Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 3 – Senedd
Meeting date: Wednesday, 8 February 2017
Members' pre-meeting: 09.15
Meeting time: 09.30

For further information contact:
Sian Thomas
Committee Clerk
0300 200 6291
SeneddHealth@assembly.wales

Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

2 Inquiry into medical recruitment – evidence session 3 – BMA Cymru Wales and Royal College of Physicians

(09.30 – 10.30) (Pages 1 – 61)

Dr Charlotte Jones, Chair of the BMA's General Practitioners Committee (Wales)
Dr Trevor Pickersgill, Chair of the BMA's Welsh Consultants Committee
Dr Gareth Llewelyn FRCP, RCP vice president for Wales
Lowri Jackson, RCP senior policy and public affairs adviser for Wales

Break (10.30 – 10.35)

3 Inquiry into medical recruitment – evidence session 4 – Royal College of General Practitioners and GP Survival

(10.35 – 11.35) (Pages 62 – 123)

Dr Rebecca Payne, Royal College of General Practitioners
Dr Isolde Shore-Nye, Royal College of General Practitioners
Dr Linda Dykes, Consultant in Emergency Medicine, Ysbyty Gwynedd and GPwSI in Community Geriatrics, BCUHB (West)
Dr Sara Bodey, GP partner Bradley's Practice, Buckley, Flintshire (GP Survival)

Dr Heidi Phillips, GP Partner Fforestfach Medical Centre, Swansea and Director of Admissions for Swansea Graduate Entry Medicine programme (GP Survival)

Break (11.35 - 11.40)

4 Inquiry into medical recruitment - evidence session 5 - Professor Dean Williams

(11.40 - 12.20)

Professor Dean Williams, Bangor Medical School

5 Paper(s) to note

Stage 1 scrutiny of the Public Health (Wales) Bill - Additional information from the Minister for Social Services and Public Health

(Pages 124 - 125)

6 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

7 Inquiry into medical recruitment - consideration of evidence

(12.20 - 12.25)

8 Inquiry into primary care - consideration of plans for future meetings

(12.25 - 12.30) (Pages 126 - 127)

Agenda Item 2

Document is Restricted

MR 20
Ymchwiliad i recriwtio meddygol
Inquiry into medical recruitment
Ymateb gan: Cymdeithas Feddygol Prydain (Cymru)
Response from: British Medical Association (Wales)

INQUIRY INTO MEDICAL RECRUITMENT

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

Response from BMA Cymru Wales

18 November 2016

INTRODUCTION

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

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 160,000, which continues to grow every year. BMA Cymru Wales represents almost 8,000 members in Wales from every branch of the medical profession.

RESPONSE

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

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

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

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

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

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

As we also outlined in our submission to the wider inquiry into the sustainability of the health and social care workforce, the capacity of the medical workforce is failing in many regards to keep pace with increasing demand and is already therefore under strain in relation to current demand. This is particularly the case within primary care where there is an increasingly acute recruitment and retention challenge amongst GPs against a backdrop where demand is continually increasing as a result of an ageing population and an increasing prevalence of chronic disease.

There are also increasing recruitment and retention challenges amongst certain specialties within secondary care which have been the driver for various service reconfiguration proposals in recent years across different

[2] Evans M, Phillips CJ, Roberts RN & Salter D (2015) *Health Professional Education Investment Review*. Available at: http://gov.wales/topics/health/publications/health/reports/education-investment-review/?lang=en

health board areas. Increasing use of locum doctors, and increasing overtime costs being reported by health boards amongst medical staff, are also signs that the current workforce provision is under severe strain.

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

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

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

Taken in the round, these indicators suggest that the workforce is struggling in many regards to provide for current health and care needs, and these challenges will no doubt become greater in the medium- to long-term as demand for service provision increases.

---

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

[4] Jenkins D, Phillips C, Cole S & Mansfield M (2016) *NHS Wales Workforce Review*. Available at: http://gov.wales/topics/health/publications/health/reports/workforce/?lang=en

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

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

Other challenges can result from changes in the make-up of the workforce. For instance, the proportion of medical staff who are female has rightly been increasing. Whilst we would certainly view this as something to be celebrated, it does need to be recognised that female doctors are, quite reasonably, more likely to choose to take career breaks or work less than full time for family reasons. In addition we have previously suggested that work should be commissioned to explore the multifactorial complexities behind why 40% of female GPs in the UK have left the profession by the age of 40. These factors mean that a greater number of doctors needs to be trained and/or recruited to maintain workforce provision.

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

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

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

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

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

The implications of Brexit for the medical workforce:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As we outlined in our earlier submission on the wider topic of the sustainability of the health and social care workforce, factors which can influence where junior doctors choose to locate to undertake their training include: high quality training; access to funded study leave; evidence of exam success; research opportunities; access to a good social life and quality of living; availability of good career opportunities for their spouses or partners; and access to good schools for their children.

In England, we are aware that provision has now been established for junior doctors who are partners or spouses to be able to submit linked applications. This can assist them to secure training posts within the same geographic area. We would support such an initiative also being introduced in Wales.

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

With regards to staff retention, which in many ways may be more of a concern than recruiting new staff, we would reiterate the points we made in our earlier response. There is a need to address the factors which are driving doctors to reduce their working hours, leave the profession or retire. These include: workload pressures; working conditions; the extent to which doctors feel valued and empowered to influence decisions or be listened to and able to raise concerns without fear of recrimination; the bureaucracy around processes such as revalidation; pension changes, including the impact on pensions of those doctors continuing to work beyond a certain stage in their careers; and worsening sustainability challenges for many GP practices.

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

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

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

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

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

Inquiry into medical recruitment

RCP Wales response

We need to show vision and national leadership

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

We need to invest in the medical workforce

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

We need to support the clinical leaders of the future

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

We need to develop a new way of working

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

Inquiry into medical recruitment

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

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

The capacity of the medical workforce to meet future population needs

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

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

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

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

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

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

The implications of Brexit for the medical workforce

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

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

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

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

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

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

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

The development and delivery of medical recruitment campaigns

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

What could we offer junior doctors in Wales?

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

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

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

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

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

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

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

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

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

More information

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

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

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

Physicians on the front line

The medical workforce in Wales in 2016

Mission: Health

Foreword

The Royal College of Physicians (RCP) president, Professor Jane Dacre, recently warned that today's NHS is 'underdoctored, underfunded and overstretched'.[1] These observations apply as much to Wales as to the rest of the UK. For the Welsh NHS to achieve its full potential to serve the people of Wales, it requires adequate resources and a committed, fully operational and integrated healthcare workforce, allied with good morale and professional satisfaction.

Wales suffers from recruitment and retention issues among the medical workforce, at both senior and junior levels. The issues underpinning these problems are varied and complex, and include geography, negative perceptions and a lack of inducements to encourage doctors to follow a career in Wales. The RCP in Wales believes that there are many initiatives that we could and should adopt to overcome these issues. I hope these ideas stimulate debate and discussion and result in action.

Delivering change in Wales

In 2014, the RCP published *Rising to the challenge: Improving acute care, meeting patients' needs in Wales*, which interprets the Future Hospital vision for the Welsh health service.[2] Through our 'local conversation' visits to hospitals across Wales, we have gathered numerous case studies where fellows and members are driving forward the Future Hospital vision and improving patient care.

Ahead of the National Assembly for Wales election in 2016, the RCP also launched *Focus on the future: Our action plan for the next Welsh government*, in which we argued that the case for change is clear.[3] Those working in the NHS have a responsibility to lead this change, supported by the organisations that represent them and empowered by national policymakers. Organisations and professionals involved in health and social care – including doctors, nurses, politicians, hospitals and national bodies – must be prepared to make difficult decisions and implement radical change where this will improve patient care.

Dr Alan Rees MD FRCP
Outgoing RCP vice president for Wales

At a glance

- The health sector employs an estimated 129,000 workers. This equates to 8% of jobs in Wales.[4]
- The NHS Wales workforce accounts for 62% of health boards' expenditure, or almost £3 billion a year.[5]
- The medical workforce makes up 8.5% of the total NHS workforce in Wales.
- The NHS in Wales spends around £350 million to support approximately 15,000 students and trainees undertaking health-related education programmes.[6]
- A third of core medical training (CMT) places were unfilled in Wales in 2016.[7]
- Only 30% of Welsh medical school undergraduates are Welsh domiciled. This compares with 85% in Northern Ireland, 80% in England and 55% in Scotland.[8]
- Only 39.5% of trainee physicians in Wales would recommend medicine to a school leaver.[9]
- In 2015, 39.8% of consultant physician appointments in Wales could not be made.[9]
- Only 43.7% of consultant physicians contribute to the acute rota in Wales.[9]
- Almost half of the consultant physicians in Wales say that there are times when they feel as though they are working under excessive pressure.[9]
- Only 76.7% of trainee physicians in Wales say that they are satisfied with their career choice.[9]
- The NHS Wales spend on agency medical staff has risen by 64% since 2014–15 and is projected to exceed £8 million by the end of 2016.[10]

Time for action

The NHS in Wales is facing a number of urgent challenges. Hospitals are struggling to cope with the combination of an ageing population and increasing hospital admissions. Between 2005 and 2014, the population of Wales increased from around 2.97 million to 3.09 million, and it is projected to increase to over 3.3 million in 2036.[11] In 2014, one in five Welsh residents were over 65 years old and Wales has a higher proportion of people aged 85 or older than the rest of the UK.[12]

All too often, our most vulnerable patients – including those who are old, who are frail or who have dementia – are failed by a system that is ill-equipped and seemingly unwilling to meet their needs. Furthermore, levels of ill health increase with levels of area deprivation. In general, those in the most deprived areas report the worst health.[13] Wales has the highest rates of long-term limiting illness in the UK, and this accounts for a large proportion of unnecessary emergency admissions to hospital. Around half the adults in Wales are being treated for an illness or condition such as high blood pressure, heart disease, arthritis, respiratory illness, mental illness or diabetes, and a third report a limitation in their daily activities due to a health problem or disability.[14] One in five adults reports fair or poor general health and the percentage who report being treated for specified illnesses generally increases with age.[13]

The rural geography of much of Wales means that some medical services are spread very thinly. This is having a negative effect on the quality of training and on workforce recruitment in some specialties. In addition, patient expectations are increasing as financial constraints grow ever tighter and, while advances in technology can save lives, the cost of providing specialist acute care continues to rise.

Legislative changes to working hours mean that we need more junior doctors to cover hospital rotas. This has happened at the same time as a reduction in training time due to the Modernising Medical Careers programme, and a fall in international medical graduates coming to the UK. In 2011, almost half of the higher specialty trainee physicians told us that since the introduction of the European Working Time Directive, the quality of both training and patient care was worse or much worse.[15]

As the population grows older, and an increasing number of people develop complex chronic conditions, there is an increased need for consultants with qualifications in general internal medicine so that patients can be managed holistically. However, in Wales, only 43.7% of consultant physicians contribute to the acute rota while 52% participate in the general medical rota.[9] There is also a great deal of variation between RCP specialties. For example, almost all consultants working in stroke, respiratory or acute internal medicine in Wales participate in the acute take. However, the figures for renal medicine (36.4%) and cardiology (36.8%) are much lower, and in some specialties, there are no consultants at all who participate in the acute take in Wales.[9] In the future, the acute admissions workload will need to be more evenly distributed between all specialties in order to allow more flexibility and prevent the unmanageable workload of acute medicine falling on the few.

At the same time, the composition of the workforce is also changing. More consultants are working flexibly or part time. To some extent, this is because there are now more women in the medical workforce – between 2007 and 2012, the number of female doctors under 30 years old increased by 18%, and in 2012, 61% of doctors under 30 years old were women.[16] The 2015 census of consultant physicians found that 33.3% of female consultants in Wales work part time, compared with 8.8% of male consultants. This trend in changing working patterns raises issues about the total number of doctors that will be required in the future if the proportion of those working part time continues to grow. If a consultant works part time, their relative contribution to the acute medical take can vary hugely. We will need to see an increase in training posts to allow for an increase in less-than-full-time working in the future.

It is worth noting that there are difficulties recruiting for many specialties in most parts of the UK, not just in Wales, and 72.7% of higher specialty trainees would still choose to train in Wales if they could turn back time.[9] However, there are trainee vacancies in every acute hospital rota in Wales, and last year, the NHS in Wales was unable to fill 39.8% of the consultant physician posts it advertised.[17] In a majority of cases, health boards were unable to appoint because there were simply no applicants.

The complexity of the challenge

The RCP report *Hospitals on the edge?*[18] set out the magnitude and complexity of the challenges facing healthcare staff across the UK, and the impact that this can have on patient care. It described:

- **a health system ill-equipped to cope with an ageing population with increasingly complex clinical, care and support needs**
- **hospitals struggling to cope with an increase in clinical demand**
- **a systematic failure to deliver coordinated, patient-centred care, with patients forced to move between beds, teams and care settings with little communication or information sharing**
- **health services, including hospitals, that struggle to deliver high-quality services across 7 days, particularly at weekends**
- **a looming crisis in the medical workforce, with consultants and trainee doctors under increasing pressure.** ■

Underfunded, underdoctored, overstretched

The NHS offers some of the highest-quality, most efficient and most accessible healthcare in the world, coming top of the Commonwealth Fund ranking of world health systems.[19] The UK has a long tradition of medical innovation,[20] and doctors working across the NHS continue to make ground-breaking medical discoveries that change the way we treat disease and care for patients. Our clinical guidelines are exported around the globe, and we attract international doctors with our world-renowned programmes of medical education and training.

That's a lot to be proud of. However, it's no excuse for complacency. The RCP has long argued that we need to rethink the way we deliver healthcare: breaking down barriers between hospitals and the community, and working in partnership with patients to deliver joined-up care.[21] To achieve this, we need a health service that is funded to meet the demands placed on it by our growing population.

The NHS budget has not kept pace with rising demand for services. Nor do we train enough doctors. The number of medical students has fallen and there is a shortage of doctors training to be medical specialists. More than a third of higher specialty trainees in Wales regularly or occasionally act down to cover rota gaps.[9] This workforce crisis has had a knock-on effect on consultant posts, with Welsh health boards failing to fill two in five of the posts that they advertise.[9]

NHS staff increasingly feel like collateral damage in the battle between rising demand and squeezed budgets – and when NHS staff wellbeing suffers, patient safety and experience suffer too. Overall, 95% of UK RCP trainee doctors report that poor staff morale is having a negative impact on patient safety in their hospital.[22]

The Welsh NHS needs a new long-term vision – no more quick fixes or temporary solutions. We need urgent action to address the immediate impact of an underfunded, underdoctored and overstretched NHS. The RCP believes patients deserve an NHS that is funded and staffed to meet their needs, now and in the future.

Key recommendations

The RCP has identified the following key priorities:

Show vision and national leadership

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

Invest in the medical workforce

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

Support the clinical leaders of the future

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

Develop a new way of working

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

The need for national leadership

Patients deserve access to high-quality care from a well-qualified workforce. Equally, doctors and other health professionals deserve to work in well-supported environments, with staffing levels that promote safe, high-quality effective care and enable them to progress their careers.

A perfect storm is fast approaching: to combat the growing medical recruitment crisis, increasing locum and agency costs and an over-reliance on trainee doctors, the NHS in Wales must be given the power and resources to develop radical solutions and take collective action, supported by strong government commitment and national leadership.

A vision for the future

A clear, refreshed strategic vision for NHS Wales should be developed. Successive reviews in the past few years have repeated this same call to action (including the Health Professional Education Investment Review[23] and the Jenkins review of the NHS workforce in Wales[24]) and yet it is still not clear how the Welsh government intends to work with patients and clinicians to do this.

