Agenda - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:

Ystafell Bwyllgora 3 - Senedd

Dyddiad: Dydd Iau, 9 Mawrth 2017

Rhag-gyfarfod Aelodau: 09.00 - 09.15

Amser: 09.15

I gael rhagor o wybodaeth cysylltwch a:

Sian Thomas

Clerc y Pwyllgor

0300 200 6291

SeneddIechyd@cynulliad.cymru

Rhag-gyfarfod anffurfiol (09.00 - 09.15)

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

2 Ymchwiliad i recriwtio meddygol - sesiwn dystiolaeth 10 - ysgolion meddygol Cymru

(09.15 - 10.15) (Tudalennau 1 - 38)

Yr Athro Keith Lloyd, Deon Ysgol Feddygol Prifysgol Abertawe

Dr Stephen Riley, Deon Ysgol Feddygol Prifysgol Caerdydd

Egwyl (10.15 - 10.25)

3 Ymchwiliad i strategaeth genedlaethol ddrafft Llywodraeth Cymru ar ddementia - sesiwn dystiolaeth 7 - pobl sy'n byw â dementia

(10.30 - 11.30) (Tudalennau 39 - 50)

Madeline Cook
Michelle Fowler
Beti George
Nigel Hullah
Emily Jones
Karen Kitch

Cynulliad Cenedlaethol Cymru

National Assembly for Wales

4 Papurau i'w nodi

Ymchwiliad i recriwtio meddygol – gwybodaeth ychwanegol gan BMA Cymru Wales

(Tudalennau 51 – 57)

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

6 Ymchwiliad i recriwtio meddygol – trafod y dystiolaeth

(11.30 – 11.40)

7 Ymchwiliad i strategaeth genedlaethol ddrafft Llywodraeth Cymru – trafod y dystiolaeth

(11.40 – 11.50)

8 Ymchwiliad i ofal sylfaenol – paratoi i gymryd tystiolaeth

(11.50 – 12.00) (Tudalennau 58 – 61)

Eitem 2

Mae cyfyngiadau ar y ddogfen hon

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-08-17 Papur 1 / Paper 1

Response to Welsh Government Consultation on Medical recruitment

Swansea University

Respondents: Suzanne Edwards, Andrew Grant, Marguerite Hill, Paul K. Jones, Keith Lloyd, Heidi Phillips & John Rees.
Collated by: Andrew Grant

Prepared for: Health Social Care and Sport Committee, Welsh Government
Date: January 9, 2017

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

1. In some areas of Wales where the medical workforce is aging the medical workforce will not be able to meet current population needs. One quarter of the GP workforce is expected to retire in the next ten years particularly within the Hywel Dda area. There are many other shortage specialties in Wales and recruitment to a range of specialties is problematic outside the major urban centres.
2. In South West Wales ARCH, a Regional Collaboration for Health offers significant opportunities for a novel and multidisciplinary approach to workforce planning, recruitment and retention, from attracting Welsh school leavers schools, through to undergraduate degrees, graduate entry medicine, and postgraduate recruitment and retention. This approach could form the basis for new ways of working to promote recruitment and retention.
3. The reduced capacity of the workforce is being addressed, in part, by the training and employment of professionals who are not medically qualified. These include advanced nurse practitioners and physician associates. Other schemes in Wales involve the use of pharmacists and optometrists to enhance the capacity of the medical workforce
4. At Swansea University we will also introduce a primary care track within the graduate entry medical programme. Students on this track within the four-year medical programme will focus on general practice and primary care even more than the rest of the cohort.
5. As well as providing primary care focused training the primary care track will offer students a better insight into the complexities, challenges and rewards of a career in general practice. A GP who is facilitating a case-based learning group will be able to support students' learning from their own knowledge and clinical experience and from the general practice perspective.
6. Undergraduate medical teaching offers variety in working patterns and stimulation from student contact. For this reason, recruitment of GPs to practices involved in the primary care track will be enhanced.
7. To increase the number of medical students entering medical careers in Wales, we will contextualize the admissions process to maximize admission of students who are Welsh domiciled.
8. The learning environment for all medical students, not just those who express an interest in a career as a GP on admission needs to be more orientated towards primary care.
9. 30 training places for general practice have remained unfilled in the past year, with Vocational training schemes in mid and west Wales having no applicants. If vacancies for retiring GPs are unfilled, there is extra pressure on remaining younger GPs who, in turn, are increasingly likely to move to part time work or to leave the profession.

10. While these places remain unfilled we will ask the GP trainers and programme directors to use their knowledge and expertise to teach and enthuse medical students. However, it is expected, in time, that their time and energy will be, once more, required to provide training for GP registrars (i.e. the next generation of GPs for all parts of Wales).

11. In order to recruit to more doctors to remain in Wales post qualification, We recommend:
    a. A significant expansion of graduate entry medicine at Swansea University as graduates from our four year course are significantly more likely to remain in Wales for their F1 and F2 posts than students from undergraduate courses. They are also significantly more likely to remain in the UK for their specialist training and to go into general practice according to the UK foundation survey. Swansea's medical school has on average 1000 applicants of whom around 300 are interviewed for 70 places.
    b. Contextual admission or ring-fenced places for Wales-domiciled students studying medicine or allied medical professions
    c. Repayment of Welsh domiciled students' loans, over a period of years post qualification, to encourage doctors to stay/return to work in Wales
    d. That Local Health Boards sponsor medical school places for applicants from their areas
    e. Every foundation doctor in Wales could spend at least 4 months in a general practice – or other specialty where recruitment is problematic.
    f. Development of a "Primary and Urgent Care Academy" at Swansea University with specific GP focussed training, recruiting into it students who express the desire to pursue a career in General Practice via the primary care track (notwithstanding the award of a full PMQ)
12. The possibility of more professionals being able to offer healthcare through the medium of Welsh should be explored with reference to the Welsh Government document "More than just words".

The implications of Brexit for the medical workforce.

13. Across the UK, EU immigrants make up approximately 10% of registered doctors and 5% of registered nurses – according to GMC, 6% of GPs are from the EEA. Immigrants from outside the EU make up larger proportions (approximately 25% of the medical workforce is trained outside the UK), but as restrictions on non-EU immigrants have affected NHS recruitment, this suggests that the same could happen if there were limits on EU immigration.
14. Withdrawal from the EU may inhibit British graduates from emigrating to EU countries. Similarly, EU-born staff may leave the UK pre-emptively due to the uncertainty created when migration restriction becomes possible. Less favourable exchange rates may also make UK (including Wales) a less attractive destination for healthcare workers to live and work.
15. Depending on how any new immigration policy is developed and implemented, there could be opportunities for attracting talented medics from other countries (Asia, Africa and the Americas, as well as the EU and EEA countries) to rural Wales.
16. There is uncertainty about whether the Barnett formula will continue to be used, changed or abandoned in post-Brexit deals. If the Barnett formula is maintained, then Wales is more likely to be worse off unless government uses the entire value of EU contributions for devolved purposes.
17. If working time legislation is repealed it may lead to an increase in doctors' working hours resulting in a disincentive for recruitment.
18. Potential for reduced investment in infrastructure (following from withdrawal of EU structural funds), which could reduce the appeal of parts of rural Wales.
19. There is a risk that lower economic growth post-Brexit will have implications for public spending that will have a significant impact on NHS funding

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

20. Increased and unsustainable demand – fuelled by past incentives to offer appointments within 24hrs has raised public expectation.

21. The transfer of work from secondary to primary care with no re-allocation of resources
22. The partnership model – requiring GPs to "buy in " to premises, often having to borrow money at well above market mortgage rates – this on a background of incurred student debt due to university fees and loans and at the time when a new GP principal has to buy their home and support a young family.
23. While working in rural Wales may be attractive for individuals – the work situation needs to take into consideration the accessibility and availability of work for their partners and dependents.
24. Trainees are more likely to remain in Wales after completing their training scheme if that scheme is based in Wales. Some schemes are UK-wide. While admission to these schemes is very competitive, trainees are very likely to return to their native part of the UK on completion.
25. While it is important for there to be a presence of trainees in Wales financial incentives could also be offered to doctors who have done some or all of their training in other parts of the UK but who wish return to Wales to practice as consultants and GPs.

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.

