MR 22
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.
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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

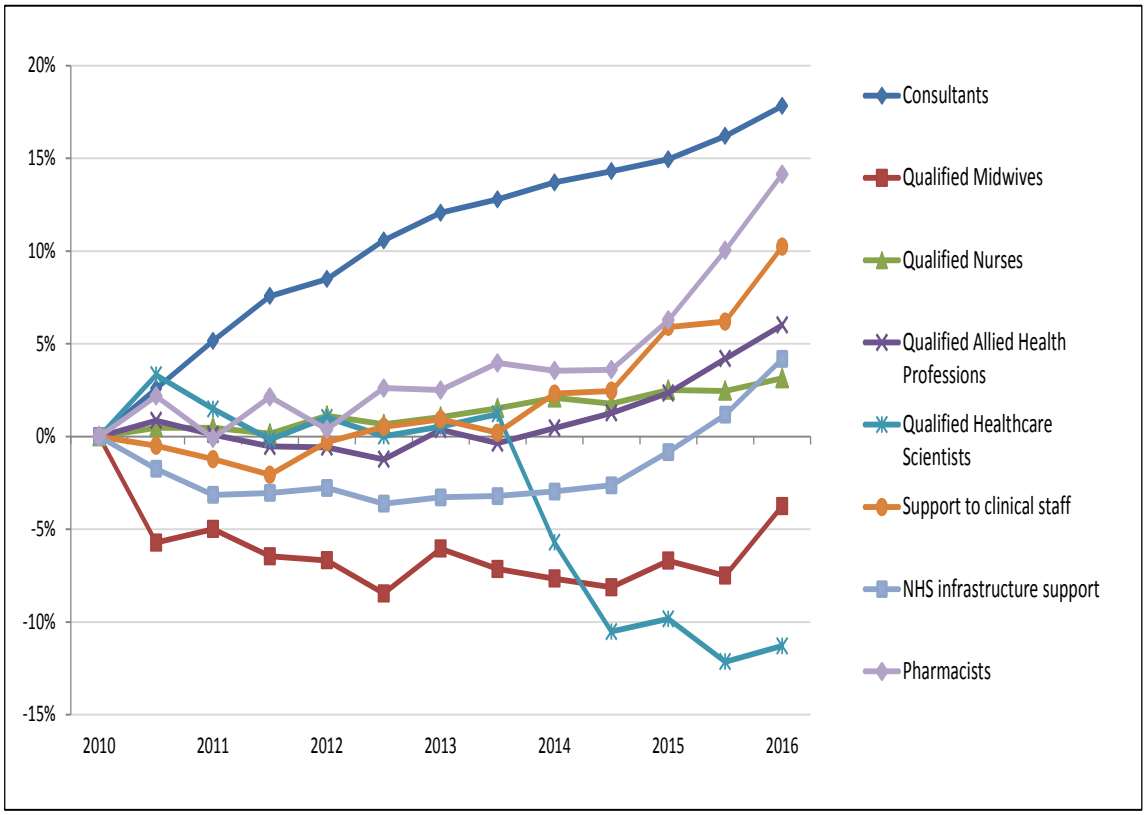
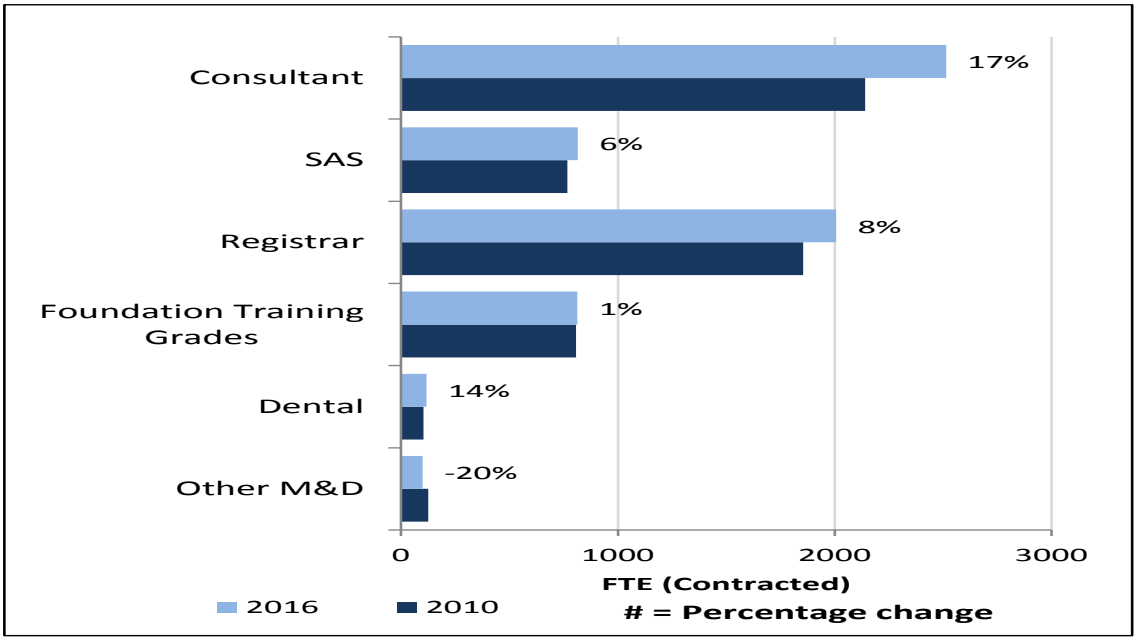


Chart 2: FTE comparison and % variance between 2010-2016 for Medical & Dental grades



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.