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

A sustainable workforce is the biggest challenge facing NHS Wales in the coming years ... There are well-publicised concerns about staff shortages in some areas, and whether the right numbers and roles of medical and healthcare staff are being recruited and retained to provide care in the future.[25]

Planning the medical workforce

More specifically, there is currently no real national strategic approach to medical workforce planning in Wales. Over the years, this has contributed to recruitment and retention challenges in the medical workforce, especially among trainee doctors. As a matter of urgency, the Welsh government must work with the NHS and medical education bodies to develop a clinically led national medical workforce and training strategy which ensures that staff are deployed and trained effectively, now and in the future. Wales has a real opportunity to develop an innovative model, and we urge that clinical leadership be placed at the very centre of that process.

The Welsh government, health boards and medical education providers must acknowledge the delicate balance between service needs and training issues and develop innovative workforce models. Every hospital in Wales depends on its trainees and there are huge implications when a unit loses its training status. Physicians working in rural and remote hospitals should be supported by colleagues working in other hospitals, not only with service provision, but also with teaching time. Hospitals across Wales should work as a collection of formal, structured alliances operating hub-and-spoke or integrated care networks. Politicians must show national leadership and support innovative solutions to keep these units sustainable.

Patient-centred service change

Reconfiguration must be patient centred, clinically led and evidence based. It must not be solely about cutting costs. Hospital services must be redesigned using a whole-system approach and secondary care clinicians should be at the very centre of this service planning. Hospitals and health boards should establish the role of chief of medicine, supported by a chief registrar, providing a direct clinical link between management, physicians and trainees.

Ministers should publicly support and promote the patient-centred Future Hospital model as a template for clinically led service redesign. The Welsh government should talk to local health and social care services about how they are embedding Future Hospital principles. Health planners should support clinicians by removing barriers to delivering the future hospital. The RCP will continue to work directly with health boards and clinicians by sharing good practice from Future Hospital partners across the UK.

All of this will need a drastic change in mindset. The RCP has long called for more clinical leadership and engagement, and more joined-up thinking between service planning and training needs. Now it is time to rethink how the future NHS workforce will train, develop their skills and practise medicine.

On the front line: What do consultant physicians do?

A consultant physician is a senior doctor who practises in one of the medical specialties. Once specialty training has been completed, doctors are able to apply for consultant posts. The typical consultant physician's time may be split between working with inpatient teams, in outpatient clinics, undertaking procedural lists and seeing newly admitted patients.

- **Responsibilities to inpatients. A consultant physician will have ultimate responsibility for any inpatients assigned to their care. They lead the inpatient team, and help to resolve ongoing issues regarding diagnosis, treatment and discharge decisions.**
- **Outpatient clinics. Patients referred, typically from primary care, are seen by consultant physicians for specialist advice. These clinics could be for general advice or around a specific condition or complaint.**
- **Procedural lists. Many specialties have procedural lists that consultant physicians are expected to undertake, such as colonoscopy (gastroenterology) or bronchoscopy (respiratory).**
- **The acute take. Many consultants will have responsibility for all patients admitted to a hospital over a set time period. These patients will be seen and the physician will ensure a diagnosis and appropriate management plan are agreed.**

The role differs greatly between specialties due to the nature of the work. For example, some consultant physicians have no assigned inpatients to their care and spend the majority of their time in outpatient clinics. They are often available for advice and consultation.

The work of the consultant goes beyond direct patient care. Consultant physicians are also expected to be involved in the teaching and training of students and junior doctors and to supervise the clinical and educational development of trainee physicians. They must also ensure that their own learning is contemporary by undertaking professional development and continuing to learn new skills and procedures. They may contribute to the understanding of their specialty through research.

It is usual for consultant physicians to take on leadership responsibilities, such as coordinating a rota for the team or developing policies for the department. They may also undertake a more formal role with the health board, such as clinical director; with the RCP, such as college tutor; or with the deanery, such as training programme director. ■

Dr Richard Gilpin and Dr Charlotte Williams
Trainee physicians, NHS Wales

Medical staff recruitment problems are threatening the existence of many hospitals and general practices in Wales. We need to train more doctors and nurses in Wales with the aim of retaining them to work in Wales. The tension between service and training needs to be addressed by developing a national workforce strategy.

Consultant physician in Wales

We need to move away from a workforce model in which we invest in either primary or secondary care, and towards more integrated team working – the hospital without walls – where specialists hold more of their clinics in the community, and GPs spend part of their time working with colleagues at the front door of the hospital. It's also important to remember that 80% of health professionals who will be delivering care in 10 years are already working in the NHS today.[5] We need to build on the skillset of our current workforce to deliver new models of care in the future.

Investing in a new way of working

The level of funding for the health service is a political choice. Based on estimates by the Nuffield Trust that there could be an unprecedented funding gap of £2.5 billion by 2025/26 in Wales,[12] the Welsh government will need to increase health spending. However, it is vital that this money does not go towards propping up the old, broken system. Ministers must promote innovative models of integration and introduce shared budgets that establish shared outcomes across the local health and care sector. Spending money on the existing system will not change anything in the long term; health boards must invest in prevention and treatment of chronic conditions and allow clinicians to innovate.

The Welsh government must promote informed public debate on local health service redesign, nationally and locally. Politicians in all parties have a real responsibility to support clinically led, evidence-based change that will deliver better care for patients. Health boards and the Welsh government must ensure that change is genuinely led by patients and clinicians, and not presented as a 'done deal' at a late stage in the planning process.

Investing in the medical workforce

Workforce planning must be a key priority. General medicine must be valued and urgent action taken to ensure that more physicians contribute to the acute take.

The Welsh government must work with colleagues in the NHS, postgraduate and undergraduate medical schools, and the royal colleges to assess how the current medical workforce needs to adapt to deliver the future model of care required by patients. The medical workforce will need to adapt to deliver continuity of care and the integration of hospital and community care in a sustainable fashion. The shape and skillset of the workforce required must be defined at a national and local level.

Taking a strategic approach

The UK has fewer doctors per head than almost every other major EU country.[1] Together with a shortage of nurses,[26] this has left our hospitals chronically understaffed, which increases pressure on hard-working NHS staff, puts patients at risk and threatens the future of the NHS. We need immediate action to relieve the current pressure on the NHS workforce, and a brave, coordinated plan to ensure that the NHS is staffed and sustainable in the long term.

The Welsh NHS needs to start planning now to ensure a strong medical workforce for the future. Over the coming years, we will need more general physicians, especially as we work towards delivering more specialist care in the community.

It is vital that we join up workforce planning with service reconfiguration. Education and training strategies should be aligned with 2017–18 NHS Wales integrated medium-term plans.[25] We need to take a national look at the future of our health service: it is likely that post-reconfiguration in Wales, we will have a smaller number of major acute hospitals providing specialist care, with other smaller sites providing ongoing secondary care, as well as an increased provision of community care.

Spreading the load

RCP consultants and trainees manage the bulk of adult emergency medical admissions into our hospitals in Wales and almost all out-of-hours cover for adult wards. Many combine general medicine with another specialty such as cardiology, stroke or respiratory medicine. Physicians care for a wide variety of patients who may be suffering from any of a number of common disorders, may have multiple conditions or complex needs, or may represent a diagnostic puzzle; it is the physician's responsibility to coordinate these patients' continuing care.

The sector also continues to raise concerns about the sustainability of the medical workforce in acute (hospital) services. Local health boards report that some specialties are difficult to recruit ... The shortage of adequately-trained medical staff has led to some services being considered unsafe.[28]

However, more and more consultants are choosing to opt out of the acute medical take. In 2012, the majority of unselected acute and general medical patient care in Wales was carried out by physicians practising in only six of the thirty RCP specialties.[27] Furthermore, the latest census shows that 58.5% of higher specialty trainees in Wales would not choose to train in general medicine if they could turn back time.[9]

General internal medicine is increasingly perceived to be a high-stress specialty with an extremely high workload. In Wales, 48.5% of consultant physicians say that there are times when they feel as though they are working under excessive pressure, with 35.4% saying that this happens often. Most concerning, 92.3% of consultant physicians tell us that they sometimes, often or always find themselves doing jobs that would previously have been done by a junior doctor.[9]

In 2016, the NHS in Wales was unable to fill 39.8% of the consultant physician posts it advertised.[17] This failure to appoint is even higher for in-demand roles focused on caring for acutely ill and older people.[29] Despite the continuing increase in demand for experts in geriatric medicine, the number of training places for this specialty fell in 2015.[29]

The acute admissions workload should be more evenly distributed between all specialties. General internal medicine should be recognised as one of the most important and most challenging specialties in acute care, and urgent action must be taken to transform it into a high status job. A larger number of physicians working in general internal medicine would allow more flexibility and prevent the unmanageable workload of acute medicine falling on the few. This would also provide the best patient care for the growing number of patients with multiple long-term conditions, and is key to the success of the proposed shift from hospital care to community care.

Reorganising the unscheduled care workforce

In recent years, Morriston Hospital in Swansea has been experiencing major challenges in delivering unscheduled care services. Doctors were faced with a 100% bed occupancy rate in medicine, a high proportion of medically fit patients occupying acute medical beds and system blockages leading to delayed transfer of care. The medical team decided to address these problems by reorganising their medical workforce and acute medical service using Future Hospital workforce principles.

The hospital has now restructured its working patterns to ensure greater involvement at the hospital front door during the week and at weekends, with immediate access to all medical specialties, including frail and older peoples' services, and the establishment of an ambulatory care service. This has resulted in improved patient flow, a consultant-delivered inpatient service, and the daily weekday review of patients by a senior doctor, working towards a 7-day service.

Consultants at Morriston have signed up to the following principles: all patients will have a named consultant, doctors will assume clinical leadership for safety, clinical outcome and patient experience, every patient will have a detailed clinical management plan based on continuity of care. Physicians will have an increasing role in general and unscheduled care. A consultant physician will be present in the hospital 12 hours a day, 7 days a week, with a second consultant present at weekends.

To achieve all this, specialty-based ward teams were established. All the specialties were group job planned and asked to deliver these standards with a particular focus on unscheduled care and inpatient work. This meant that they had to divide the work between themselves and most have rotas with one or two consultants doing predominantly inpatient work for 1 month at a time. The redesign needed significant investment and the health board agreed to the appointment of a number of extra physicians to deliver general medicine with a focus on frail and older patients.

The team at Morriston can list a number of successes so far. There are now consultant ward rounds 5 days a week and the specific standards listed above have largely been achieved. Geriatric medicine provides an in-reach service to the acute medical admissions unit (AMAU). There are also daily retrieval visits to the AMAU by stroke, gastroenterology and respiratory specialists. There are two consultants on call at weekends, a reduction in length of stay, and medical outliers on surgical wards are down to single figures.

Access to the stroke unit has improved. However, medical recruitment is the greatest single challenge we face. We have failed to fill four consultant posts this year. Of 26 core medical training posts, 13 were unfilled in August 2016. Future progress is uncertain unless medical recruitment in Wales can be improved. ■

Dr David Price
Clinical director of medicine, Morriston Hospital
Abertawe Bro Morgannwg University Health Board

Underdoctored: What can we do in the short term?

- **NHS Wales should adopt a more joined-up, nationally coordinated approach to recruitment.**
- **Health boards should invest in physician associate roles which can free up trainee time for education.**
- **Health boards should reinvest unspent trainee money in new roles, eg clinical fellowships.**
- **Community placements for medical students and trainees should be further developed.**
- **Graduate entry into medical school should be encouraged, especially for Welsh domiciled students.**
- **Both undergraduate and postgraduate medical training should focus on long-term conditions.**
- **Accreditation and structured support for teaching hospitals should be considered.**
- **Using technology in a more innovative way, especially in rural areas, should be encouraged.**
- **Rural medicine, especially in mid-Wales, should be developed as an advanced medical specialty.**
- **Develop Certificate of Eligibility for Specialist Registration (CESR) conversion courses with structured mentoring and support for staff and associate specialist doctors.**

Consultants should be required by their employers to complete continuing professional development (CPD) in internal medicine as well as their specialty and the majority of medical trainees should train dually in internal medicine and their specialty, supported by consultant supervision and feedback.[30] Physicians working in non-training middle-grade jobs should also be supported to develop their careers and enhance their professional skills. Health boards must take swift action to prioritise the acute take and ward cover in consultant job plans, although this will need careful planning to ensure that it does not come at the expense of specialty commitments. Health boards must also recognise the risk to the service of losing those consultants who are nearing retirement, and act to retain these senior physicians and their knowledge and experience for as long as possible, especially in more remote hospitals.

Building the evidence base

The Welsh government, NHS Wales, the Wales Deanery, the royal colleges and universities should work together to invest in data collection which would provide a robust evidence base for medical recruitment strategies and campaigns. We need to better understand the drivers for recruitment and retention. Not enough research has been done so far, and too many decisions are based solely on anecdotal evidence about why we cannot recruit doctors to work in the Welsh NHS.

A healthy NHS workforce

The Welsh government should invest in the health and wellbeing of its NHS workforce by implementing National Institute for Health and Care Excellence (NICE) public health guidance for employers on obesity, smoking cessation, physical activity, mental wellbeing and the management of long-term sickness. Staff engagement and wellbeing are associated with improved patient care and better patient experience. The Welsh government should consider staff health and wellbeing as part of its medical workforce and training strategy, invest in mentoring and coaching schemes, and promote national sharing of good practice on staff health and wellbeing. Health boards should also take a greater interest in consultant and trainee welfare. Trainees who move between different health board employers on a regular basis report frequent problems as a result, including unreasonable rotas, little notice of shift allocation, inflexible working patterns, payroll errors and missed salary payments, and difficulty getting access to passwords and login details during the changeover between hospitals. These experiences mount up over the years, and can have a considerable negative effect on workforce morale. Having one single employer – NHS Wales – instead of separate health board and trust employers could help to ensure that all junior doctors are treated and valued as long-term NHS employees during the length of their training rotations.

A new workforce model

The Royal Glamorgan Hospital in Llantrisant is a district general hospital with around 61,400 emergency department attendances every year. Around 30% are admitted. The board serves a population with extremely high rates of deprivation and faces major recruitment challenges. Only 15% of the medical intake was being managed on an ambulatory basis, and medical patients were often managed on non-medical wards.

We decided to create a single medical division, combining medical and emergency care. We defined the skills and competencies needed for each stage of the patient experience, and then designed the workforce around these competencies. We ensured that paramedics were able to refer directly to medicine, increased the number of staff on the rota, and developed the internal medicine team. We also reorganised the nurse teams and developed the role of medical team assistant. The new workforce model has made it easier to recruit, increased ambulatory care to 25% of cases and improved patient satisfaction. It has decreased the time from 999 arrival to consultant physician review, and there are fewer medical patients in non-medical beds. ■

Dr Ruth Alcolado
Clinical lead for medical remodelling
Cwm Taf University Health Board

Supporting the clinical leaders of the future

Good care in the future depends on good training now. Medical education and training must be prioritised when designing health services. Patients deserve to be cared for by expert doctors.

Trainee and medical undergraduate numbers must be increased. Junior doctors and medical students must be supported and encouraged to stay in Wales by being offered innovative new training pathways, an improved workload, and more opportunities to take part in clinical leadership and quality improvement programmes.

Underdoctored and overstretched

The UK does not train enough doctors to meet demand. There are fewer medical students now than in 2010,[31] despite an increasing number of patients. The number of qualified doctors training to be medical specialists has also fallen,[29] and in recent years there have been difficulties in filling significant numbers of specialty training posts.[32] The shortage of medical registrars increases the pressure on existing doctors-in-training, discourages CMTs from moving into these roles and compromises patient care.

Wales currently struggles to recruit enough trainees to fill hospital rotas; 33% of core medical trainee places were unfilled in 2016.[7] This problem must be tackled head on; the Welsh government and NHS Wales must take action to promote Wales as an excellent place to live and work as a doctor.