26. The presence of more doctors in training does not necessarily translate into more doctors in the NHS - significant numbers leave the UK for other countries such as Australia. As proposed by NHS England, could it be helpful to require a commitment to practise in their country of study post-graduation for a fixed number of years? There is increasing evidence that graduates from the Swansea graduate entry programme are more likely to remain in Wales than those from undergraduate courses. The ethos of the course and its use of placements in South and West Wales will help recruit and retain doctors there. An increase in activities focusing on retention is planned.

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

27. Stronger links are needed between medical school places, foundation numbers and work force planning As mentioned above ARCH, a regional collaboration for health, offers a model for joined up service and workforce planning between the NHS and university partners who provide that training.
28. Partnerships between Welsh medical schools and Welsh secondary schools, particularly those in areas where recruitment of doctors is difficult but where few local school leavers apply for medicine need to be created and strengthened. Welsh students leaving university with a good first degree should be encouraged to consider the option of graduate entry medicine. This will require partnership between medical schools and other Welsh universities.

Supplementary Response to Welsh Government Consultation on Medical recruitment

Swansea University

Respondent: Professor Keith Lloyd, Dean, Swansea University Medical School
Prepared for: Health Social Care and Sport Committee, National Assembly for Wales
Date: 28 February, 2017

Dear Sir / Madam,

Swansea University Medical School has already submitted evidence in response to the committee's consultation, and to address core questions relating to the capacity of the medical workforce to meet future needs, the implications of Brexit, factors influencing recruitment and retention of doctors, the delivery of medical recruitment campaigns to date, and the extent to which recruitment processes are joined up.

The committee have subsequently asked for my views on the evidence received to date from the range of organisations responding to the consultation, some of which relate to admissions to Welsh medical schools.

I understand that of particular interest and concern is *evidence the committee has heard about apparent difficulties for Welsh students getting into Welsh medical schools, but being subsequently accepted to study medicine in England and low numbers of Welsh domiciled students being accepted to medical school in Wales*. The supplementary evidence given here seeks to address these points and also to provide further related information where this is thought to be useful to the committee's considerations.

Context

Swansea University Medical School's quality profile, student satisfaction and outputs are consistently good. At the point of qualification Swansea medical graduates top the UK survey for F1 preparedness. After qualification, Swansea medical graduates are significantly more likely than their Cardiff counterparts to remain in Wales, to go into higher training in the UK, and to enter general practice. These findings come from the last three years' data provided by the UK Foundation Programme Office. Elsewhere, the 2017 Complete University Guide and the Times & Sunday Times University Guide both rank Swansea among the top 10 medical schools in the UK. Last year the medical school was recognised at a UK level for its work towards gender equality by the award of Athena SWAN silver status.

Admissions to Welsh Medical Schools

The medical School focuses on Graduate Entry Medicine (GEM) which provides the quickest route for training doctors in Wales, with students graduating in 4 years, rather than 5 or, in some cases, 6 years. GEM is a very popular course and each year almost 1000 applications are made to undertake study. Of these around 288 are interviewed by the University with between 175 and 200 being deemed appointable. At present 72 new places are funded each year by the Welsh Government.

As part of its strategy - and in support of the on-going needs of the medical workforce in NHS Wales reflected in evidence to the committee from almost all respondents - the medical school is keen to increase its GEM provision as well as other undergraduate and postgraduate places in subjects which are allied to medicine and life sciences.

We are taking a range of actions to support this ambition and to positively affect access to study medicine:

- We have recently introduced a pathway from our undergraduate degree programmes into the Graduate Entry Medicine programme. This is a significant attraction for applicants to our undergraduate degrees whilst also increasing the likelihood that our medicine graduates will stay and practise in Wales (having been here 7-8 years). Over 50% of UK applicants to our “feeder” B.Sc. degrees are Welsh-domiciled

- From this year onwards we are introducing a foundation year for the Applied Medical Sciences B.Sc. programme. This will provide an alternative entry route for students who have the right level of qualifications but are without the required results at A-Level for direct entry onto the 3 year Applied Medical Sciences course (which then has a pathway through to the medicine degree) and will therefore contribute to the widening access agenda.

- We are creating a number of general modules that underpin or provide some component part of a variety of different undergraduate courses so that new, federalised programmes of study can be used to support a wider range of courses in subjects allied to medicine, and needed by the Welsh NHS.

These actions are part of the schools aim to work with health board partners to develop an end-to-end approach to education and training which can deliver against the workforce requirements of NHS Wales by educating tomorrow’s doctors and life scientists in a way that makes sure supply is matched with demand and graduates enter the workforce with a rounded understanding of how the NHS operates. Creating a better university offer, with a wider range of courses, more ways to access and move between them is a core part of this.

However, the process begins much earlier than university entry and I agree with the view of many others who have given evidence that more needs to be done to encourage and facilitate school age children in Wales to gain access to medical school. To this end, the medical school already plays an active role in engaging with secondary schools and further education colleges and we are keen to build on this through working in partnership with health boards. This includes though the development of the Talent Bank approach being taken forward under the ARCH Programme. At the other end of the educational journey it is important to offer graduates and qualified clinicians the opportunity to continue their development through specialisation and/or academic opportunities. The depth and breadth of the medical school’s offering in these areas are also being reviewed.

Welsh Domiciled Students

Each medical school sets its own entry criteria. There is of course a balance to be struck between the level at which the 'entry score' is set and the potential of the applicant to go on to successful study and practice. The setting of the score is therefore subject to regular and stringent review. In this context it is worth noting that 49 students (of varying domiciled status) who were accepted on to the GEM course in 2016/17 only received an offer from Swansea. At the same time we have a very low attrition rate for the course (c.1%) and have again come top of the NHS F1 Trainee Survey for overall preparedness to practice - as determined by students themselves.

Admissions data also shows that 80% of the Welsh domiciled students who were offered a place to study at Swansea in last year's intake took up that place, with 100% doing so the year before. The data also shows that in 2016/17, 4 students had 3 offers and chose Swansea and 1 student had 4 offers and chose Swansea.

Whilst we do not hold direct information about where an applicant may go on to study if they are unsuccessful in securing a place at Swansea, the information above would suggest that we do well developing future doctors and that if there is an issue of Welsh domiciled students studying in England as a result of not securing a place in Wales, it is not as a result of Swansea Medical School's admission policy.

I do however recognise the value of encouraging more Welsh domiciled students to study in Wales. Students who study close to where they live are more likely to stay to practice after qualifying. In Wales there are also other attendant benefits such as an understanding of the distinct health issues of an area and the likelihood that the individual will speak Welsh or at least have a sound educational basis from which to take up the language again. By its very nature, GEM attracts older students who are even more likely to have responsibilities and ties to the area in which they live than 18-year old undergraduates.

Admissions data show that 32% of all students enrolled in GEM across all years of study in 2013/14 were Welsh domiciled which is in keeping with figures suggested by the Higher Education Funding Council for Wales and the Welsh NHS Confederation in their evidence to the committee (MR21 and MR 30 respectively). It should be noted however that there are fluctuations in the number of Welsh domiciled students enrolling on the GEM course each year (the figure was 42% in 2010 for example). Nevertheless, these fluctuations do not result in the current picture being as bad as Welsh NHS Confederation evidence goes on to suggest with 19% of the current GEM student cohort being Welsh domiciled (the confederation's evidence suggest the current figure may be as low as 8-10%). Meanwhile, written evidence to the committee from Dr Heidi Phillips (Director of Admissions for GEM Programme in the medical school) shows that of the 822 students accepted onto the course since it began in 2010, 28% have been Welsh domiciled. Dr Phillips' evidence (MR28) provides further information on the origins and destinations of GEM students and I need not repeat it here.

More can be done however and the school is working to increase the number of Welsh domiciled students including through the introduction of contextual admission arrangements. 'Contextual admission' is a term used to describe the use of additional information, including school performance data and socio-economic markers, to provide context for individual applicants' university applications and achievement. It is a process used by many UK medical schools and like many other institutions, Swansea University is

working to increase participation and widen access in higher education by students with no previous family experience of university education and from disadvantaged groups. Each application is still considered on its merits to ensure fairness and consistency. Such arrangements operate within current policies but allow discretion in the sifting of applicants once a minimum level of entry criteria (in part established through GAMSAT scores) has been met.

As set out in our previous evidence the school would also be supportive of ring-fenced places for Wales-domiciled students studying medicine or allied medical professions. Meanwhile a further relatively easy-to-introduce initiative would be a national programme of additional support for Welsh applicants who are considering medicine and which explains and demonstrates the interview process. This would help prospective Welsh students who, in the experience of the school's admissions team, are often not as well prepared as some of their counterparts from elsewhere even when their GAMSAT scores are similar.

