyl.

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

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

1.4 Lle bynnag y bo modd, rhaid symud at fodelau nad ydynt yn canolbwyntio ar feddygon nac ar fodelau gwasanaethau dibynnol. Mae angen cyfleu hyn yn y cynllun strategol 10 mlynedd newydd ar gyfer y gweithlu. Ym maes

Ymarfer Cyffredinol, bydd cyfleoedd i newid y gymysgedd sgiliau a modelau gofal newydd deniadol lle bydd gweithwyr medrus y GIG (h.y. nyrsys arbenigol, fferyllwyr, cynorthwywyr meddygon) yn ymgymryd ag o leiaf rai o rolau traddodiadol yr ymarferydd cyffredinol.

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

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

## 2. Goblygiadau Brexit ar gyfer y gweithlu meddygol

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

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

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

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

2.5 Oni allwn recriwtio a chadw meddygon yr Undeb Ewropeaidd yng Nghymru, bydd angen inni edrych ar rannau eraill o'r byd neu hyfforddi rhagor o

fyfyrwyr sy'n hanu o Gymru a'u hannog i wneud eu hyfforddiant ôl-raddedig yma drwy gynnig pecynnau cymell cynhwysfawr (ariannol ac anariannol) iddynt barhau i weithio yng Nghymru am gyfnod penodol.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Atodiad 1**

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

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

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

Mae cyfyngiadau ar y ddogfen hon