The 2015–16 census found that 16.7% of higher specialty trainees have considered leaving the medical profession entirely in the past year, and only 31.7% think that they are finding an appropriate balance between training in general medicine and in their main specialty.[9] Even worse, 11.6% of higher specialty trainees told us that they rarely enjoy their job, and 62.8% said their job sometimes, often or always gets them down.[9]

Recruitment problems are threatening the existence of many hospitals and general practices in Wales. We need to train more doctors and nurses in Wales with the aim of retaining them to work here.

Consultant physician in Wales

The trainee recruitment crisis feels like an oncoming train at the moment … it is difficult to get hospital management, who are responsible for our day-to-day working, to acknowledge this.

Trainee physician in Wales

Not so 'junior': The journey from medical student to consultant

- **5 years at medical school.** After medical students complete their undergraduate medical degree, they enter postgraduate medical training.
- **2 years of foundation training.** This is the first stage of postgraduate training. Referred to as junior doctors, doctors-in-training or trainees, they work on rotations across the NHS, including in hospitals and GP practices.
- **2 years of core medical training (CMT).** Trainees have made the choice to become a physician (rather than a GP, surgeon or other type of doctor). They do four to six rotations in different medical specialties. Some medical trainees take a different route and enter the acute care common stem (ACCS), which combines 3 years of acute medicine, critical care, anaesthetics and emergency medicine.
- **4 years of specialty training (ST).** Trainees have now decided what type of hospital specialist they want to be, choosing from around 30 medical specialties including cardiology and geriatric medicine. They take on increasingly senior roles, including as the medical registrar. At the end of specialty training, doctors can apply for a consultant post. It is worth remembering that many trainees spend valuable additional years doing academic research, participating in leadership programmes, or gaining experience in other countries. This increases the overall length of training time. ■

What could we offer junior doctors in Wales?

- structured mentoring and support programmes
- more clinical leadership and quality improvement opportunities
- more innovation and academic research opportunities
- taught MSc and MD degree opportunities
- more flexible working patterns and training pathways
- one-off grants to ease the financial burden of professional exams. ■

On the front line: What do trainee physicians do?

Doctors-in-training, often known as trainees or junior doctors, deliver patient care in a range of settings as well as meeting annual objectives to progress their training. These terms cover doctors who have a range of skills and experience from those who have graduated from medical school in the past year to those who have been practising medicine for over a decade and are preparing to complete their training and become consultants.

They are responsible for assessing and admitting the majority of unwell patients who attend hospital via emergency or A&E departments and outside of normal working hours, as well as looking after inpatients on the ward. A typical day includes identifying all patients for which their team is responsible and ensuring they are all seen and reviewed on a ward round; booking and reviewing tests and diagnostics; communicating with patients, relatives and other medical teams; and making arrangements for patients to be discharged. They may also see patients referred from the community in an outpatient clinic to decide ongoing treatment and support and undertake routine procedure lists.

They are usually the first to attend an unwell or deteriorating patient and have no option to opt out of weekend, overnight or shift work. Posts are rotated every 4 to 6 months, with longer posts of up to 1 year offered to more senior trainees. These ensure that trainees are exposed to range of learning environments and skills, and can be in multiple different hospitals or areas.

They are also responsible for their own professional development. They have to undertake a set number of supervised procedures to ensure competence. Doctors-in-training must complete professional examinations, which for trainee physicians includes the three-part MRCP and specialty examinations with written and practical elements. They also must ensure their learning is up to date through reading journals and attending courses and conferences. ■

Dr Richard Gilpin and Dr Charlotte Williams
Trainee physicians, NHS Wales

My personal view is that bespoke training, flexibility and mentorship alongside widespread opportunities to develop medical education, leadership or research skills from an early stage are the key to fantastic training.

Trainee physician in Wales

Table 1 Number of unfilled core medical trainee (CMT) posts in Wales, August 2016[7]

Site	Posts (total)	Vacancies
Ysbyty Wrexham	14	5
Ysbyty Glan Clwyd	18	11
Ysbyty Gwynedd	16	6
Bronglais Hospital	4	4
Withybush Hospital	10	8
Glangwili Hospital	7	3
Prince Philip Hospital	5	3
Morriston Hospital	29	13
Singleton Hospital	10	1
Princess of Wales Hospital	9	5
Royal Glamorgan Hospital	10	3
Prince Charles Hospital	13	2
Velindre	4	0
Holme Towers	2	0
Nevill Hall Hospital	11	1
Royal Gwent Hospital	24	6
University Hospital Wales	26	3
University Hospital Llandough	6	0
Total	**218**	**74**

Plugging the gaps

Trainee rota gaps are reported by 42.9% of respondents in the 2015–16 census of consultants in Wales as 'frequently causing significant problems in patient safety' and by a further 45.8% as 'often [causing problems] but there is usually a work-around solution so patient safety is not usually compromised'. Only 11.3% of respondents told us that rota gaps infrequently or never cause a problem[9] (see Table 1).

More than a third of higher specialty trainees told us that they regularly or occasionally act down to cover gaps in the core medical trainee rota.[9] Almost two-thirds of these specialty trainees told us that they feel as though they are sometimes, often or always working under excessive pressure, with 63.2% telling us that this was down to insufficient trainee numbers.[9]

The number of medical undergraduate and CMT posts in Wales should be increased. Rota changes should allow trainees to work within the same teams for a block of time, to improve continuity of care and enhance training and learning on the job. CMT roles should be timetabled to ensure clinic time and dedicated teaching time. Hospitals with poor trainee feedback should produce plans outlining how they will change immediately or they should risk losing those trainees.

Many trainees are in financial difficulty and this contributes to the appeal of working for an agency, working abroad or changing careers ... I worry often about whether I can afford to complete mandatory aspects of my training – as do many others.

Trainee physician in Wales

The NHS in Wales may want to consider offering financial support with mandatory fees as part of a package to recruit and retain trainee doctors. The Emergency Medicine Trainee Association has found that the unavoidable cost of training is £15,286.[33] This places a huge burden on trainees, with different amounts of study leave provision in different areas. Mandatory professional examinations are not covered by the Wales Deanery or health boards, and can be added to union and professional body membership fees, training fees, General Medical Council (GMC) and medical indemnity costs, few of which are avoidable. Easing this financial stress could go a long way to help recruitment and retention.

Developing a homegrown workforce

Increasing training numbers is clearly a long-term solution, as is the creation of a medical school in north Wales and the continued development of the postgraduate school in Swansea. However, the situation is critical. Overall, 39.8% of consultant appointments in Wales could not be made in 2015.[9] In more than half of the cases, this was because there were no applicants at all. There are simply not enough doctors out there.

It is crucial that Wales makes a more concerted effort to attract its own students to medical school in Cardiff and Swansea. These students may be more likely to stay in Wales for their postgraduate training, and if they do leave, they are more likely to return home afterwards. Only 30% of students in Welsh medical schools are Welsh domiciled. This compares with 55% in Scotland, 80% in England and 85% in Northern Ireland.[8] This is against a worrying drop in Welsh domiciled students applying to study medicine in the first place; according to UCAS, this number has fallen by 15% in the last 5 years, a steeper decline in Wales than across the rest of the UK.[34] Medical schools must offer more undergraduate places to Welsh domiciled students in order to grow and retain a homegrown workforce, and they should invest in outreach programmes that encourage applications from rural, remote and Welsh speaking communities.

The rota gaps in many smaller, rural hospitals in Wales can result in isolated working for junior doctors. They also mean that there is not enough face-to-face consultant teaching time for some trainees. Training pathways specialising in rural and remote healthcare should be developed in Wales and advertised across the UK to encourage the best trainees to apply.

To recognise how healthcare will change in the coming years, these rural training jobs should be built around the integrated patient journey, and made more attractive through new opportunities to gain postgraduate qualifications or formal experience in service improvement or leadership roles. If Wales can innovate to meet its own specific training problems, this could attract trainees from across the UK who might be interested in developing new skills.

A national approach to innovation

Once again, it is time for a national medical workforce and training strategy. Without a strategic approach, workforce planning in Wales has become patchy and uncoordinated. The NHS in Wales needs a vision for the future, and this vision must inform national workforce planning – the number of training posts, from medical school onwards, must be planned across the system. The announcement of investment in primary care is welcome, but must not lead to shortages in specialist medical care. This can only be addressed if there is a coherent plan to increase the overall number of training places across medicine, from medical school onwards.

The Welsh government and NHS Wales must focus on addressing recruitment and training challenges, particularly in north and west Wales. Specialty and subspecialty numbers must now be planned nationally with direct clinical input, and there must be a renewed attempt to address training rotation concerns: medical registrars report that moving between north and south Wales is very unpopular, especially when families are involved.

Cross-border rotations should be established with hospitals in England, and health boards should communicate more effectively with their trainees: doctors beginning rotations should know their schedule much earlier than they do at present. Wales needs to take the lead and innovate on issues such as broad-based training, specialty medicine in the community and rural training pathways.

More trainees are needed

The key barrier to recruiting junior and middle-grade trainees is the heavy workload of those working in medical specialties. Due to an ageing population and an increase in patients who are living with long-term, chronic conditions, the future NHS will need more doctors qualified in general medicine – yet there are not currently enough trainees to cover the existing workload.

One RCP survey of medical trainees in the UK found that the workload of the middle-grade medical registrar was perceived to be greater than that of their contemporaries in other specialties: 59% of junior doctors said that they thought medical registrars have a heavy workload and 37% thought that their workload was 'unmanageable', while 69% of medical trainees thought that the work–life balance of registrars was poor.[18] In comparison, only 2% of surgical trainees – and no GP trainees at all – said they thought their registrars' workload was unmanageable.

These perceptions actively discourage junior doctors from going into medical specialties: application rates into training schemes involving general medicine are declining.[18] Regular gaps have begun to appear in medical training programmes – gaps which must be filled by expensive locum staff.

When asked if financial incentives, improved use of technology, or reduction in workload would make junior doctors more likely to become medical registrars, it is the reduction of workload that is cited by almost all as the most important factor.[35] This is another reason why medical trainee numbers should not be reduced; increasingly unmanageable rotas will make recruitment problems even worse.

Although we are training more doctors than ever, because many are choosing to work flexibly or part time and others are leaving the profession, there is a net loss overall. There are too few CMT posts in the UK to fill the specialty higher training posts available, a shortfall which is exacerbated by a significant number of core medical trainees leaving general medicine for specialties such as general practice or clinical oncology. Trainees in Wales should be followed through the system and asked why they are leaving and what would persuade them to return.

The clinical leaders of tomorrow

More support should be offered for academic research and education training pathways, including the provision of requisite postgraduate courses. There should be research opportunities available to all trainees. Wales should continue to invest in clinical leadership and training programmes such as the Welsh Clinical Leadership Training Fellowship scheme.

The RCP works with the Wales Deanery to appoint college tutors at every hospital in Wales. These consultant physicians support the education and development of trainee physicians. However, a more recent development is the appointment of associate college tutors, a leadership role which is undertaken by at least one core medical trainee at every hospital in Wales. Associate college tutors are encouraged to develop skills to improve patient care and medical training and represent their colleagues at directorate level. This is a strong example of how the Wales Deanery and the RCP are supporting trainees early in their careers to begin preparation for more senior leadership roles.

There is too much pressure on front line staff so people leave. This is currently made worse by increasing demand – population growth, people getting older. The other major problem is fewer staff, due to vacant posts which we cannot fill. It is not exactly lack of funding – more that we lack people coming out of training that we could employ.

Consultant physician in Wales

Preparing medical students to work on the NHS front line

During 2010, Cardiff University School of Medicine commenced a major curriculum review. This followed data from the National Student Survey and UK Foundation Programme which showed that Cardiff students were reporting lower levels of preparedness for practice and familiarity with practical procedures. In response, Cardiff University launched the Harmonisation Programme, designed to enhance the transition between undergraduate and postgraduate education to prepare graduates for practice in the modern NHS. Medical students are embedded within clinical teams around Wales and take responsibility for patient care in a supervised and safe learning environment. This pioneering project allows around 350 undergraduate students a year to experience the real world of a junior doctor.

The team worked closely with Swansea University Medical School and the Wales Deanery to develop a timetable of clinical placements. By matching medical students with postgraduate doctors for the 8-week junior student assistantship, we are able to provide a supervised clinical placement that centres on the direct care of patients in acute settings. Final year students take responsibility for patient care within a supervised environment. Students rotate between the hospital and the community to ensure a balanced view of primary/secondary care.

Medical students shadow their postgraduate colleagues for 2 months, and those with a job offer in Wales get to spend their final placement – called their senior student assistantship – in the hospital where they will be working as junior doctors after graduation. This allows students to get to know colleagues in their future workplace, familiarise themselves with systems and protocols, and prepare them for the front line of a busy NHS hospital. Around half the Welsh medical students stay in Wales for their first job, and we believe that the system is having a powerful effect on their self-confidence. This final placement allows them to directly manage patients under the supervision of hospital teams, and 93% of students rated the teaching on placement as good or very good and 91% thought that the clinical supervision was good or very good.

The programme has delivered what it set out to achieve with 80% of Cardiff University graduates saying they felt prepared for their first post in a hospital. The next challenge is to demonstrate how this work will improve the care, experience and safety of patients. The new structure ensures that students are ready for their career in medicine, and demonstrates the commitment of the Welsh NHS to training the next generation of doctors. ■

Dr Stephen Riley
Director of the C21 Programme
Cardiff University School of Medicine

Giving trainees a voice

In August 2016, two health boards in Wales each appointed a chief registrar, a trainee doctor who acts in a liaison role between medical trainees and senior clinical managers. This leadership development post has a key role to play in supporting trainees, medical education programmes and quality improvement initiatives. Both these posts are part of the RCP Future Hospital chief registrar pilot programme. This initiative must be rolled out across all health boards in Wales to encourage senior trainees to develop leadership and education skills.

The chief registrar: A trainee leadership role

As the first ever chief registrar in Wales, I had the opportunity to be involved with decision making at a directorate level, regularly offering opinion and feedback from trainees. I was able to advocate for junior doctors and I attended meetings on their behalf to negotiate changes to the on-call rota. This was very successful and we managed to come to a compromise that all parties were happy with.

I also negotiated the payment offered to medical doctors who take on additional locum shifts to ensure there is fair recompense for both additional hours and where shifts are changed at short notice, which has been met with praise from within the junior doctor body. There have been situations where trainees have felt undermined by managers and worried about the performance of their peers, and in the role of chief registrar, I was able to advise them and take their concerns forward in confidence.

Junior doctors are in a unique position. They see examples of good and bad practice in different hospitals during their rotations. Through the chief registrar, junior doctors were able to suggest changes based on other working practices, including quality improvement and service reform. In my time as chief registrar, we improved handover and discharge processes and developed written protocols on patient flow. I believe that the experience has been incredibly positive not only for me, but also for other junior doctors and the wider service. ■

Dr Robin Clwyd Martin
Former chief registrar
Cardiff and Vale University Health Board

A new way of working

Hospitals should deliver expert care far beyond the walls of the building – the hospital is part of, not separate from, the community. Patients must have access to the expert care that they need, when they need it.

The current challenges facing the Welsh NHS mean that we will need to find ways to reduce hospital admissions and improve patient care in the community. Many physicians already work between hospital and community clinics, but electronic information and communication systems are crucial. To ensure a safe service, we need to make sure that community facilities are fit for purpose, and that the workforce has the necessary skills. There needs to be political recognition that service reconfiguration will not save money in the short term; indeed, the transition process will require substantial investment.

Health boards should implement the Future Hospital workforce model, with more specialist medical care delivered in the community.[21] Integrated working and shared outcomes with health and social care partners should be the norm; physicians and medical teams should spend part of their time working in the community in order to deliver more specialist care in, or close to, the patient's home.