Retention

It is also worth noting the Wales Deanery's view in their evidence (MR06) that Wales has generally retained two thirds of its medical school 'output' in part as a result of the quality of the training students receive. This is a of course a subtly different point to Welsh domiciled students as here graduates may have originated from elsewhere in the UK or further afield. Both quality of training and increasing Welsh domicile are however seeking to deliver the same end – the retention of qualified medical professionals in the Welsh NHS. The picture on retention put forward by the Wales Deanery is supported by the Foundation Programme's analysis of foundation places which shows that Swansea GEM students are more likely to remain in Wales than Cardiff graduates (62% to 54% in 2016). Evidence submitted by Dr Phillips, and drawn from a questionnaire of all GEM students indicates that 67% of GEM students who studied at Swansea are still in Wales, further substantiating this picture.

However, graduates who train in Wales but then leave to work elsewhere are both a service and financial loss to NHS Wales. This is why the school is introducing near-peer support for GEM students from F1 and F2 doctors as part of our student offering as an initial step in improving retention by ensuring that students are supported by people who have begun to work in the region. The review of the school's continuing professional development offering is also intended to be a component in an improved retention offering.

More widely, through involvement in the ARCH programme with ABMU and Hywel Dda University Health Boards we will also using our expertise to build on existing mentoring and development schemes to establish a more ambitious range of retention initiatives. Furthermore, if the City Deal is supported, for example, there will be a substantial investment in health and well-being and life science centres across South West Wales, attracting students to train and stay within the region for the opportunity to experience new and cutting edge healthcare delivery environments and partnerships with the life science sector.

Over and above these actions the school also proposed in its previous evidence that the repayment of student loans over a period of years post qualification for those students who remain in Wales should be explored as a retention incentive. Packages which offer

financial benefit in return for service have recently been introduced by the Welsh Government for those who take up GP specialty training in areas which have been hard to recruit to. Nursing bursaries have also been maintained on the understanding of agreeing to a two-year service tie-in. Whilst there is of course on-going pressure on the NHS finances - including the funding of training and continuation of SIFT - the fact that the total system cost of training a GEM student amounts to approximately 114k over the 4-year course, means that there is potential for return on investment through targeted use of such any such package.

Finally, given the committee's recent inquiries into the GP Workforce in Wales and into Primary Care, members may also wish to note that recent analysis of recruitment to general practice undertaken by the GMC shows that 29% of students who spent all 4 years studying GEM at Swansea entered General Practice. This is in keeping with findings from the Foundation Programme whose analysis shows that Swansea graduates are more likely to enter general practice than Cardiff graduates in successive years at 31% versus 17% in 2014 and 43% versus 21% in 2015.

In conclusion, Swansea University Medical School welcomes the Health, Social Care and Sport Committee's ongoing work on the subject of medical recruitment and feel we are well placed to assist in developing innovative solutions to respond to the challenges facing the NHS Wales though the continued redesign, education and training of the workforce.

Exposure and Training in Emergency Medicine in Wales

A brief report produced by
Cardiff University and the
All Wales School of Emergency Medicine

for the

Health, Social Care and Sport Committee,
Welsh Assembly Government

Author: Dr Huw Lloyd Williams

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Speciality Trainee Year 5, Emergency Unit, University Hospital of Wales

Room 28/1, Wales Heart Research Institute, School of Medicine, Cardiff University, Heath Park, Cardiff

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1. INTRODUCTION / AIM

This short report does not aim to analyse Emergency Medicine Exposure and Training in Wales but simply to present trainee's perceptions, raw data and facts relating to three key timeframes throughout an Emergency Physician's training:

1. Undergraduate Education,
2. Foundation Programme and
3. Emergency Medicine Speciality Training.

Section 2 details Emergency Medicine exposure at undergraduate level (please note that this does not include the post-graduate medical degree course at Swansea University). Section 3 details Emergency Medicine exposure in the Foundation Programme. Section 4 reports on the perceptions of Emergency Medicine Trainees in Wales with regards to three broad areas: 'Living and Working in Wales', 'Training' and 'Work and Career Development'. In this last section, the Emergency Medicine trainee's perceptions were gained by conducting an online anonymised survey. All data gathered from this survey has been presented in an unabridged and unedited format.

2. UNDERGRADUATE EXPOSURE

2.1 Outline of Emergency Medicine exposure in the C21 Undergraduate Curriculum

An undergraduate medicine curriculum must balance all of the general and specific areas of learning required to provide a broad-based training and excellent clinicians. There is currently exposure to Emergency Medicine during three of the five years of the undergraduate course. During the second year, there is a *'Rural Pre-hospital Emergency Medicine Day'* which includes a mock road traffic accident. During the third year of the course student partake in an 8-week clinical placement in a module entitled *'Hospital Front Door'*. The amount of time on this clinical placement spent in the Emergency Department varies between different placement centres but the emphasis is on acute patient care. In the final year, 12 to 14 students experience a 7-week *'Senior Assistantship Programme'* based in an Emergency Department with the Foundation Year 1 Doctor the student will replace following graduation. This approach has been shown to improve the students self-reported preparedness for practice in their first job. There are multiple other opportunities for students to experience Emergency Medicine as they undertake their other learning experiences but this is much more difficult to quantify. There are other opportunities, as described below, for students to gain more exposure to Emergency Medicine if they have an interest. Cardiff Medical School are actively seeking ways to enhance learning for students with an aim of enhancing recruitment and retention for those hard-pressed specialties. There are currently, two Emergency Medicine clinical staff (1 x Professor and 1 x Registrar) employed by Cardiff University on a part-time basis who regularly teach on the undergraduate course.

2.2 Student Selected Components

There are a number of Student Selected Components (SSCs) throughout the undergraduate medical course at Cardiff University. These are either fixed SSCs (to which the student applies) or 'unique' SSCs (which are arranged between the student and a tutor). Some of these SSCs relate to Emergency Medicine. However, there are varying numbers of such SSCs each year, they do not deliver standardised teaching in Emergency Medicine and not all of these SSCs necessarily include a clinical placement in an Emergency Department.

2.3 New Intercalated Degree in Pre-hospital and Emergency Medicine

A new intercalated BSc degree in Emergency, Pre-hospital and Immediate Care (EPIC iBSc) will start in September 2017. The intake will grow from 10 to 15 over a three-year period (10 students in 2017/2018, 12 students in 2018/19 and 15 students in 2019/20). The degree will provide students with 21 weeks of clinical placement (in either an Emergency Department or in the pre-hospital setting) as well as 6 weeks of face-to-face teaching (lecturers, tutorials, simulation, clinical skills sessions) on topics relating directly to emergency or pre-hospital medicine. Four new Emergency Medicine clinical staff (4 x Consultants) are to be employed by Cardiff University on a part-time basis (0.4 FTE) to teach on this new degree.

2.4 Extra Curricula Societies related to Pre-hospital and Emergency Medicine

There are two large Cardiff based medical student societies related to 'Pre-hospital' and 'Emergency Medicine'. The 'Cardiff Medics First Responders Society' are medical students trained in pre-hospital life support and respond to Category Red 999 calls in the Cardiff area. This society has been running since 2006 and self-fund their training and equipment (which includes defibrillators and oxygen).

The 'Pre-hospital Emergency Medicine Society' organise their own fortnightly evening lectures delivered by Emergency Physicians. This society has been running since 2010 and arrange clinical placements (evening shifts) outside the medical course at the Emergency Unit, University Hospital of Wales.

3. FOUNDATION YEAR 1 AND YEAR 2 EXPOSURE

3.1 4-month posts in Emergency Medicine (Wales) in Foundation Year 1 Programme

Foundation Year 1

Aberystwyth	Bronglais Hospital	6
Bridgend	Princess of Wales Hospital	6
Cardiff	University Hospital of Wales	3
Haverfordwest	Withybush Hospital	3
Llanelli/Carmarthen	Glan Gwili Hospital/Prince Philip Hospital	8
Merthyr Tydfil	Prince Charles Hospital	3
Rhyl	Glan Clwyd Hospital	3
Wrexham	Wrexham Maelor Hospital	6
Total number of 4-month Emergency Medicine posts available (2017/18)		***38***

3.2 4-month posts in Emergency Medicine (Wales) in Foundation Year 2 Programme

Foundation Year 2

Abergavenny	Nevill Hall Hospital	12
Aberystwyth	Bronglais General Hospital	6
Bangor	Ysbyty Gwynedd *	12
Bridgend	Princess of Wales Hospital *	12
Cardiff	University Hospital of Wales	21
Haverfordwest	Withybush Hospital	6
Llanelli/ Carmarthen	Prince Philip Hospital/Glan Gwili General Hospital	15
Merthyr	Prince Charles Hospital	9
Newport	Royal Gwent Hospital	15
Rhyl	Glan Clwyd Hospital	6
Swansea	Morriston Hospital	21
Wrexham	Wrexham Maelor Hospital	6
Total number of 4-month Emergency Medicine posts available (2017/18)		***141***

**** figures include three academic posts available at these sites***

3.3 4-month posts in Emergency Medicine (Wales) pre-application to Speciality Training

Although once the traditional route, application direct from the Foundation Year 2 Programme is becoming a less frequent event. The application process for Speciality Training starts in November. Therefore, exposure to Emergency Medicine for doctors applying directly from the Foundation Programme (in the Wales Deanery) is not the sum of the total number of Foundation Year 1 and 2 posts. In fact, only 85 4-month posts are available before the application date for Speciality Training.

3.4 Other Emergency Medicine Exposure

There are some opportunities for 'taster weeks' in Emergency Medicine for Foundation Year 1 doctors. These are organised by the educational supervisor on request of the Foundation Doctor with the local Emergency Department. Historically, the number of such taster sessions has been low.

4. EMERGENCY MEDICINE TRAINING

The perceptions of the 'All Wales School of Emergency Medicine' (AWSEM) trainees were gained by conducting an online anonymised survey. 41 of the 48 trainees responded (response rate = 87.5%).

4.1 Demographics of Emergency Medicine Trainees

Number of AWSEM Trainees (by Grade and Department Placement)

	CT/ST1	CT/ST2	CT/ST3	ST4-6	Vacant posts
Bangor	1	1	1	1	*ST4-6 x1*
Wrexham	1	-	-	1	
Morriston	2	2	1	3	*ST3x1*
POW	2	-	-	3	*ST4-6 x1*
UHW	2	2	2	3	
PCH	-	-	-	4	*ST3 x1*
Gwent	1	1	3	6	
NHH	2	2	1	-	*ST4-6 x3*
Totals:	*11*	*8*	*8*	*21*	*7*

SOURCE: AWSEM

Source of Undergraduate Medical Degree

Wales: Cardiff	21	50.00%
UK (outside Wales)	17	40.48%
EU (outside UK)	0	0.00%
Outside EU	2	4.76%
Total Responses:	*42*	

SOURCE: AWSEM Trainee Survey January 2017

Majority of training / postgraduate posts prior to entering EM Specialty Training

Wales: Cardiff	23	56.10%
UK (outside Wales)	16	39.02%
EU (outside UK)	0	0.00%
Outside EU	2	4.88%
Total Responses:	*41*	

SOURCE: AWSEM Trainee Survey January 2017

Training Grade of Respondents

CT1-3 / ST1-3	21	50.00%
ST4-7	21	50.00%
Total Responses:	*42*	

SOURCE: AWSEM Trainee Survey January 2017

Training Placements (majority of training to-date in North or South Wales)

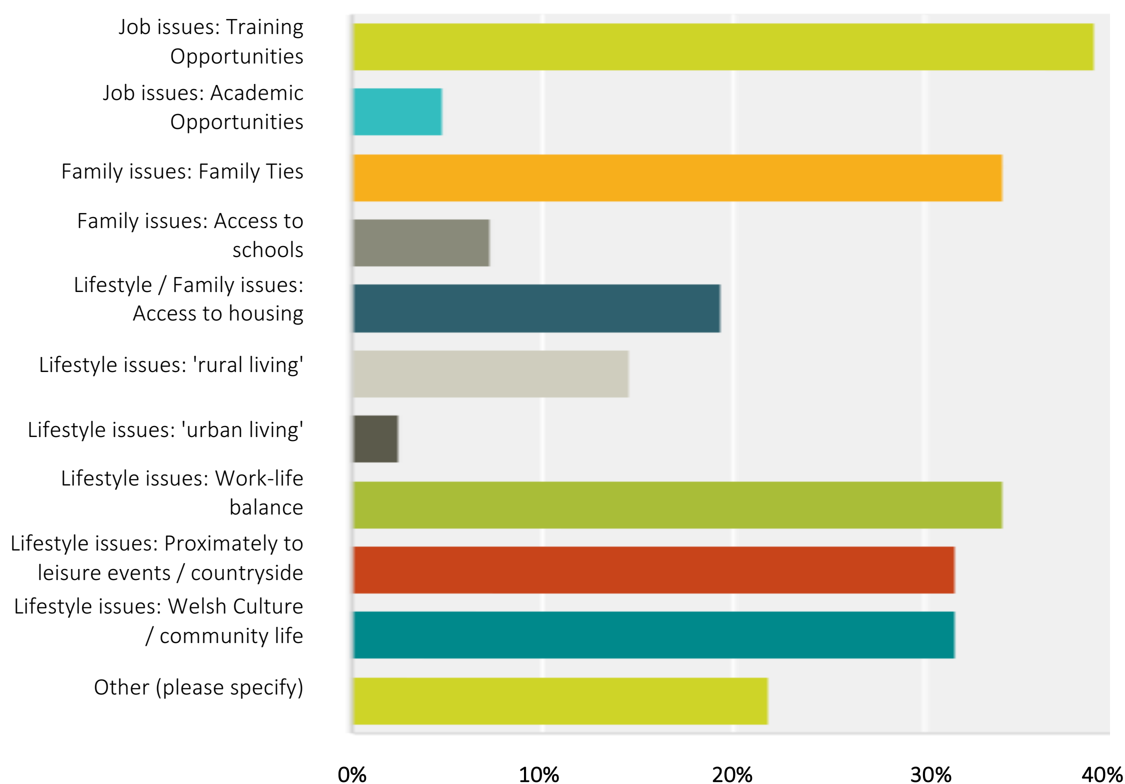
North Wales	3	7.14%
South Wales	37	88.10%
Other Deanery	2	4.76%
Total Responses:	*42*	

SOURCE: AWSEM Trainee Survey January 2017

4.2 Trainees' Perceptions: Living and Working in Wales

Trainees' Perceptions: What was it that made you want to train in Wales?

Job issues: Training Opportunities	17	40.48%
Job issues: Academic Opportunities	2	4.76%
Family issues: Family Ties	15	35.71%
Family issues: Access to schools	3	7.14%
Lifestyle / Family issues: Access to housing	8	19.05%
Lifestyle issues: 'rural living'	6	14.29%
Lifestyle issues: 'urban living'	1	2.38%
Lifestyle issues: Work-life balance	14	33.33%
Lifestyle issues: Proximately to leisure events / countryside	13	30.95%
Lifestyle issues: Welsh Culture / community life	14	33.33%
Other (please specify)	9	21.43%



Other responses included:

i. *Opportunity for partner to work in the arts*
ii. *Friends*
iii. *Nationally appointed job system*
iv. *already lived in wales*
v. *Familiarity, having worked in Wales before*
vi. *Friends based in Wales by and large*
vii. *Abergaveny close to Hereford*
viii. *It was not my first choice*
ix. *Second choice deanery, geographically closest to partner's work*

SOURCE: AWSEM Trainee Survey January 2017

Trainees' Perceptions: Are you likely to stay in Wales until the end of your training?

Yes	35	83.33%
Maybe	5	11.90%
No	2	4.76%
Total Responses:	*42*	

SOURCE: AWSEM Trainee Survey January 2017

Trainees' Perceptions: Are you planning to seek a consultancy post in Wales following training?

Yes	26	61.90%
Maybe	15	35.71%
No	1	2.38%
Total Responses:	*42*	

SOURCE: AWSEM Trainee Survey January 2017

4.3 Trainees' Perceptions: Training

Trainees' Perceptions: How would you describe your experience of training in Wales ?