Collaboration between different parts of the NHS workforce will help services to become sustainable for the future. The role of the hospital should be as a hub of clinical expertise and technology for the local population, particularly for diagnostics and treatment. The focus should be on developing ways of working that enable patients to leave hospital safely as soon as their clinical needs allow.

In the face of rising demand for healthcare coupled with a shortage of staff in certain specialties across the UK, we have tended to simply call for more people to be trained in traditional roles and professions. However ... continued growth of the overall workforce based on existing models of service provision is not sustainable.[5]

Working in partnership to improve care for older people

At the Royal Gwent Hospital in Newport, a recent project has developed new integrated working between the health board, the local authority and the third sector. Many older people who are admitted to hospital needing emergency or urgent medical care may have significant social, rather than medical, issues contributing to their situation. This can be prevented by improving the 'community resilience' of older people – that is, the ability of older people to stay safe and independent in their own homes.

The project aims to keep older people safe and independent in their own homes and reduce hospital admissions. Trained care facilitators discuss with older people what simple interventions can help improve their resilience, and produce a Stay Well Plan. The older people are identified using risk stratification – a computer algorithm that identifies how likely it is that someone is going to present to hospital over the next year. Those at high risk are offered the Stay Well Plan. The interventions outlined in the Plan could include interventions such as mobility aids and benefit checks. The care facilitator also discusses carer support and crisis resilience, so a written record is kept for the older person, their family and healthcare professionals.

This is an excellent example of how the future workforce should change to deliver holistic care as part of an integrated team, with clinicians working closely with local authorities and the third sector. Future models of care should have a greater reliance on proactive risk-based identification of patients rather than referral-based systems. The future workforce should make use of statistical algorithms to identify people who would benefit from an intervention rather than wait for deterioration in their health to trigger a referral. Finally, services will be co-produced with patients. People who use a service must be equal partners in the design of that service. In this project, the format and design of the Stay Well Plan was developed using the insight, expertise and experience of the older people and their families.

The project has so far made contact with over 800 older people, and aims to contact 4,000 in total over the next 2 years. ■

Dr Richard Gilpin and Dr Charlotte Williams
Trainee physicians, NHS Wales

Underfunded and overstretched

New ways of working will need to be developed. This will require investment. A whole system approach across primary, community, secondary and social care is now required to deal with the impact of unscheduled care. The NHS is underfunded, underdoctored and overstretched. In our hospitals, we are seeing the impact of cuts to social care, with vulnerable people too often bounced around a fragmented system. We need to move away from services that are planned in silos and look at one small part of a patient's treatment, to joined-up planning across health and care. We need to give front-line clinicians and their partners in social care the time and space to innovate, and the freedom and support to step beyond their organisation's walls.

Wales should lead the way by developing new integrated workforce models in rural communities. Medical education and training should equip doctors with the expertise to manage older patients with complex needs, including frailty and dementia, and to lead and coordinate the 'whole care' of patients in hospital and the community. Many physicians already work between hospital and community clinics; the NHS in Wales should build on these pockets of good practice and take a planned approach to establish specialty care in the community. The Commission on Generalism has noted that 'generalism has a more extreme role to play in remote and sparsely populated communities [of the UK]'.[16]

Time to lead the way

The role of the community physician should be developed. Wales should actively promote itself as a place to develop highly specialist skills in rural and community-based medicine. Furthermore, geography is important to trainees, and we know that most trainees would like to gain a consultant post where they have undertaken specialist training. This could boost applications to consultant posts in Wales in future years. The work of the Mid Wales Healthcare Collaborative offers huge potential in this area and the RCP will continue to engage proactively with its work. Wales has a real opportunity to lead the way on innovative community health service design.

The current workforce is designed to deliver services to historic models and patterns of care. The way we deliver care has evolved, and so must the workforce.[6]

Supporting other clinical roles

Excellent patient care depends on cohesive, organised and well-resourced team working and the NHS should develop and embed other clinical roles into the future hospital workforce in Wales. Staff and associate specialist grade doctors in Welsh hospitals should be encouraged, and supported in their career progression.

Appropriate staffing levels across the team are essential and enable hospitals to deliver more effective, efficient and patient-centred care. Nursing shortages should be addressed, and innovative models of staffing involving allied health professionals such as occupational therapists and physiotherapists should be promoted. The roles of advanced nurse practitioner and physician associate should be developed as core members of the clinical team. Working alongside doctors, physician associates can provide crucial support, especially in secondary care, such as taking patient histories or ordering and interpreting diagnostic tests.

However, any increase in staffing numbers for these posts should not be at the expense of consultant expansion, and there can be no reduction in the medical education budget in Wales. Simply making up the numbers by recruiting non-training grades or other healthcare professionals to cover rota gaps is a short-term solution to a much bigger, multi-faceted problem. If the financial divide between medical and non-medical education is removed, there is a significant risk that funding for higher cost subjects will be redirected into training and education for other healthcare professions. While medical training may be expensive, it is a long-term investment in patient safety and high-quality care.

Using technology to improve the patient experience

Health boards should embrace innovation in order to improve communication with patients and between healthcare professionals and to improve quality of care and the patient experience. People increasingly expect to interact with health services using personal technology such as smartphones and tablets; where appropriate, patients and clinicians should be able to use telehealth and telemedicine, particularly in remote and rural areas.

Telemedicine needs to be further embedded into everyday practice. Clinicians must continue to challenge resistance to change. The RCP Future Hospital development site in north Wales – CARe delivered with Telemedicine to support Rural Elderly and

Delivering specialist diabetes care in the community

Managing a chronic disease such as type 2 diabetes requires the input of a multidisciplinary team across primary and secondary care. Historical models of care for diabetes have separated primary and secondary care elements and have led to the fragmentation of care, duplication of workload and long waits for senior specialist advice.

In Cardiff, which has a total of just over 23,000 people registered with diabetes, we have moved towards a more seamless diabetes service. We started with a small pilot study and began implementing the full model of care in 2010. Each of the 69 GP practices in the health board is allocated a diabetes consultant who visits the practice twice a year for case notes review, dissemination of best practice guidelines and face-to-face dialogue with GPs and their practice nurse.

There are eight full-time equivalent diabetes consultants and two academic diabetes consultants. Each consultant mentors 6–8 practices depending on the list size. In addition, GPs can request advice from their supporting consultant via an electronic system (similar to email but with robust audit) with a 5 day maximum response time for medication and management queries. Requests for advice are automatically routed to the appropriate consultant. This ensures that GPs have access to timely senior advice and develop a rapport with their consultant without the patient having to wait to be seen in an outpatient clinic. Secondary care outpatient referrals are triaged electronically to the appropriate consultant via the Welsh Clinical Communications Gateway (WCCG). The consultant can approve and book the referral into a clinic or request additional information. The latter opens a dialogue that may resolve the query. In addition, we have developed local type 2 diabetes prescribing guidelines which guide treatment choice and highlight cost differences between classes of treatment. The guidelines are intended to support primary care prescribing and draw attention to more cost-effective prescribing where possible.

Over the first 2 years of implementation, new referrals to secondary care clinics fell by 35%. As a consequence, the waiting time for outpatient appointments fell from just under 6 months to between 4 and 6 weeks depending on the clinic. An audit of primary care found greater confidence overall in managing diabetes but especially in initiating non-insulin injectables, combining therapies and dose titration of oral and injected treatments. Practice staff find the electronic access to senior consultant advice within a working week particularly helpful. Advice offered for an individual patient will frequently be applied to other similar clinical scenarios leading to a ripple training effect. More recently, we have demonstrated improved glycated haemoglobin (HbA1c) results in patients who have been discussed either during visits or electronically, and hope

Frail patients (CARTREF) – is a telemedicine project that aims to improve access to care for frail older patients in rural Wales. The project allows patients to have follow-up hospital appointments by video clinics and means that patients and relatives can see specialists without travelling. The team can demonstrate patient satisfaction rates of 80%. This is just one of many examples of innovative clinical telemedicine and the future hospital workforce in Wales; best practice must be shared more consistently and rolled out in a structured way.

I see physician associates as part of the solution for the shortages in medical manpower – of course not to replace doctors but certainly to help with some of the tasks that take up most of our day.

Consultant physician in Wales

that this will lead to a fall in HbA1c across primary care due to greater confidence and ability to manage diabetes. We have also started to see new prescriptions for analogue insulin plateau and start to fall, while human insulin prescriptions are starting to rise with the potential for cost savings. This is an area we'd like to develop over the next 2 years.

So far, these changes have been made in a cost-neutral environment by asking primary and secondary care colleagues to work together in a different way. The model continues to evolve and we are recruiting community diabetes specialist nurses to support practices.

We hope to fund these posts through more cost-effective use of human insulin where appropriate and reviewing the stop criteria for medications that are no longer effective. We also believe that this model could be helpful in supporting primary care to manage other chronic diseases. Its success depends on developing close, sustainable links with primary care. I am grateful to my colleagues in primary and secondary care for the hard work that has gone into establishing and sustaining this innovative model of care. ■

Dr Lindsay George
Clinical lead for diabetes, University Hospital Llandough
Cardiff and Vale University Health Board

The multidisciplinary team at the National Poisons Information Service

The National Poisons Information Service (NPIS) in Cardiff is a multidisciplinary team consisting of 11 poisons information scientists who provide telephone advice to the NHS, supported by four consultant clinical pharmacologists and toxicologists and two specialist clinical pharmacology registrars.

In the UK, over 140,000 people are admitted to hospitals with exposure to suspected poisons each year and over 3,000 die from the effects of poisoning. NPIS provides advice on the management of these people throughout the UK, as well as to Ireland at night. In some cases, reassurance can be given and unnecessary admission avoided. In others, advice on poisons management can be life-saving. NPIS (Cardiff) regularly obtains among the highest service user satisfaction scores of the four UK NPIS centres. Staff also contribute to the TOXBASE database, which contains over 17,000 product entries. This is the first-line toxicology online advice service to the NHS and last year there were 608,868 TOXBASE user sessions and 1.69 million separate page views of TOXBASE entries. By consolidating expert resources it has been possible to deliver a high-quality, cost-effective service, which saves the NHS more money than it costs. NPIS (Cardiff) also leads on the UK Poisons Information Database, a unique database that has enabled identification of trends in poisoning and advice to improve public health on everything from liquid detergent sachets to novel psychiatric substances.

The Welsh Poisons Unit is made up of NPIS and the Gwenwyn poisons treatment ward at University Hospital Llandough. While NPIS (Cardiff) provides advice nationally, Gwenwyn ward delivers high-quality care to poisoned patients locally in Cardiff. It is a purpose-built six-bed unit staffed by nurses, including two ward-based psychiatric nurses, supported by a team of clinical pharmacologists and toxicologists, enabling a truly holistic approach. This dedicated unit has enabled the more efficient management of patients and was associated with a fall in average length of stay from 34 to 18 hours, so despite increased demand, no extra beds were necessary. By liaising closely with the Welsh Ambulance Service, over 80% of the 1,200 to 1,800 patients requiring admission are admitted directly, avoiding over 1,000 unnecessary attendances at the emergency department and providing safe, high-quality care.

The development of an integrated clerking pack has streamlined admissions while improving record keeping. This multidisciplinary approach was recognised by a chairman and chief executive award in 2012. The team continues to develop, and plans to introduce a new shorter treatment for paracetamol poisoning. ■

Dr John Thompson
Director and consultant clinical pharmacologist
National Poisons Information Service (Cardiff)

How can the RCP help?

Influencing change in Wales

This RCP report on the medical workforce in Wales follows the publication of *Focus on the future*, our action plan for the new Welsh government,[3] and *Rising to the challenge*, which sets out our vision for acute care and the Future Hospital model in Wales.[2] Through our policy development, our work with patients, and our local conversation visits to hospitals, we are working to achieve real change across hospitals and the wider health and social care sector in Wales.

The census of consultant physicians and medical registrars in the UK

On behalf of the Federation of the Royal Colleges of Physicians, the RCP conducts an annual census which is sent to all UK consultant physicians and medical registrars in the general medical specialties. In the census we request information about job plans, workloads and responsibilities. We consider this to be the highest quality data available in the UK concerning the medical workforce.

Underfunded, underdoctored, overstretched

Being a doctor is intense, rewarding and challenging. A cared-for workforce delivers better outcomes for patients. The RCP has committed to valuing and supporting NHS doctors. We will:

- work with our member doctors to find new solutions to workforce pressures
- push for action from across government and the NHS
- showcase the very best of medicine.

About us

The RCP aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led.

Our 33,000 members worldwide, including 1,200 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Involving patients and carers at every step, the RCP works to ensure that physicians are educated and trained to provide high-quality care. We audit and accredit clinical services, and provide resources for our members to assess their own services. We work with other health organisations to enhance the quality of medical care, and promote research and innovation. We also promote evidence-based policies to government to encourage healthy lifestyles and reduce illness from preventable causes. Working in partnership with our faculties, specialist societies and other medical royal colleges on issues ranging from clinical education and training to health policy, we present a powerful and unified voice to improve health and healthcare.

Get involved

On the RCP website, you can read about existing examples of innovative practice and listen to doctors talking about how they achieved change in their hospital. You can also inform the RCP's work in Wales by sending us your comments, ideas and examples of good practice.

To help shape the future of medical care in Wales, visit our website:
www.rcplondon.ac.uk/wales

To tell us what you think – or to request more information – email us at:
[redacted]

Tweet your support:
@RCPWales
#MedicineisBrilliant
#MeddygaethynWych

References

1 Royal College of Physicians. *Underfunded. Underdoctored. Overstretched. The NHS in 2016.* London: RCP, 2016.

2 Royal College of Physicians. *Rising to the challenge: Improving acute care, meeting patients' needs in Wales.* Cardiff and London: RCP, 2016.

3 Royal College of Physicians. *Focus on the future: Our action plan for the next Welsh government.* Cardiff and London: RCP, 2016.

4 NHS Wales Workforce, Education and Development Services (WEDS). *NHS Wales workforce: Key themes and trends.* January 2015 [Accessed 30 September 2016].

5 NHS Wales. *A planned primary care workforce for Wales.* Welsh government, 2015 [Accessed 30 September 2016].

6 The Welsh NHS Confederation. *The NHS Wales workforce briefing paper.* January 2015 [Accessed 30 September 2016].

7 Wales Deanery data.

8 NHS Education for Scotland. *Domicile of UK undergraduate medical students.* Edinburgh: NES, March 2013.

9 Federation of the Royal Colleges of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK 2015–16.* London: RCP, 2016.

10 Costs supplied by NHS Wales Workforce, Education and Development Services (WEDS).

11 Public Health Wales Observatory. *Demography 2016.* Public Health Wales, 2016.

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

13 Welsh Health Survey 2015: Health status, illnesses, and other conditions [Accessed 30 September 2016].

14 Welsh Health Survey 2015: Initial headline results [Accessed 30 September 2016].

15 Royal College of Physicians. *Census of consultant physicians and medical registrars in the UK.* London: RCP, 2011.

16 General Medical Council. *The state of medical education and practice in the UK report: 2013.* London: GMC, 2013.

17 Royal College of Physicians. Jan–Dec 2015 AAC data for Wales.

18 Royal College of Physicians. *Hospitals on the edge? The time for action.* London: RCP, 2012.

19 The Commonwealth Fund. *Mirror, mirror on the wall: How the US health care system compares internationally,* 2014.

20 Royal College of Physicians. *Research for all.* London: RCP, 2016.

21 Future Hospital Commission. *Future Hospital: Caring for medical patients.* London: RCP, 2013.

22 Royal College of Physicians. Survey of medical trainees, April 2016 [publication date: October 2016].

23 Evans M, Phillips C, Roberts R, Salter D. *Health Professional Education Investment Review,* 2015.

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

25 National Assembly for Wales, *Key issues for the fifth assembly,* 2016 [Accessed 30 September 2016].

26 BBC News. Wales NHS nurse shortage 'compromises care', RCN claims. May 2014 [Accessed 30 September 2016].

27 Royal College of Physicians. *Census of consultant physicians and medical registrars in the UK, 2012.* London: RCP, 2014.

28 National Assembly for Wales, *Key Issues for the Fifth Assembly,* 2016 [Accessed 30 September 2016].

29 Federation of the Royal Colleges of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK, 2014–15: data and commentary.* London: RCP, 2016.

30 Greenaway D. *Shape of Training: securing the future of excellent patient care.* Final report of the independent review led by Professor David Greenaway. General Medical Council 2013.

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

32 Joint Royal Colleges of Physicians Training Board. *2015 Annual Specialty Report,* JRCPTB. March 2016.

33 Emergency Medicine Training Association. *Costs of Training Survey July 2016.* [Accessed 30 September 2016]

34 UCAS. Deadline Applicant Statistics: October 2015. [Accessed 30 September 2016]

35 Royal College of Physicians. *Hospital workforce: Fit for the future?* London: RCP, 2013.

Physicians on the front line

The medical workforce in Wales in 2016

The RCP president, Professor Jane Dacre, recently warned that today's NHS is 'underdoctored, underfunded and overstretched'.[1] These observations apply as much to Wales as to the rest of the UK. For the Welsh NHS to achieve its full potential to serve the people of Wales, it requires adequate resources and a committed, fully operational and integrated healthcare workforce, allied with good morale and professional satisfaction.

Wales suffers from recruitment and retention issues among the medical workforce, at both senior and junior levels. The issues underpinning these problems are varied and complex, and include geography, negative perceptions and a lack of inducements to encourage doctors to follow a career in Wales. The RCP in Wales believes that there are many initiatives that we could and should adopt to overcome these issues.

Royal College of Physicians (Wales)
Baltic House
Mount Stuart Square
Cardiff CF10 5FH

Tel [redacted]
Email [redacted]

www.rcplondon.ac.uk/wales

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

Consultation on the implications for Wales of Britain exiting the EU

RCP Wales response

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

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

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

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

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

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

SeneddEAAL@assembly.wales

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

28 November 2016

Consultation on the implications for Wales of Britain exiting the EU

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

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

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

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

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

NHS workforce and staffing

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

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

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

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

Key asks of government

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

Medical research

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

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

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

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

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

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

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

Key asks of government

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

Public health

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

    a. **Environment and consumer protection**

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

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

b. **Disease prevention and control**

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

Key asks of government

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

NHS finances

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

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

Conclusion

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

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

Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-05-17 Papur 3 / Paper 3

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

Royal College of GPs Wales:

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

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

1. Currently there are severe problems in relation to retention and recruitment of GPs to all types of posts (partnered, salaried GPs and locums) across Wales. This applies to work within practices in and out of hours' services. The problems are more severe in more rural areas and in areas in north and west Wales New models of practice are developing and although expanding the general practice workforce to include other professionals is welcome, this means that the work of the GP is changing and becoming more complex, including managing a multidisciplinary team. GPs can then be left dealing with more complex cases and spending longer working at the top of the license and knowledge which can lead to increased stress and burn out Some GPs are already choosing to leave the profession due to stress and increasing workload. The skill set for managing a broad team is different and there are additional indemnity cost which can be high related to supervising a wider multidisciplinary team. Again, this may have implications for retention and recruitment both of new trainees and for GPs who wish to come to Wales for the rest of the UK and other parts of the world where the GP model exists.
2. Brexit will have implications for health and social care service. Many of the professionals currently come from the EU. Uncertainty about their future

employment as well as the potential effects for their families whether those are in the UK or not, will make new applicants less likely. Those currently in post may leave the UK. The terms of Brexit may prevent this but the current uncertainty will have its affect. Brexit may enable professionals from other countries to come here more easily but again we need to see how this develops and there is likely to be a negative impact on recruitment and retention in the next few years.

3. Several models are currently being tried to bridge the gaps in services. These models need to be assessed fully, including the cost implications. Lessons learnt need to be spread across Wales and potential benefits implemented more widely.

4. The future demographics of society with the increasing age of the population plus the urbanisation preferred by young people mean that the rural areas are being left with older more complex patients without family support. This has great implications for both health and social care models of delivery and the workforce as often younger doctors wish to work in more urban environments, where there is a broader range of opportunity for their partners and family including choice of schools, colleges and employment as well as social opportunities and travel.

5. In addition to ensuring recruitment of a strong GP workforce we have a major problem with practice nurse recruitment. Prior to the 80s there were few practice nurses as some of these functions were performed by district nurses and health visitors who were linked to GP surgeries. With time the roles of those professions have altered, which we welcome and practice nurses gradually developed to support their current indispensable role particularly in supporting the care of the chronically ill, the elderly and vaccinations. Their expertise has been developed often in house with support from GPs and is very different from the role of a hospital nurse and even an experienced district nurse or hospital nurse needs specialised training to provide the rounded services offered in practices to both adults and children.

Many of the practice nurses are reaching retirement and it is difficult for practices to get appropriate staff to fill the gaps. There needs to be dedicated training for these nurses with potential support for practices to enable them to receive the training. Training for practice nurses is being

developed and nurses need supported exposure to general practice as part of their undergraduate training.

6. There are similar issues for the broader healthcare professionals who are now having placements in primary care. The way that they work in secondary care is often very different from primary care. There needs to be supported undergraduate exposure and post graduate courses to ensure that these new and expanding roles are fit for purpose and meet the needs of the population as well as the practices of the future. As primary care employs more of these health professions there may be implications for secondary care. In some areas, this is already occurring.

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

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

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

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

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

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

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

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

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

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

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

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

MOUNTAIN MEDICINE
BANGOR EMERGENCY DEPT

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

Medical Recruitment:
Learning from Bangor ED

Dr Linda Dykes
Consultant in Emergency Medicine
Ysbyty Gwynedd, Bangor

Introduction

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

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

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

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

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

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

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

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

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

- ❌ The capacity of the medical workforce to meet future population needs, in the context of changes to the delivery of services and the development of new models of care [although with my EM/GP/WAST/Community Care of the Elderly experience I have an interest in this this)
- ❌ The implications of Brexit for the medical workforce.
- ✅ The factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas.
- ✅ The development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere.
- ✅ The extent to which recruitment processes and practices are joined-up, deliver value for money and ensure a sustainable medical workforce.

Where we were, and where we are now

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

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

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

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

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

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

What are Clinical Fellows?

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

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

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

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

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

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

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

In a tough recruitment market, mediocre jobs will get nowhere

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

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

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

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

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

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

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

Linda Dykes Clinical Fellow programme director

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

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

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

What makes your target recruits tick?

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

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

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

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

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

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

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

Doctors and recruits (and their life-stages)

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

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

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

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

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

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

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

… and be scrupulously honest about what you cannot fix

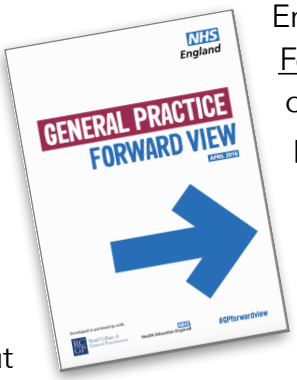
Everyone is wary about job adverts that promise the world, and yet do not deliver the package in full.

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

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

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

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



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

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

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

What is it about your job that is unique?

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

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

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

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

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

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

MENU

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

STARTER

Included in all packages

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

MAIN COURSE

Emergency Medicine the way it should be

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

DESSERT

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

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

Pre-Hospital Emergency Medicine

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

Medical Education

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

Management/Quality Improvement

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

MOUNTAIN MEDICINE
BANGOR EMERGENCY DEPT

www.mountainmedicine.co.uk

Step Five: Build up your brand

Who are you and what do you stand for?

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

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

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

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

MOUNTAIN MEDICINE
BANGOR EMERGENCY DEPT

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

(right)

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

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

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

Links:

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

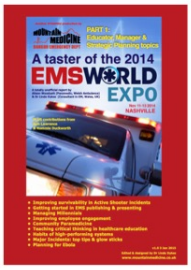
www.scribd.com/BangorED
(our unofficial filesharing site)

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

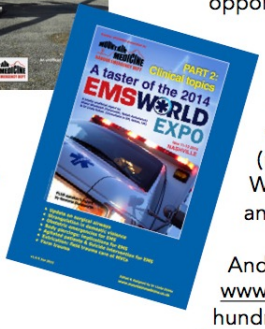
We also **produce and print flyers and leaflet the toilets at some conferences**. We pay for these ourselves, too.

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

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



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



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

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

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

Step Six: Advertise your wares

Attractive adverts come last, not first!

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

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

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

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

Treating your recruits well

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

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

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

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

A word about recruitment practices and HR support

It shouldn't feel like wading through treacle

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

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

- National problem

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

2. GPs returning to the UK

- National problem

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

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

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

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

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

- Problem noted in BCUHB, but may be widespread

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

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

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

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

A word about recruitment practices and HR support

4. Policies for overseas doctors commencing posts

- Problem noted in BCUHB, but may be widespread

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

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

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

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

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

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

Appendix One

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

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

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

Introduction

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

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

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

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

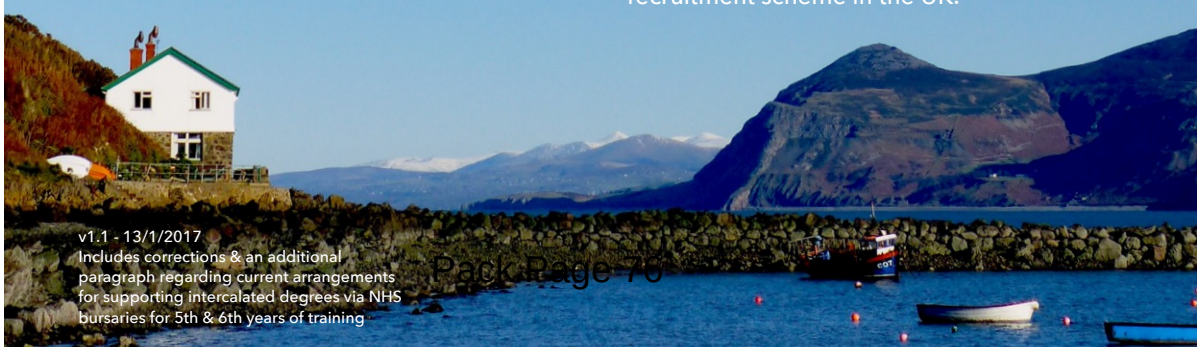
But it takes more than decade to train a GP from scratch, and we are desperately short of GPs *now*. Furthermore, only about half of UK medical graduates choose to enter General Practice.

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

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

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

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



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

Step 1a: Recruit your GP

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

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

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

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

Posts should be developed with features such as:

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

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

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

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

Step 1b: Recruit your medical student

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

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

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

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

Caveat: stunning scenery is not enough

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

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

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

Step 2: Does the GP wish to learn Welsh?

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

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

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

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

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

The "Hiraeth" Strategy

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

Step 3: Make use of the Medical Student

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

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

Another option: using other HCPs instead of Medical Students

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

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

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

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

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

What would it cost?

Intensive Welsh Courses

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

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

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

Paying Medical Students during the intercalated year

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

What would it save?

About £40,000 per post, per year

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

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

Saved lives and better healthcare outcomes

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

Summary of anticipated benefits

Supports future GP recruitment to rural areas

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

Supports provision of healthcare bilingually

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

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

Provides a mechanism to improve GP recruitment

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

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

Appendix Two

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

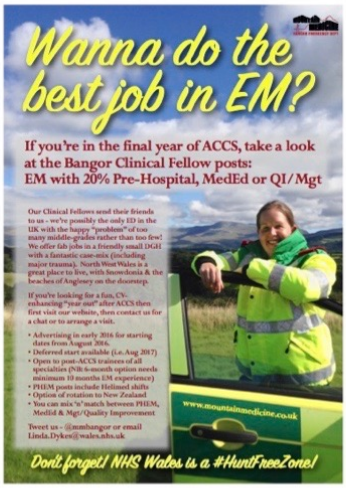
Our recruitment round for 2017/18 has just completed. We attracted a record number of applicants with only social media advertising - more than a dozen flyers over a 12-week campaign - producing a saving of more than £7000 on the customary full-page colour BMJ advert.

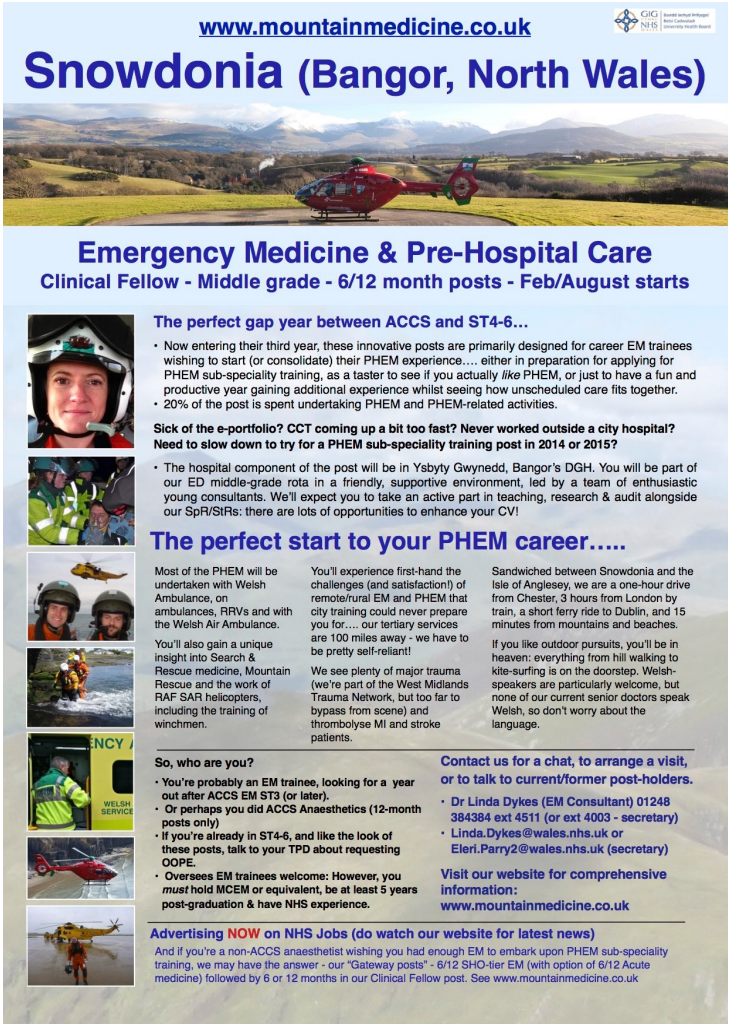
(right)

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

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

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





(left)