35 Responses:

i. *Excellent, supportive teams, good teaching and learning opportunity, work with an inspiration team of doctors.*
ii. *Very good , deanery team are very supportive and friendly*
iii. *Good, very supportive.*
iv. *It's a friendly and supportive deanery, with a wide range of hospitals to experience*
v. *Good*
vi. *Supportive lots of opportunities. Some difficulties due to differences between nhs Wales and nhs England*
vii. *Great regional teaching program. Some aspects of medicine appear to be behind the times (technology etc) compared to England which could be much improved.*
viii. *Enjoyable*
ix. *Mostly good.*
x. *Mixed*
xi. *Great.*
xii. *very good*
xiii. *Increasingly frustrating, in my second year of training on my medicine rotation I feel solely like service provision and issues with recruitment have led to an understaffed rota which is constantly putting us under pressure. Thank you email from our medical directors at times of service breaking points are of little worth when staffing issues are not addressed consistently. Rota gaps across the pressured departments are hugely detrimental to staff morale and most concerning of all to patient care. If these conditions do not improve, I fear clinician burnout will only continue to exacerbate the problem.*
xiv. *Mixed*
xv. *Good*
xvi. *good*
xvii. *So far excellent*
xviii. *Very good, but quite dependent on which hospital you are based in. Our regional teaching is excellent and vastly better than that offered to other speciality trainees.*
xix. *Supportive, friendly*
xx. *Supported*
xxi. *Excellent*
xxii. *Excellent on the whole. We are very supported by Amanda Farrow.*
xxiii. *Mostly enjoyable, friendly people.*
xxiv. *Wales is an enjoyable place to work, a wide variety of hospitals and patients make for a great mix. It's really frustrating to see campaigns such as the GP work live wales campaign aimed at other specialities and very little at Emergency Medicine.*
xxv. *EM training excellent*
xxvi. *Excellent support through AWSEM*
xxvii. *Interesting.....having spent over 8 years working and training in England, it is odd to find medical practice that has been in place for some time there, is now only just making it into Welsh hospitals.*
xxviii. *Fantastic*
xxix. *Excellent*
xxx. *Fantastic*
xxxi. *Mixed. My anaesthetic and ICU placements have been well supported and with consultants willing to teach. My EM placement was not like that and I was just there for service provision. In the North there is no provision for EM trainees and I have yet to work with training registrars in EM. Pressure on the department and consultant disengagement have meant few educational opportunities within my specialty. A lack of HSTs has meant that the tier is filled with clinical fellows who could be very junior and from outside EM.*
xxxii. *Great, well supported and feel appreciated as a trainee*
xxxiii. *Good flexibility to facilitate south Wales only training. And access to OOP if required*
xxxiv. *Amazing*
xxxv. *Excellent*

SOURCE: AWSEM Trainee Survey January 2017

Trainees' Perceptions: Have you needed to move around Wales as part of your training?

Yes	24	61.54%
No	15	38.46%
Total Responses:	*39*	

SOURCE: AWSEM Trainee Survey January 2017

Trainees' Perceptions: Was this an Issue / Problem?

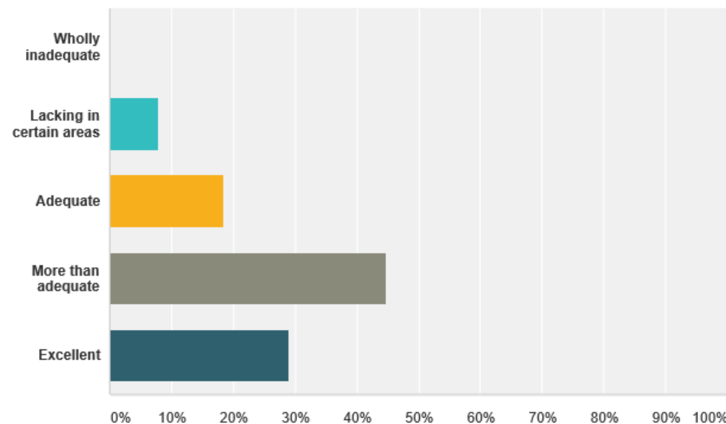
25 Responses:

i. *No - all training based in South Wales- Newport to Swansea*
ii. *Yes, especially when my family got bigger with children , It would be more advantageous if trainee knew from the start South, North or 50% between both*
iii. *No, had to move within English LETB as too large to stay in one place so no excess disadvantage*
iv. *Yes. Having to move 200 miles away from my husband caused my marriage to break down.*
v. *No*
vi. *Not so far as the deanery have been accommodating to preferences and I as a trainee I am able to stay in South Wales for the duration of my training which is great.*
vii. *No*
viii. *Yes*
ix. *Yes, local hospital doesn't have training places*
x. *Sometimes - if rota's aren't adaptable to allow for long travelling time and sleeping rooms are not available*
xi. *As an emergency medicine trainee, I haven't had to travel around, as the school are very accommodating to preferences to make work/life balance possible. Compared to friends who are facing spending a year apart from their husband, or uprooting the whole family when given a rotation far from home, which would be a significant problem.*
xii. *Definitely, especially if you have a family*
xiii. *Large area covered by deanery*
xiv. *No*
xv. *If I had to move around to North Wales repeatedly I would either not be doing EM or I would choose an alternative deanery.*
xvi. *Yes. I will not move to Cardiff or Swansea or further*
xvii. *Yes. The geographic split north/south alleviates that somewhat, but even within the north, there are only two hospitals approved for training. For the specialist skills (paediatrics) it necessitates travel to Liverpool. That's a hell of a journey!*
xviii. *It is a very large deanery*
xix. *Yes*
xx. *Yes, the geography of Wales makes moving between north and south very difficult. Being in the North has been brialliant with very unique experiences. But with everything South Wales based there are likely to be opportunities that I have missed. Some of this has been helped by forming links to Mersey Deanery. I would recommend training in North Wales, but better provision is needed to allow North and South Wales Trainees to meet. Greater study budget to allow for the £150/trip down to South Wales for teaching and training. As it is often a 10-12hr around trip.*
xxi. *Yes, this is definitely a disadvantage particularly as my partner's work and our mortgage is based in England. Although I have not had to move yet there is a strong chance that I will have to move to a hospital based a number of hours away during my training.*
xxii. *Commuting over an hour each way is always difficult especially with shift working. I see this as a minor disadvantage to training in Wales. However, this does mean experiencing different cohorts of patients based on location.*
xxiii. *No*
xxiv. *This was not a difficultly - there was options to stay in South Wales*

SOURCE: AWSEM Trainee Survey January 2017

Trainees' Perceptions: What level of support have you received from senior colleagues at the Emergency Departments involved in your training to-date?

Wholly inadequate	0	0.00%
Lacking in certain areas	3	7.69%
Adequate	7	17.95%
More than adequate	17	43.59%
Excellent	12	30.77%
Total Responses:	*39*	



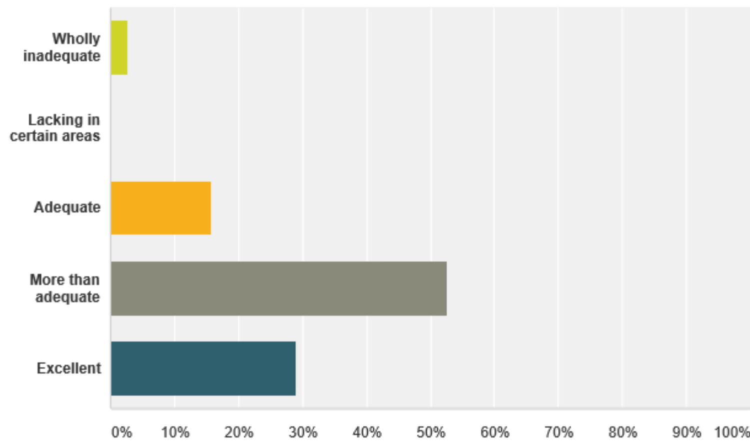
17 Comments:

i. *This varies significantly between departments. EM trainees almost get no support while working in UHW this whether working in EM or Acute medicine compared to other departments in South Wales. This is mainly driven by work load coupled with lack of staff. This environment has significant impact on training. Unfortunately, the senior colleagues got sucked into this and they left with no options but to sacrifice maintaining, developing training opportunities.*
ii. *Many offers to help with training needs as they arose. Additional time spent on WBPAs, reports, etc… beyond duty.*
iii. *The seniors in my experience are, for the most part, very supportive*
iv. *Understanding, keen to provide training opportunities, despite service pressures*
v. *not had an ED placement in wales*
vi. *Generally very good*
vii. *The support to get back in to training after a period of locum work was invaluable in restoring my love of the speciality*
viii. *Motivated and inspiring senior colleagues generally have helped to keep my motivation going when I'm flagging with all the portfolio tick boxes! I have also been lucky to have senior colleagues who were supportive of my year out, but also that have helped me settle back in after a year away in a very different environment.*
ix. *Always available for advice no matter how busy the department.*
x. *Some of the best senior registrars and consultants have been found in the Emergency department. The Gwent deserved a specific mention due to their great support and approachability.*
xi. *Poorer training in UHW compared to other hospitals in S. Wales*
xii. *Very supportive in all departments*
xiii. *A focus in opportunities provided to non-training grades that are actively denied to the training grade.*
xiv. *Generally excellent. Lacking in certain hospitals.*
xv. *Clinically they could be supportive but depending on the consultant this was mood dependent. No educational opportunities were offered and when asked for them directly i was mostly told that they were too busy. Which was true. They seem so overworked and stressed they never had time to teach or even fully discuss a case.*
xvi. *Excellent clinical and Pastoral Support. They have looked after me the trainee as a person.*
xvii. *Great support from consultant colleague. However, there is a lack of higher specialty trainees and a reliance of locum staff.*