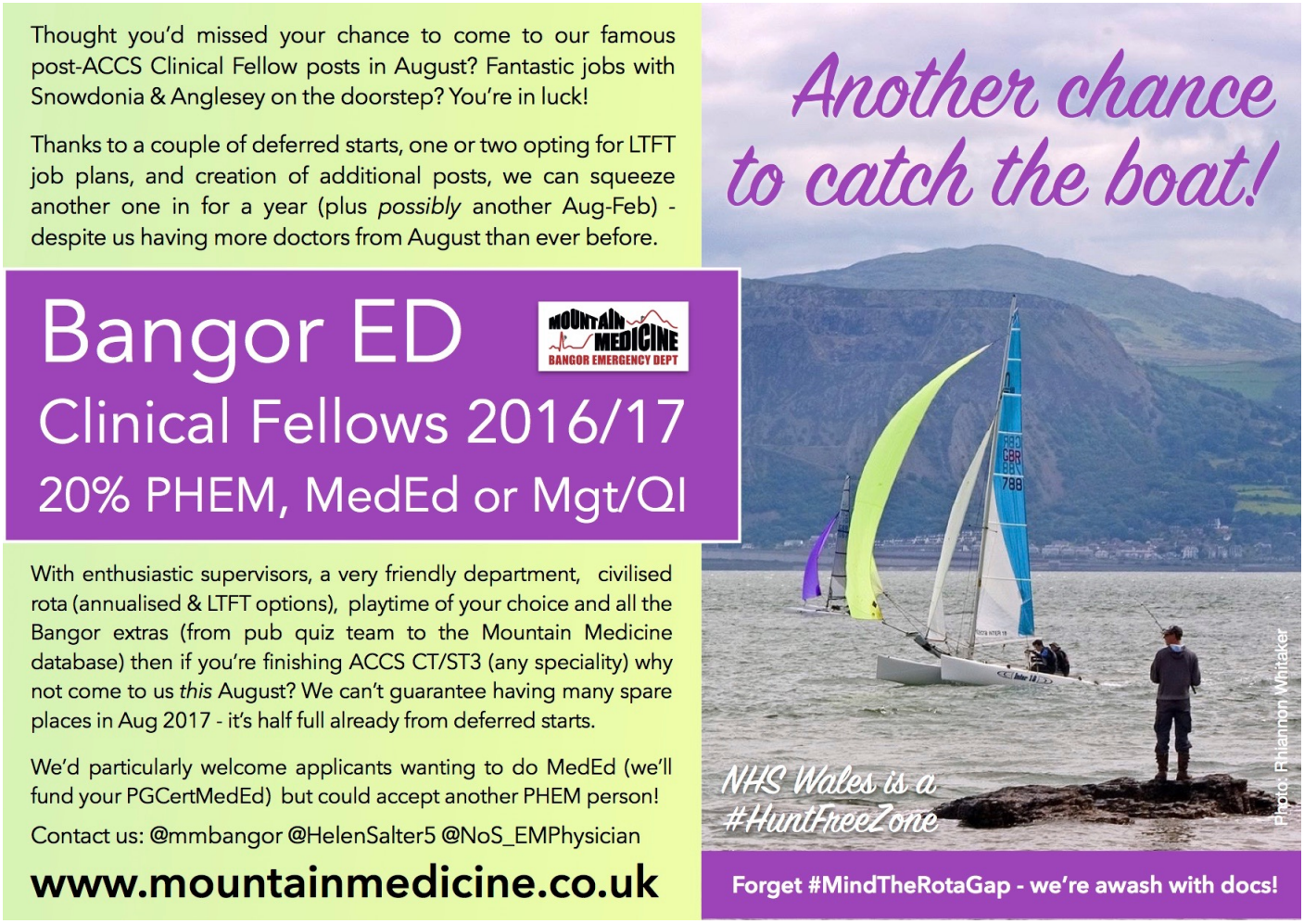
Early flyer from 2013: the posts at that time were still new and unfamiliar to our target audience.

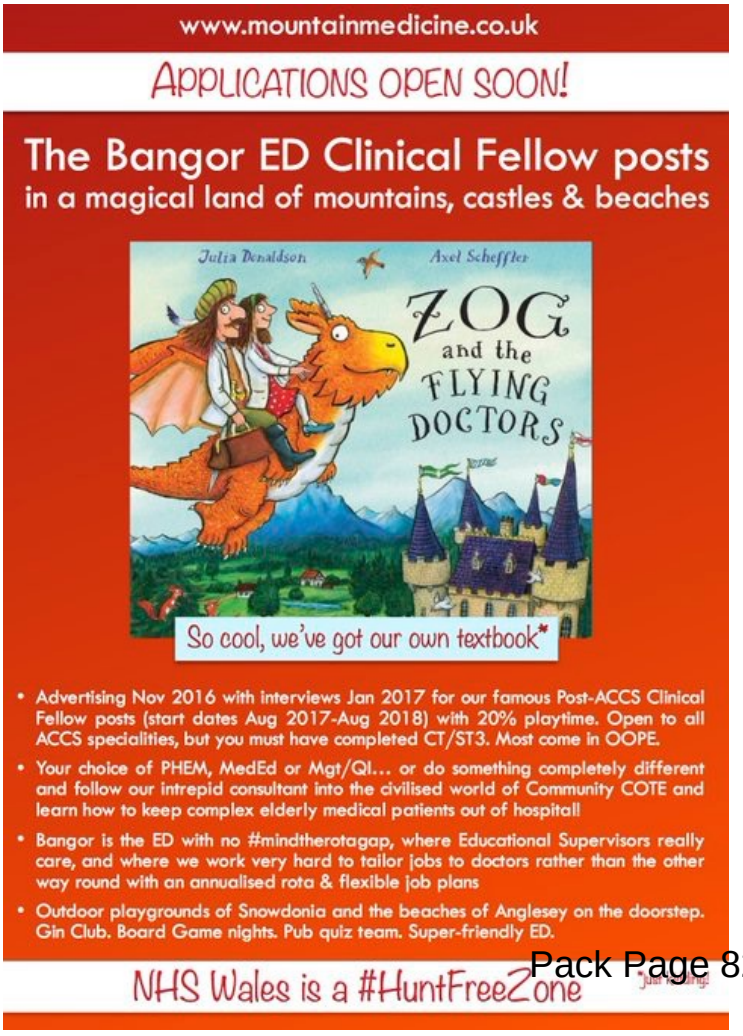
Today, they are discussed on social media, and doctors we have had no direct contact with recommend them on the Junior Doctors Contract Forum.

(below)

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

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





(above)

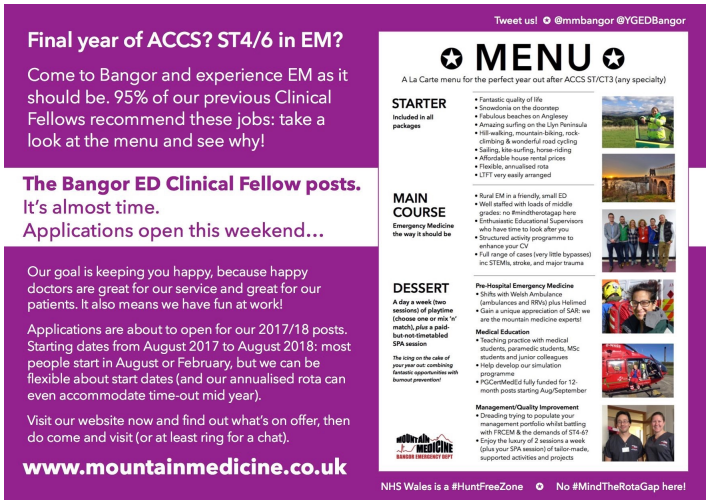
Catch-up flyer from late Spring 2016 - trying to avoid the "oops we have a space" feeling by emphasising the flexible nature of the posts (e.g. LTFT options) as a reason for having spaces at short notice - which was perfectly true.

(left)

Early pre-recruitment flyer for 2017/18.

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

Medical Recruitment: Learning from Bangor ED



More unofficial flyers from the 2017/18 recruitment campaign.

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

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

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

Appendix Three

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

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

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

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

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

10 July 2015

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

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

From medical school to PHEM sub-specialty training

contents

from the project instigator

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

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

Dr Linda Dykes
10th July 2015

summary & recommendations

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

background

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

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

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

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

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

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

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

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

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

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

what there is already (in Wales & beyond)

Undergraduate PHEM schemes elsewhere in the UK:

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

PHEM schemes in Wales: Postgraduate

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

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

PHEM schemes in Wales: Undergraduate

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

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

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

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

proposed scheme: outline/components

1. Curriculum

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

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

2. WAST Placements

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

3. Participation in Community First Responder Scheme

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

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

4. Training sessions/CPD

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

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

5. Mentorship

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

6. Assessment

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

WAST placements (provisional)

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

what's in it for WAST?

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

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

3. Increased access to CPD opportunities for WAST paramedics

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

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

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

what's in it for the Medical Schools?

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

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

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

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

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

what's in it for the Health Boards?

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

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

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

logistical challenges

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

the strategic fit

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

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

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

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

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

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

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

training opportunities with WAST at medical school & beyond

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

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

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

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

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

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

what happens next?

STAGE ONE - Spring 2015

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

STAGE TWO - July-October 2015

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

STAGE THREE - 2015/16 Academic Year

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

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

- Roll out to all Health Boards who wish to participate

references

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

Websites of other schemes

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

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

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

January 2017

My background

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

The Workforce Problem

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

Where do GPs come from?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Potential Benefits

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

Potential Pitfalls considered

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Factors affecting recruitment

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

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

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

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

Factors affecting retention

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

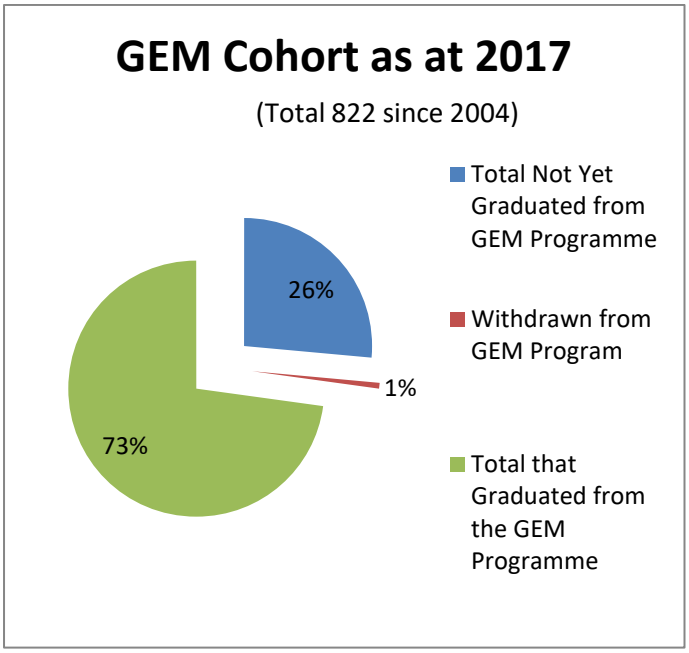
in medicine and with particular emphasis on general practice. The project was a success with increased collaboration between Cardiff and Swansea Admissions teams and the identification of school students who are now more enthused about medicine in general and general practice in particular. Expansion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

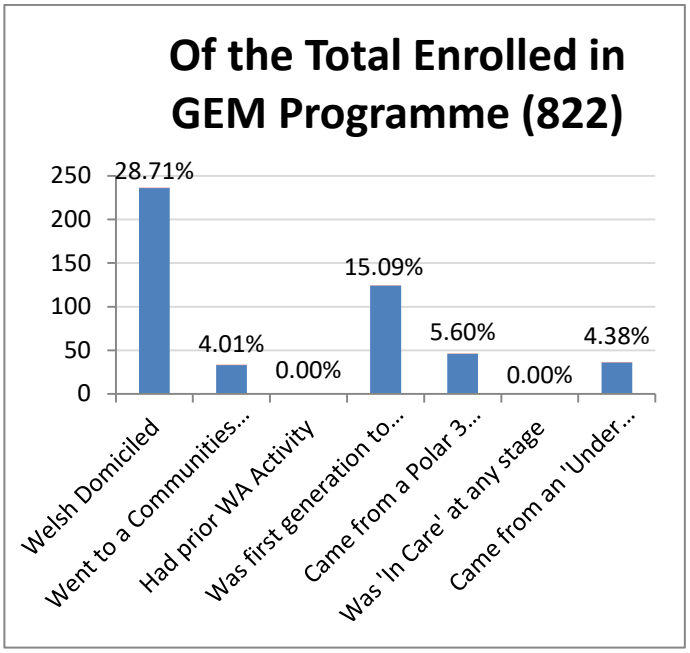
Appendix A: Origins and Destinations of GEM Students - Data

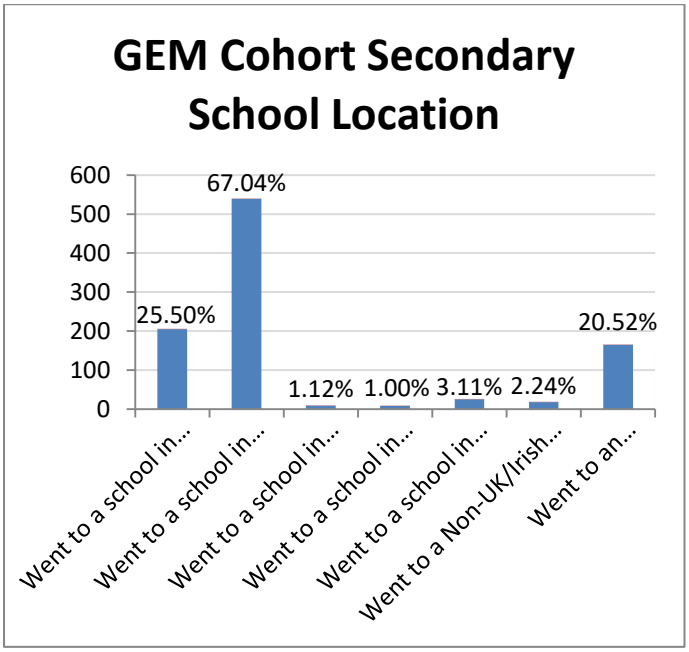
	Qty	%
Total Enrolled in GEM since inception	**822**	**100.00%**
Welsh Domiciled	236	28.71%
Went to a Communities First School	33	4.01%
Had prior WA Activity	0	0.00%
Was first generation to go to Uni	124	15.09%
Came from a Polar 3 location	46	5.60%
Was 'In Care' at any stage	0	0.00%
Came from an 'Under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

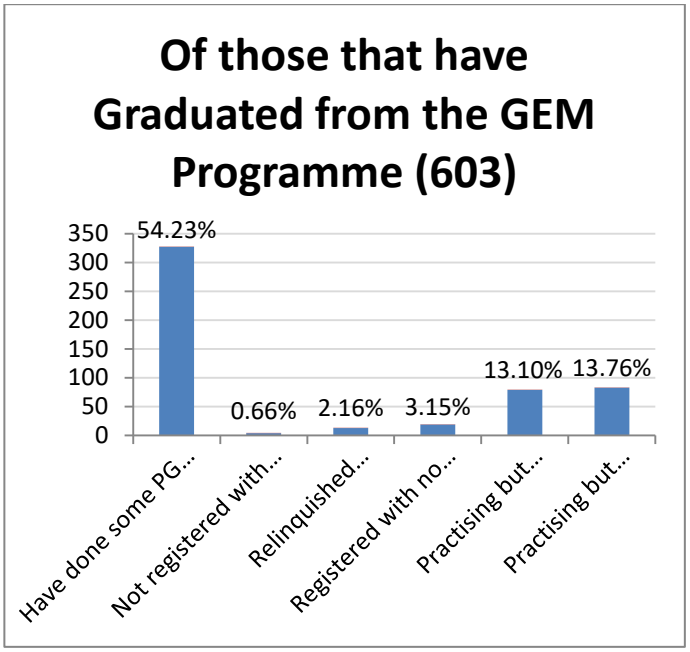
			No.In Wales	% in Wales	No.Outside Wales	% Outside Wales
Of those Currently Practising with a known location	**520**	**86.24%**	262	50.38%	258	49.62%
Currently in Foundation training	188	31.18%	94	50.00%	94	50.00%
Eligible to have entered GP training (Alumni)	**459**	**76.12%**	143	31.15%	316	68.85%
Those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

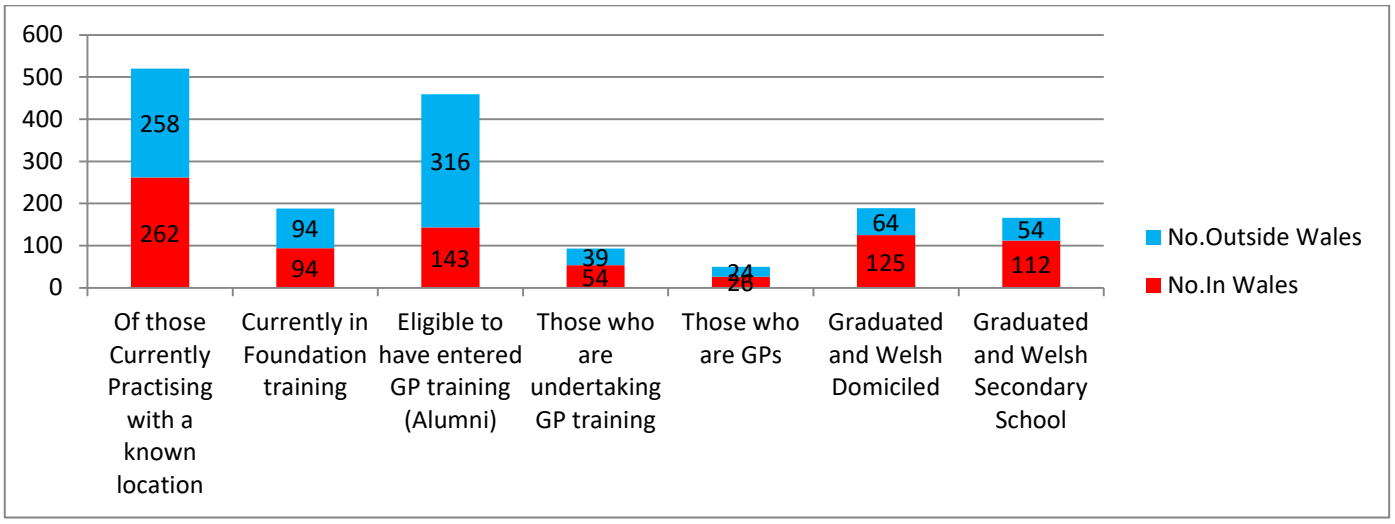
Origins and Destinations of GEM Students - Graphs







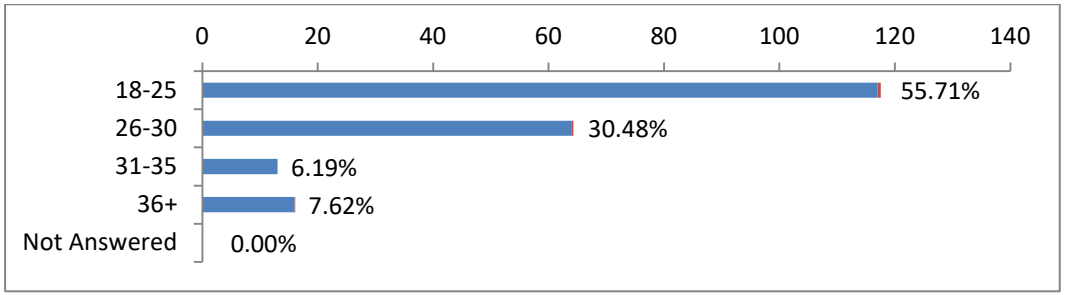



600
500
400
300
200
100
0
258
262
94
94
316
143
39
54
24
26
64
125
54
112
Of those Currently Practising with a known location
Currently in Foundation training
Eligible to have entered GP training (Alumni)
Those who are undertaking GP training
Those who are GPs
Graduated and Welsh Domiciled
Graduated and Welsh Secondary School
No.Outside Wales
No.In Wales

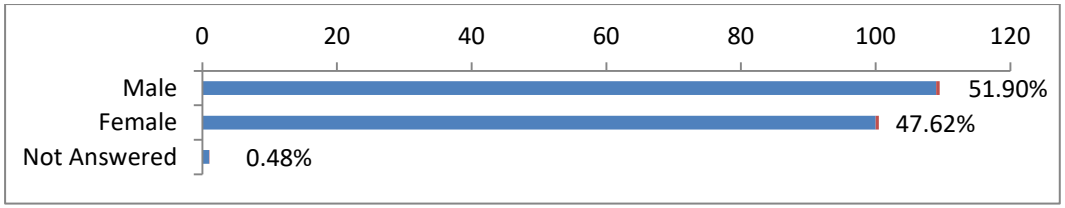
Appendix B: Swansea Student Survey

Total Responses **210**

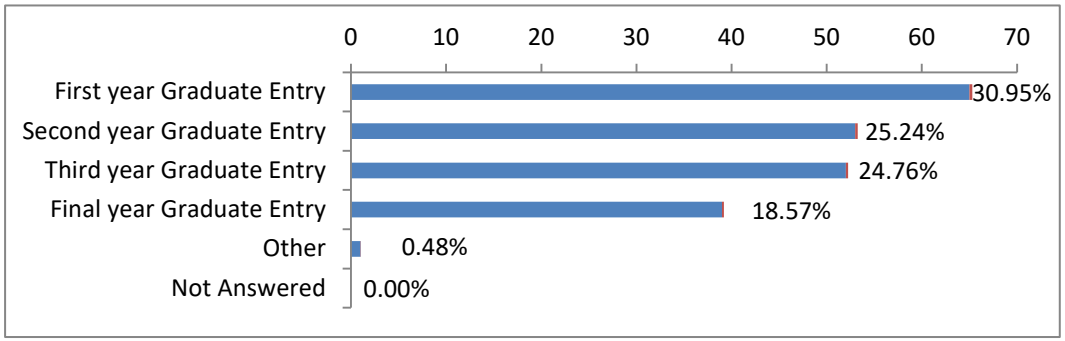
Age	Responses	%
18-25	117	55.71%
26-30	64	30.48%
31-35	13	6.19%
36+	16	7.62%
Not Answered	0	0.00%



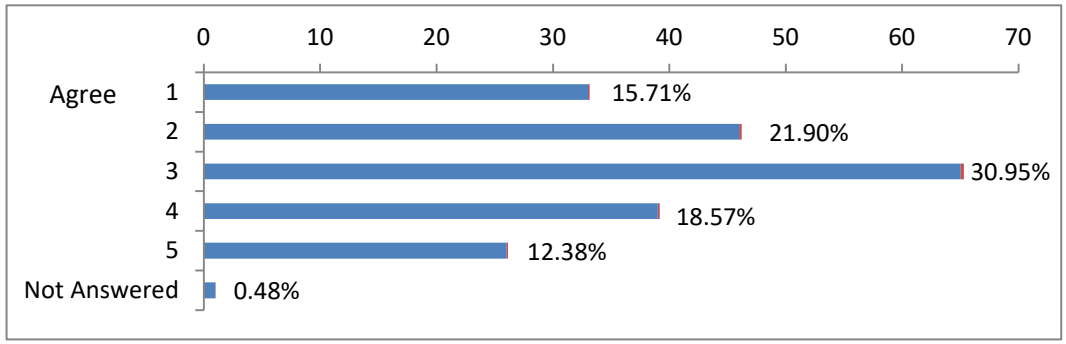
Gender	Responses	%
Male	109	51.90%
Female	100	47.62%
Not Answered	1	0.48%



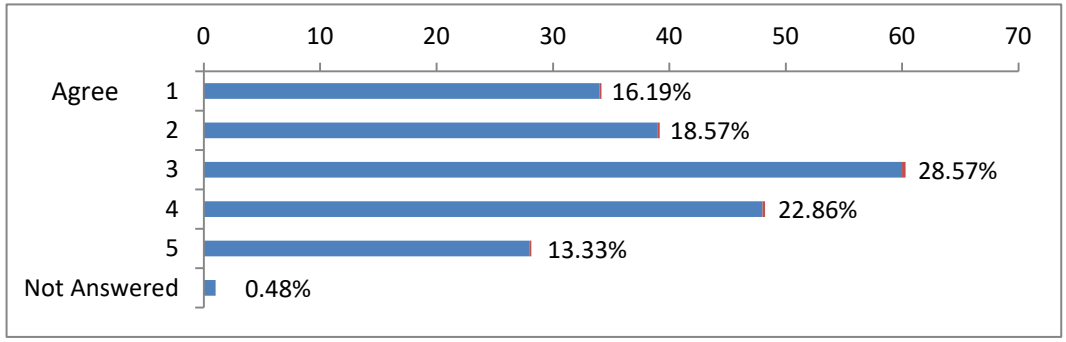
Year of Study	Responses	%
First year Graduate Entry	65	30.95%
Second year Graduate Entry	53	25.24%
Third year Graduate Entry	52	24.76%
Final year Graduate Entry	39	18.57%
Other	1	0.48%
Not Answered	0	0.00%



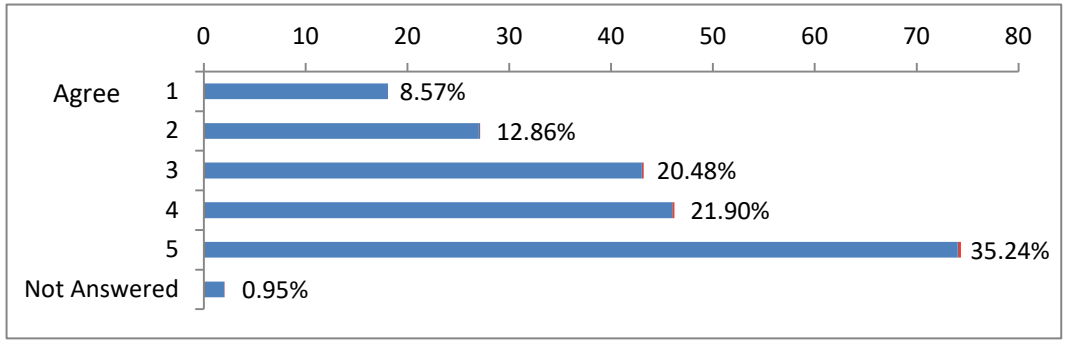
Junior in Wales, Speciality Elsewhere	Responses	%
1	33	15.71%
2	46	21.90%
3	65	30.95%
4	39	18.57%
5	26	12.38%
Not Answered	1	0.48%



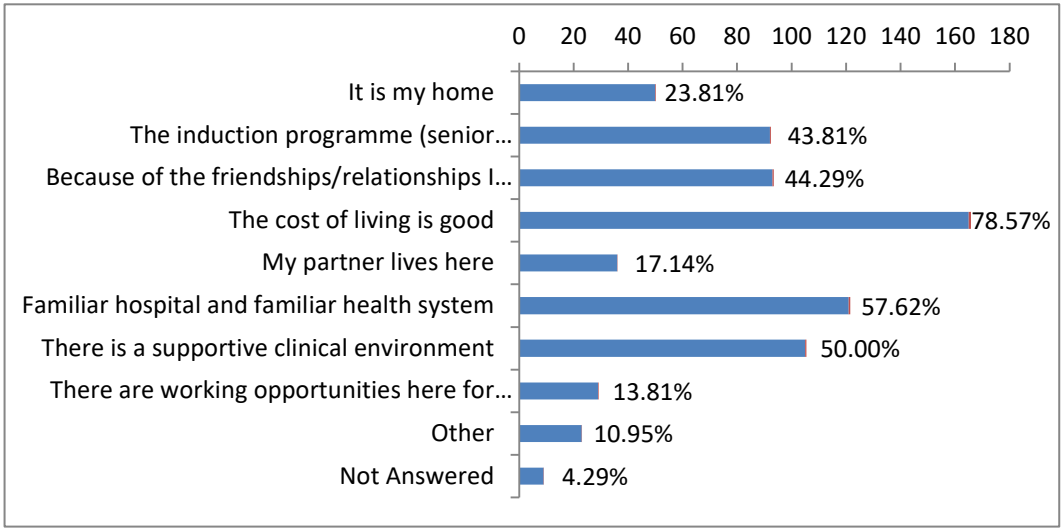
Junior in Wales, Speciality in Wales	Responses	%
1	34	16.19%
2	39	18.57%
3	60	28.57%
4	48	22.86%
5	28	13.33%
Not Answered	1	0.48%



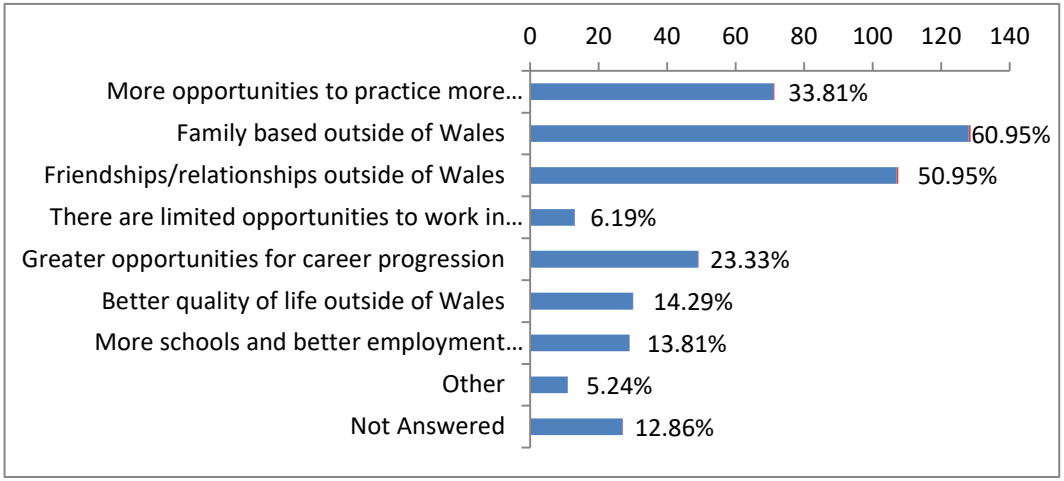
Do not wish to work in Wales	Responses	%
1	18	8.57%
2	27	12.86%
3	43	20.48%
4	46	21.90%
5	74	35.24%
Not Answered	2	0.95%



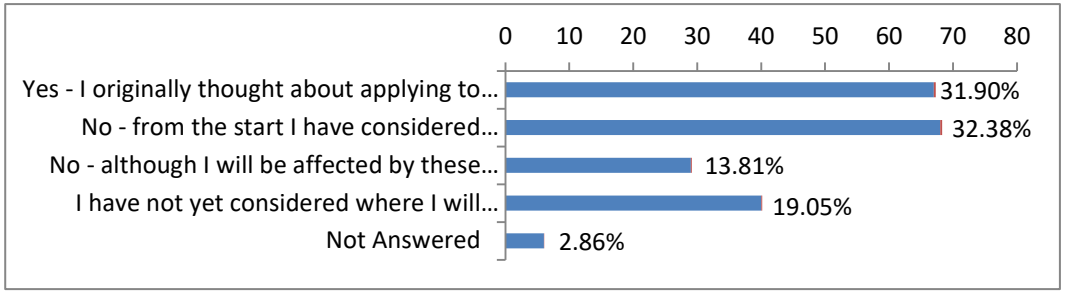
Pros and Cons of Working in Wales	Responses	%
It is my home	50	23.81%
The induction programme (senior assistantship)	92	43.81%
Because of the friendships/relationships I have made	93	44.29%
The cost of living is good	165	78.57%
My partner lives here	36	17.14%
Familiar hospital and familiar health system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