SOURCE: AWSEM Trainee Survey January 2017

Trainees' Perceptions: What level of support have you received from training bodies to-date (namely: AWSEM, RCEM Wales and/or RCEM)?

Wholly inadequate	1	2.56%
Lacking in certain areas	0	0.00%
Adequate	6	15.38%
More than adequate	20	51.28%
Excellent	12	30.77%
Total Responses:	*39*	



13 Comments:

i. *The support I personally received from school of Emergency Medicine is excellent, I can't think of better way of building relationship with trainers*
ii. *Additional support offered by Wales Deanery enabled me to complete training and was easy to access when required.*
iii. *AWSEM are great - the curriculum targeted training days are incredibly helpful, and peer to peer support is strongly present. I haven't really found RCEM to be supportive, however*
iv. *Great support from AWSEM and RCEM Wales when required.*
v. *AWSEM have been supportive, and innovative in ways to attract and retain trainees*
vi. *Excellent teaching days.*
vii. *AWSEM provide regular teaching to update skills and knowledge. RCEM produce ED specific guidance for common ED presentations.*
viii. *AWSEM is very supportive of us all.*
ix. *AWSEM invaluable, supportive, main strength of Wales programme*
x. *Dr. Farrow and AWSEM have been very supportive. I wish I had known how approachable and useful they were earlier.*
xi. *AWSEM and RCEM have been very useful. However, no solution has been found to address the lack of North and South Wales Trainees meeting for training. I.e. a North Wales Study Budget to allow the money to travel to South Wales for training my help. The cost and time are really high.*
xii. *AWSEM have been great with good support. RCEM have been adequate but my main interaction has been re: payment of fees and exams etc..*
xiii. *AWSEM cannot do enough for its trainees!*

SOURCE: AWSEM Trainee Survey January 2017

Trainees' Perceptions: Are there any factors that have caused difficulty in accessing training? (e.g. distance from training venues or work pressures that make study leave difficult)

26 Responses:

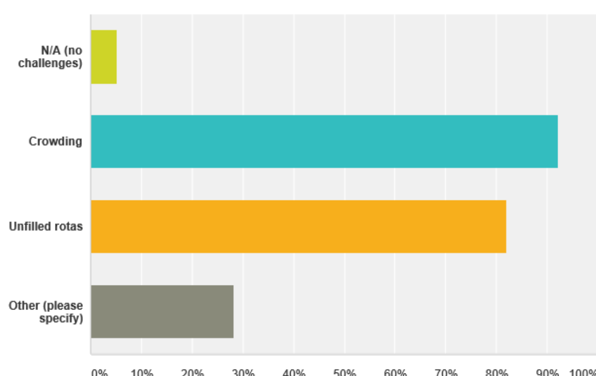
i. *Nil*
ii. *The main issue that come up every year is the coordination between regional teaching and rota commitments . some department are well advanced in this others put shop floor cover priority over training opportunities*
iii. *Service pressures when on-shift distracted from training as little time to engage with consultants. Flexibility of staffing by locums have paradoxically made it easier to get the days off I need but has meant using more off-days for study with significant pressure on family life.*
iv. *It can be difficult to get study leave to attend training, especially in non-ED specialties during ACCS*
v. *No*
vi. *Rota gaps and shortages in staff generally in ED can make it difficult to access training. Pressures on the acute stream. In general also impact on departments ability to maximize training opportunities*
vii. *Yes, rota difficulties make attending regional teaching difficult at times. Lack of parking at some sites also makes attending teaching challenging at times (e.g. Needing to leave home very early to ensures arriving on time to spend a while trying to park)*
viii. *Rotas that are not necessarily in EM departments but other specialties.*
ix. *Work stress. It makes you resent your work and your colleagues so you try to avoid it wherever possible. It's not healthy and it's entirely fixable. If you red line an engine long enough, it will eventually break. All you need is take your foot off the accelerator once in a while.*
x. *Work pressures*
xi. *Work pressures - working a night rota when there are already staff shortages and insufficient doctors to staff rotas - makes taking holiday/leave difficult and limited to your given rota (sometimes at very LATE notice with absolutely no flexibility)*
xii. *in one hospital only - had to negotiate a training rota with non-clinical managers who hadn't attempted to understand the training needs of an EM HST - eventually successful outcome after months of meetings*
xiii. *Only that some processes such as claiming travel expenses to distant rotations aren't overly clear*
xiv. *During my medical rotation I was unable to attend any study days and couldn't take all my annual leave due to short staffing. Other rotations have been good at accommodating study leave requests.*
xv. *Trying to fit it all in & have a life*
xvi. *No*
xvii. *Staffing levels in ED meaning can be difficult obtaining Study Leave.*
xviii. *No.*
xix. *Always very far away*
xx. *Rota / workload in RGH made training time difficult otherwise no clear concerns.*
xxi. *High quality training (mandatory teaching) is inaccessible to those in the North within the Wales Deanery - not realistically at any rate. There is a kindness extended from the Mersea Deanery that allows us to join them at their EXCELLENT teaching 1/2 days every week. This is a life-saver!! The only disadvantage being the time and costs to travel there. (Still significantly more achievable than traveling South mind you!)*
xxii. *I found training in UHW difficult due to staff motivation at the time*
xxiii. *Long commutes*
xxiv. *During my EM placement I found it impossible to get study leave due to the rota and leave rules. It is difficult in North Wales as the vast majority of educational activities occur in the South. This is a 9 hour around trip on a good day and probably a nights stay as well. With no extra money or leave for travel plus the lack of EM support this makes training in North Wales difficult.*
xxv. *Yes the geography of Wales makes moving between north and south very difficult. Being in the North has been brilliant with very unique experiences. But with everything South Wales based there are likely to be opportunities that I have missed. Some of this has been helped by forming links to Mersey Deanery. I would recommend training in North Wales, but better provision is needed to allow North and South Wales Trainees to meet. Greater study budget to allow for the £150/trip down to South Wales for teaching and training. As it is often a 10-12hr round trip. If an additional stipend/ bursary was allocated to North Wales Trainees above the standard trainee budget this would make training awesome. North Wales is a great place to train in EM, but with South Centric teaching this makes accessing training/ teaching challenging. Primarily due to cost and time. Although efforts have been made to address this in North Wales, with only a small number of Trainees and Consultants this is difficult. Please support Trainees in North Wales. We need Doctors in EM in North Wales.*
xxvi. *No*

SOURCE: AWSEM Trainee Survey January 2017

4.4 Trainees' Perceptions: Work and Career Development.

Trainees' Perceptions: What are the challenges you have encountered in your work in the front line in Wales?

N/A (no challenges)	2	5.13%
Crowding	36	92.31%
Unfilled Rota	32	82.05%
Other (please specify)	11	28.21%
Total Responses:	*39*	



11 other responses:

- i. *There is a deep feeling among us as trainees that we are facing the challenge alone. This is because we don't see management official when really needed, so communication between management and clinical staff is a big challenge to improve. We need to see that somebody else feeling our pain. another challenge is the flexibility of training, credibility and recognition of Emergency Medicine. The strategy for this does not seem to have been developed or implemented well. If there are one, then we do not see it.*
- ii. *In-hospital specialities not always supportive in taking referrals or seeing patients in timely fashion*
- iii. *Running out of resources, e.g. beds, ventilators, dialysis machines etc…*
- iv. *Relations with other specialities makes meeting national guidelines difficult in some health boards. Radiology suppor, in particular.*
- v. *Challenging patients. Expectations greater than what we can provide as an ED.*
- vi. *General public don't know how to appropriately utilise emergency services*
- vii. *Some aggression and violence*
- viii. *Not being able to park. I often turn up to work for a midday start or a 10am start and spend over 60 minutes looking for a space around the hospital - never mind in the hospital carpark!*
- ix. *Lack of access to organised patient pathways for outpatient management. Often requiring referral and admission to specialties to get these organised. Poor access across the whole of North Wales for dental care resulting in a higher than previously experienced attendance for dental issues at the ED (all hours).*
- x. *Rota is very demanding and is not staffed as the Royal College recommend*
- xi. *Rota hours, difficulty taking leave, rural poverty*

SOURCE: AWSEM Trainee Survey January 2017

Trainees' Perceptions: Have the recent changes to the medical contracts in England discouraged you from considering completing your training in England?

Yes	26	66.67%
No	13	33.33%
Total Responses:	*39*	

SOURCE: AWSEM Trainee Survey January 2017

4.5 Trainees' Perceptions: Other / General Comments

Trainees' Perceptions: Do you have any other general comments?

11 other responses:

i. *Proud to work in Wales with an excellent cohort of colleagues and consultants*

ii. *Not knowing where one will be for the whole of their training in advance of applying for jobs is something that should change*

iii. *The general quality of HST in North Wales is reportedly better than most, however there really must be a drive to increase the opportunities to train in all three hospitals in the North, in addition to the already existing OOPT arrangements in Liverpool. (Undoubtedly excellent!) There is a fabulously pragmatic approach to EM training within Wales and without doubt is one of the biggest pro-factors for staying.*

iv. *Referral pathways for tertiary centres are also difficult for us and I wonder if this will get worse if the NHS in England and Wales more further apart. As a holiday destination, I do not know if we get remuneration from English patients. This certainly has not translated to extra front line resources. The lack of a clear plan from Betsi means the are many rumours about the future direction of the trust and this causes unease amongst staff about reorganisation of services especially considering the large geographical area.*

SOURCE: AWSEM Trainee Survey January 2017

Eitem 3

Mae cyfyngiadau ar y ddogfen hon

BMA

Cymru Wales

Indemnity

Concerns relating to indemnity costs for GPs have escalated over the last few months and are now being raised by individual practitioners and whole practice teams covering both in and out of hours General Practice on a regular basis.

There is a pressing need to urgently find solutions to prevent services from collapsing given we are now in the winter pressure period.

Overview

- Increasing reports that rising indemnity costs is making some work, especially Out of Hours work (OOH), prohibitive for GPs. *Consequent impact of this will be on the sustainability of GP services across the 24/7 period.*
- Welsh Risk Pool is available for OOH clinicians working in Health Board run OOH services and has been offered to sessional doctors working in Health Board managed practices. In some cases this has led to lower indemnity premiums, but not in all cases - and it does not cover other private organisations providing some OOH care in Wales i.e. ShropDoc. However, it must be noted that the Welsh Risk Pool does not cover the individual, it covers the organisation that is funding it for its vicarious liability in clinical incidents arising out of a complaint. That means that there other important areas that clinical practitioners need covered, as outlined below, and the frequent comment that "Welsh Risk Pool" is the solution is not as straightforward as it seems.
- Some specific initiatives in England have offered to cover rising indemnity fees:
    1. Clinician presence in 111 call centres – however not all Clinical Commissioning Groups (CCGs) availed themselves of this, and of those that did, it is not known what the impact was on the OOH centres. It is important that careful evaluation of these is carried out given the potential for OOH sessions to be cancelled to enable GPs to work in these pilot services and the subsequent impact of that on the running of OOH Services. One service should not be destabilised to staff another. This is something that Wales needs to be aware of given the development of the 111 service. One positive of GPs working in English 111 centres, however, is that at least one medical defence organisation (MDO) is able to highlight the additional cost of doing unscheduled work in various settings versus scheduled in-hours GP work.
    2. £30 million commitment has been made available each year for two years towards the costs of GP practice indemnity, through a payment to practices of 52p/patient to recognise the increase in indemnity premiums (further details on this scheme can be made available).
- Out Of Hours services have seen little or no investment in Wales since 2004 and this has been widely reported as impacting on the ability to reconfigure services / enable more acceptable terms to be offered to doctors willing to work in OOH centres. This negative impact needs to be reversed.

- Issues of escalating indemnity costs have been long known, and for some time expected to rapidly increase, and we are now seeing the stark reality of that as subscription renewals are received – i.e. doctors are unable to undertake more clinical sessions as it is unaffordable to cover the indemnity costs, or take on additional roles if it adversely affects their premiums. To date, despite representations there has largely been a closed door to addressing this but that now appears to be changing, and the First Minister has made a commitment to work on a solution for GP practices[1].
- It is important to note that while indemnity costs are increasing, this should not be conflated with a decline in patient safety and overall standards. There is clear evidence that the costs of payouts in cases where a patient is awarded damages are increasing. Medical defence organisations have to collect enough money from their members to ensure these pay outs can be made, so it is highly likely that the rises in cost experienced by GPs is related to the increases in damages being awarded. The intention of awarding damages is to put the victim back in a position they were in had the clinical negligence not occurred, which can include loss of earnings and cost of future treatment. These costs are increasing due to factors such as increasing life expectancy and advances in medical treatment. Also, under our present legal system (in England and Wales), each time a novel payout is made, the bar for all future payouts increases.
- The workforce is changing with new, and greater use of, other health professionals in primary care, and thus the risk of their attracting claims has increased due to the rise in consultations they have with patients. ***This changing workforce profile is particularly relevant in Wales with the current recruitment / retention issues and implementation of new models of working in primary care.*** This shift in the workforce has significantly affected group indemnity subscriptions and premiums for individual roles within a practice which again adversely impacts upon practice income. Particular concern has been raised around physician's associates and what level of cover they would attract.
- There is an issue around ensuring the nomenclature and description of these roles is consistent across the board in order that correct subscription rates are applied. There is a need to move away from in hours / out of hours to scheduled / unscheduled care and the environment within which such individuals work (i.e. own patients / other patients with or without access to records).
- It is unlikely that the Medical Defence Organisation costs will reduce, especially as they base costs on actuarial proof of rising claims (for all OOH clinicians). Without tort reform then the costs of each claim is not going to reduce. In addition, there are concerns that the impact of the reduction of the discount rate consultation being undertaken by Westminster will mean higher costs of claims, and thus premiums will have to rise even further.
- There is a need to educate and update doctors in how the defence subscriptions are calculated with respect to assessment of risk and factors that are taken into consideration.
- Expenses are no longer being covered by the Doctors & Dentists Review Body (DDRB) remuneration awards – up until 2 or 3 years ago, the indemnity expense would be largely covered.
- In England, the NHS Litigation Authority and Medical Defence Organisations are reporting liabilities of up to £28.6 billion for claims already in the pipeline. We are not aware of what the figure is in Wales.

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[1] BMJ 'We want the best doctors in Wales, wherever they come from, says first minister' (Oct 2016)

- New potential providers of medical indemnity are emerging – however, the current alternatives to the three main organisations often have limitations to the cover offered and / or exclude certain conditions (e.g. meningitis). The costs of this cover is often prohibitive – some have been quoted upwards of £30k per annum
- The BMA 2016 Annual Representative Meeting voted to request we look into indemnity for whole 24/7 period and it has been suggested that indemnity cover for senior GPs may be a retention "golden egg".

Does the duration of a session affect indemnity?

We are often asked this question, so below we provide an overview of the current situation and the impact it has on clinicians depending on what approach the defence organisations adopt.

- GPC UK and GPC Wales has received many concerns about what constitutes a session for indemnity purposes, in order to ensure that GPs don't inadvertently breach the limitation of their cover. Some MDOs set a fixed or tiered number of sessions, others average the number of hours over the year.
- If doctors are able and willing to do additional sessions, then they need clarity about session duration in order to properly calculate the additional cost to be incurred. It is still unclear whether the MDOs consider a session to be a 4 / 6 / 8 hour shift OR whether one is covered for a "session" irrespective of that duration. The defence organisations need to be clearer on this on their websites and in information sent to GPs.
- The preferred option for GPC Wales is to have an annual rolling average number of sessions to facilitate flexible working. By annualising sessions this will allow holiday periods to be used in calculations, and thus probably reduce costs rather than using weekly session limits. Annual leave would contribute to the number of total sessions you are allowed to work. For example if a doctor works 8 sessions in practice and two in OOH, if their contract / partnership agreement has 8 weeks annual leave (40 days) then this can be taken into consideration in calculating the level of cover for indemnity work and thus put the doctor into a "lower bracket". The Medical Protection Society (MPS) has already adopted this approach. This also ensures that doctors are not over-insuring themselves, which is a concern that has been raised regularly by individual doctors.

Medical Defence Organisations

Below is the information taken from of the three main defence organisations on what they regard as a 'session':

The Medical Defence Union (MDU) website states:

For some members subscriptions are based on sessions. If you are unsure if your subscription is session based or you have any questions about calculating sessions, please contact our membership team on 0800 716 376.

If you do more than one type of GP work, each type of work should be shown on your renewal documents. If we have asked you to calculate an average number of sessions worked per week, please use the following calculation:

Hours per week x *Weeks per year worked ÷ 52 weeks ÷ 4 hours in a session =*

Average number of weekly sessions

Please remember it is your average number of weekly sessions across your membership year on which your subscription is calculated.

The Medical Protection Society (MPS) website states:

Scheduled care sessions are defined as work undertaken during the scheduled opening hours of the practice (Mon – Sun, 8.00am – 8.00pm) where registered patients are seen by appointment and where staff have access to the patient's full general practice records. Unscheduled care is anything that falls outside of scheduled care. This includes care given at any time in walk in / urgent care centres. A session will normally be defined as a half-day. Where this is inappropriate, a session can be considered to be a continuous period of work of between 3.5 and 5 hours. When you are employed for a set number of hours each week, this number should be divided by four to obtain the sessional equivalent for subscription calculation.

The Medical and Dental Defence Union Scotland (MDDUS) website states:

MDDUS classifies a session as a half-day, which is normally a morning or an afternoon and should last no longer than five hours. Likewise, those working in the evening or overnight should classify sessions in blocks of five hours. For example, midnight to 8am should be classified as two sessions.

The questions on what constitutes a session for indemnity purposes which we still need clarity on are:

1. If working late into the night doing practice work e.g. administrative work or running late and last patient appointment is after 6.30pm, do these hours require extra cover? Discussions with MDOs have highlighted that if the extra hours are to do normal practice business then additional cover is not needed, but this assurance is required in writing so that GPs have clear guidance going forward.
2. If doing unscheduled care for just your practice population does that count as "sessions" or "hours" within your normal subscription? This will be relevant as clusters begin to look to offer innovative ways of providing access to patients in response to workload demands.
3. If doing unscheduled care for a group of practices with access to the patient record can you include this within your normal "sessions" or "hours"? Again this is relevant as clusters are looking at novel ways of providing additional access to patients.
4. Out of Hours organisations book sessions of varying duration – therefore, if an organisation books 8 hour sessions does that count as one session or two?
5. Some, but not all, MDOs allow annualisation of sessions. This being universally available could potentially be useful in the event of a pandemic outbreak in that would enable clinicians to do some short term additional work

How is a doctor's individual risk assessed?

This again is important and not well understood across the health care arena.

- As soon as a doctor qualifies and is able to write a prescription autonomously they are classified as a "risk".
- When working in a practice environment where governance is good with clear policies, access to records, knowledge of patients then doctors present a relatively low risk.
- When you take the same doctor and put them in a different role their risk changes – although working unscheduled hours for their own patients with access to records is considered no additional risk.
- Working unscheduled hours for a group of practices with access to records is considered a slightly higher risk.
- Working unscheduled hours in an out of hours or other unscheduled care setting with less familiar patients and without full access to full records makes doctors a higher risk. Similarly, if doctors cover unfilled shifts they are considered a higher risk.
- There are further individualised issues for doctors working in relatively unique areas such as medical journalism and elite sports.

What other factors affect an individual / practice's subscription rate?

- Diversity of workforce e.g. practice nurse claims are rising according to MPS[2]. There is currently a difference in approach across the three MDO organisations – some include cover for nurse practitioners as part of a group policy – others don't.

  Practices are reporting significant increases in premiums due to expanded role of other non-doctor clinicians. GPs need to be mindful of the widening skill mix being used in practices – in particular consideration needs to be given to:

  i. Concept of physicians associates as they are currently unregulated and have variable training –would the defence organisations simply cover these practitioners or would there be a limitation on the claim cover provided which could be dangerous to the practice.
  ii. Clinical pharmacists or other healthcare professionals employed by Health Boards, rather than a practice, will have Welsh Risk Pool cover **BUT** GPs need to ensure any additional or extended roles are covered – this needs discussion / clarification with MDOs as to who provides that cover, and where vicarious liability lies in event of an individual working across groupings of practices.
  iii. Ensuring practices inform their defence organisation who is doing what in the practice to ensure they are adequately covered.

- The amount of sessions / hours worked by the range of roles in the practice.
- Previous complaints.

What about the Welsh Risk Pool?

- Welsh Risk Pool cover is already in place for Health Board run Out of Hours Organisations across Wales (private providers excluded). It also covers many GPs working for NHS

[2] MPS Rising Nurse Claims https://www.medicalprotection.org/uk/practice-matters-issue-1/rising-nurse-claims (2012)

organisations in capacity as a *GP with Special Interest* or HB employed salaried GPs. It has recently been extended to some GP sessional doctors working for HB managed practices.
- It has to be made clear that Welsh Risk Pool in itself does not cover everything as it looks after the organisational risk from a complaint, and in particular only the clinical elements of a complaint. It does not cover:
    1. Criminal proceedings
    2. Disciplinary proceedings, including referral to the General Medical Council (GMC).
    3. Coroners court attendance
- The current liabilities of claims that the Welsh Risk Pool is managing is unknown.
- It is important to remember that the Welsh Risk Pool's core function is to reimburse losses incurred by NHS Wales bodies in relation to clinical negligence, whereas Medical Defence Organisations are subscription-based organisations acting in the interest of their individual members.
- Lastly, Welsh Risk Pool cover cannot simply be extended; if Welsh Risk Pool were able to take on covering all GPs, then there needs to be early discussions with MDOs to identify the "run in" and "run off" cover to ensure that an individual GP or claimant is not left in an uncertain position with respect to a claim. This is mainly around commercial business issues but needs to be considered.

The options?

We are aware that NHS Wales recognises indemnity is an increasing problem. Indemnity premiums are likely to rise given that the Welsh Government's prudent healthcare agenda encourages the shift of care into the community and making best use of all healthcare professionals in delivery. If this aspiration is to be realised a solution to indemnity challenges is certainly required.

Options to address and rebalance this could include:

- **A commitment from NHS Wales that individual practitioners should incur no additional indemnity costs for doing unscheduled care work for 111 or an Out of hours organisation.** This would mean a solution found for those working for a private Out of Hours provider (which the Welsh Risk Pool cannot cover as it is not an NHS Body).
- **A commitment to ensure professionals working across a cluster have their indemnity provided by the Welsh Risk Pool via the HB and that any vicarious liability of practices is underwritten by Welsh Government.**
- **NHS Wales to reimburse all / part payment of indemnity fees** (in line with Welsh Local Medical Committee conference policy).
- **Pay an Out of Hours top up premium for OOH work or other work prioritised by NHS Wales**, recognising unique challenges facing GPs now and in the future (e.g. unscheduled work covering clusters or groupings of practices).
- **Block contracts**: It is not clear if Medical Defence Organisations would wish to look at this but is worth pursuing.
- **A hybrid model** of Welsh Risk Pool Indemnity with MDO top-up for in hours as well as OOH GP care. The fact that practices are engaged with Clinical Governance Self-Assessment Toolkit and regularly have clinical governance reviews, means that the Welsh Risk Pool and the defence organisations can be reassured that all practices in Wales should have good governance of their organisations.

- **Pay a contribution towards GP practice and / or individual clinician indemnity.** This is something that has been mentioned in a few arenas including by one MDO which includes up to two sessions OOH in its subscription levies.

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Mae cyfyngiadau ar y ddogfen hon