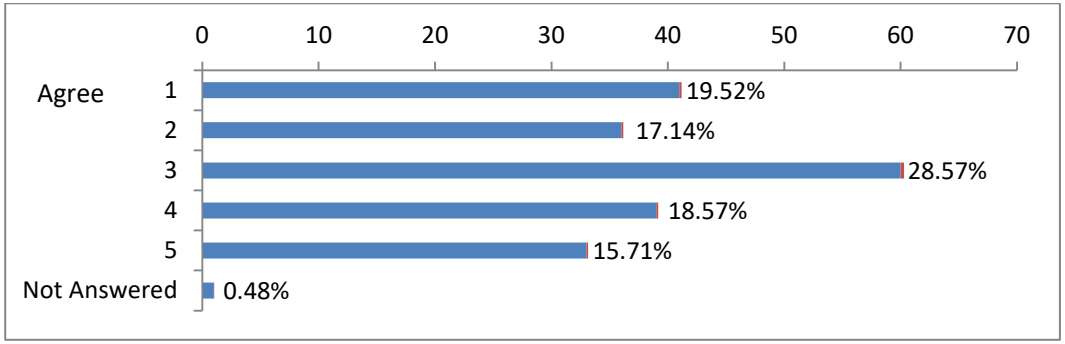
Factors not to want to work in Wales	Responses	%
More opportunities to practice more specialised medicine outside of Wales	71	33.81%
Family based outside of Wales	128	60.95%
Friendships/relationships outside of Wales	107	50.95%
There are limited opportunities to work in my desired location in Wales	13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



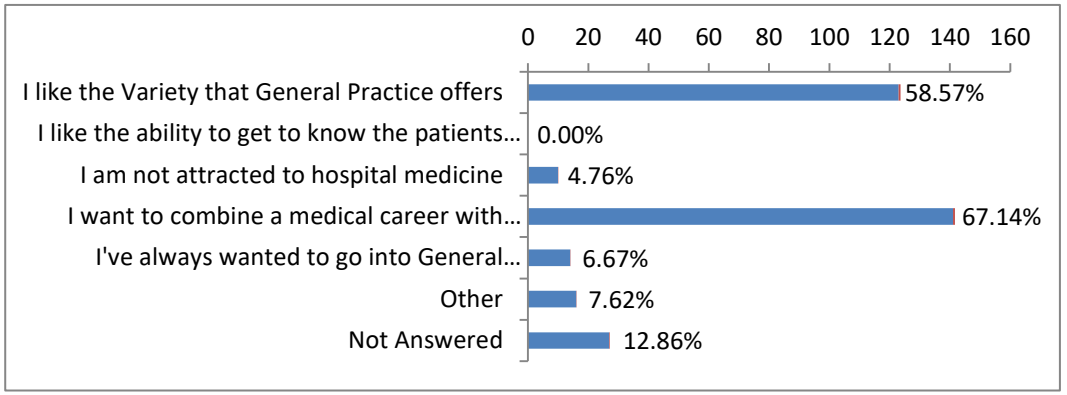
Have changes to Junior contract affected your choice	Responses	%
Yes - I originally thought about applying to another deanery however, these changes have made me consider Wales as my primary option	67	31.90%
No - from the start I have considered applying to Wales therefore, these	68	32.38%
No - although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



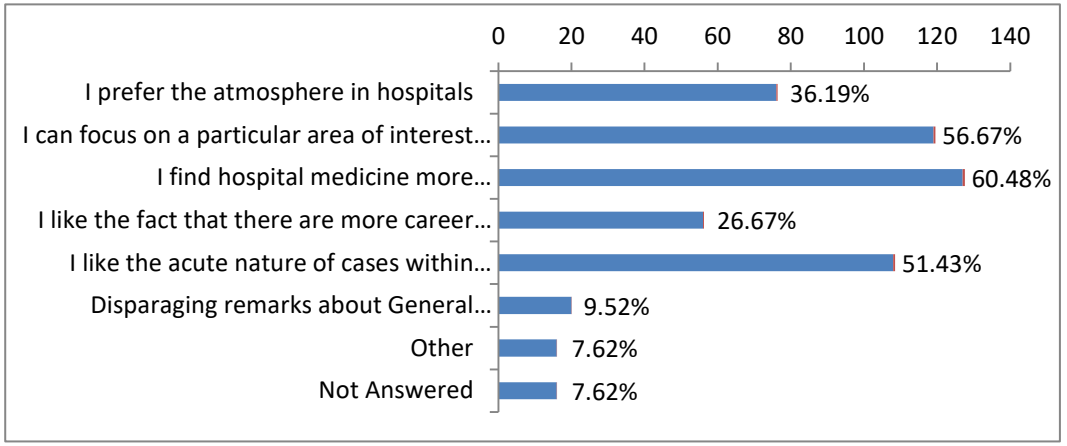
I am considering GP as a career	Responses	%
1	41	19.52%
2	36	17.14%
3	60	28.57%
4	39	18.57%
5	33	15.71%
Not Answered	1	0.48%



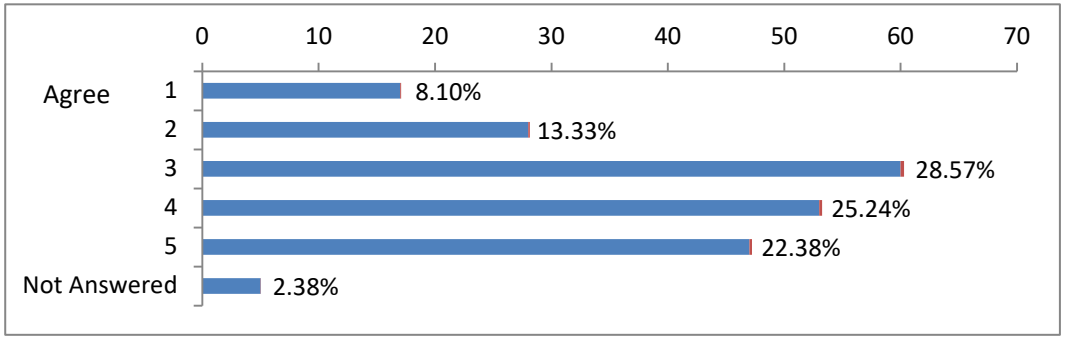
Aspects that have made you consider a career in GP	Responses	%
I like the Variety that General Practice offers	123	58.57%
I like the ability to get to know the patients and their needs	0	0.00%
I am not attracted to hospital medicine	10	4.76%
I want to combine a medical career with family life	141	67.14%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



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



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



Appendix C: All Wales GP Survey - Data

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

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

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

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

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

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

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

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

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

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

Leave GP within 10 years	Respondents	%
1(most likely)	83	19.3%
2	46	10.7%
3	60	14.0%
4	45	10.5%
5(least likely)	196	45.6%
Total	430	100.0%

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

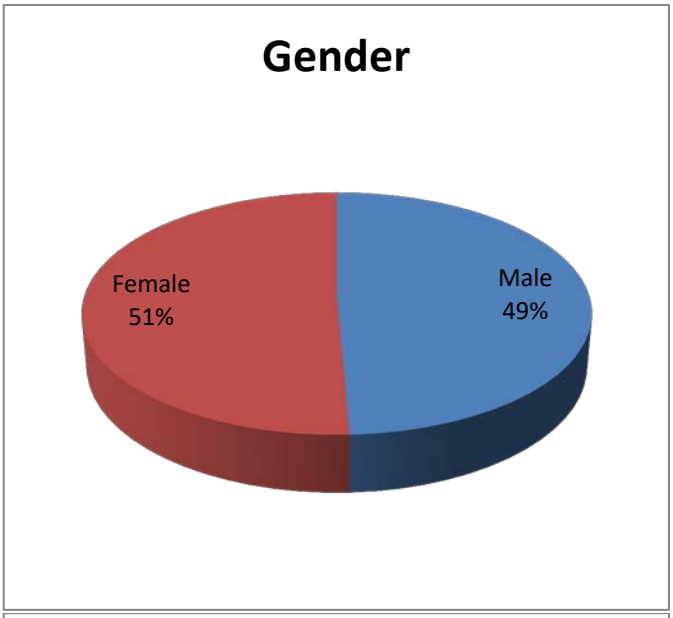
Distance from Secondary School	Respondents	%
Unknown	55	12.8%
0 to 25 miles	134	31.2%
25 to 50 miles	47	10.9%
50 to 75 miles	31	7.2%
75 to 100 miles	23	5.3%
100+ miles	140	32.6%
	430	100.0%

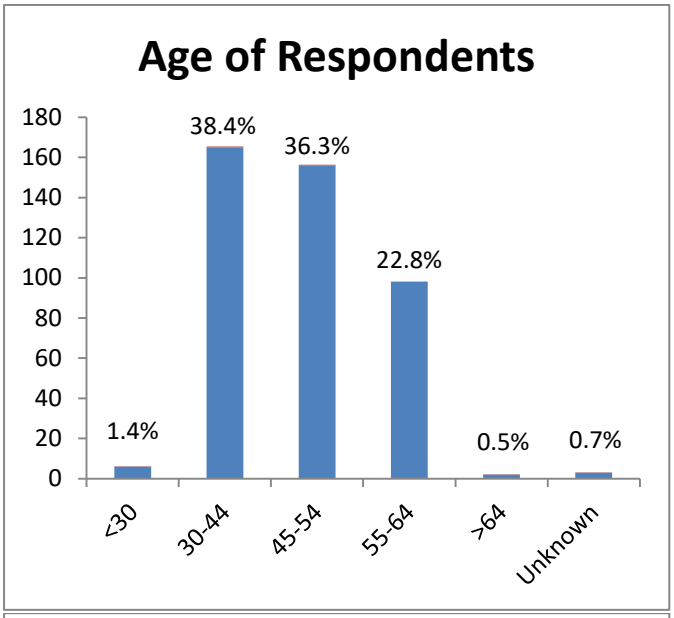
Distance from Welsh Secondary School	Respondents	%
0 to 25 miles	124	56.9%
25 to 50 miles	38	17.4%
50 to 75 miles	20	9.2%
75 to 100 miles	10	4.6%
100+ miles	26	11.9%
	218	100.0%

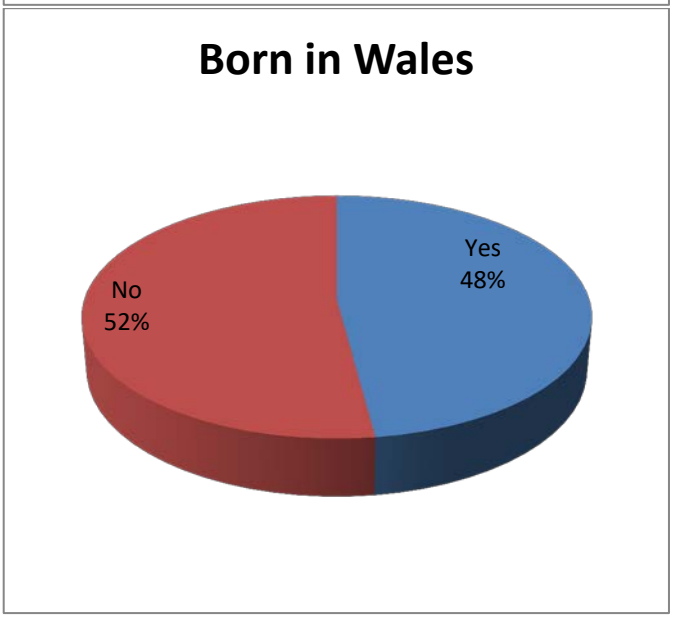
Distance from Welsh Secondary School	Respondents	%
0 to 10 miles	64	44.4%
10 to 20 miles	44	30.6%
20 to 30 miles	25	17.4%
30 to 40 miles	11	7.6%
40 to 50 miles	18	12.5%
	144	100.0%

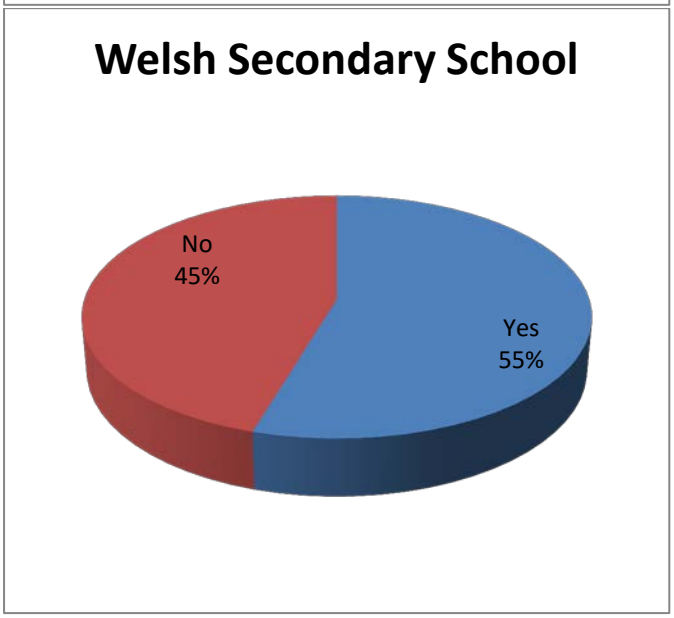
Factors for Practicing in Wales	Respondents	%
It is my home	213	49.5%
My partner/family lives here	182	42.3%
Familiar hospital and familiar health system	64	14.9%
Different political system and approach to health	33	7.7%
To care for dependents	15	3.5%
Other	123	28.6%

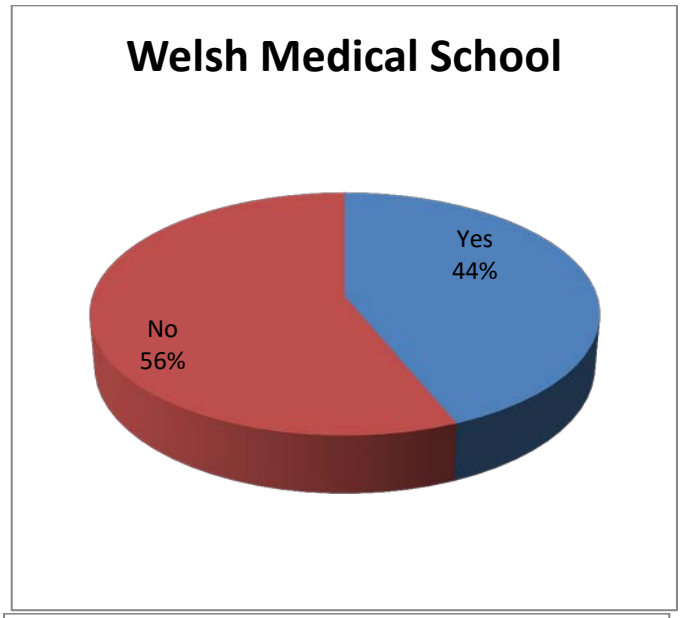
All Wales GP Survey - Graphs

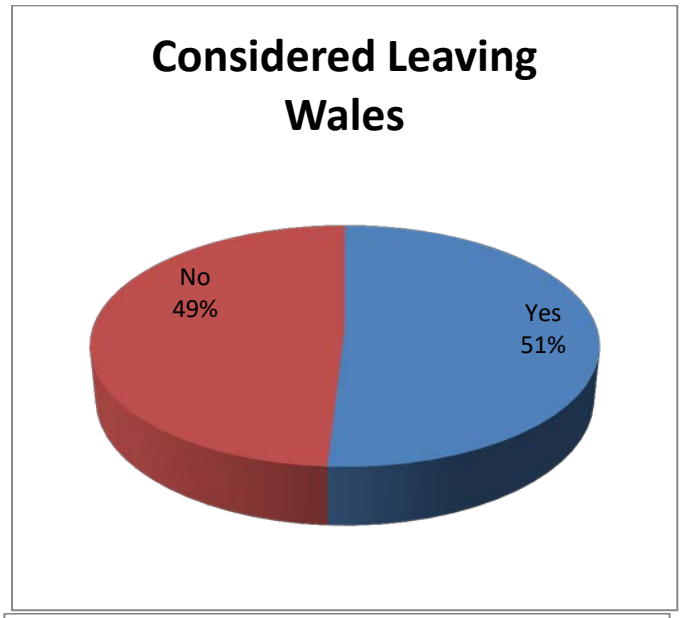


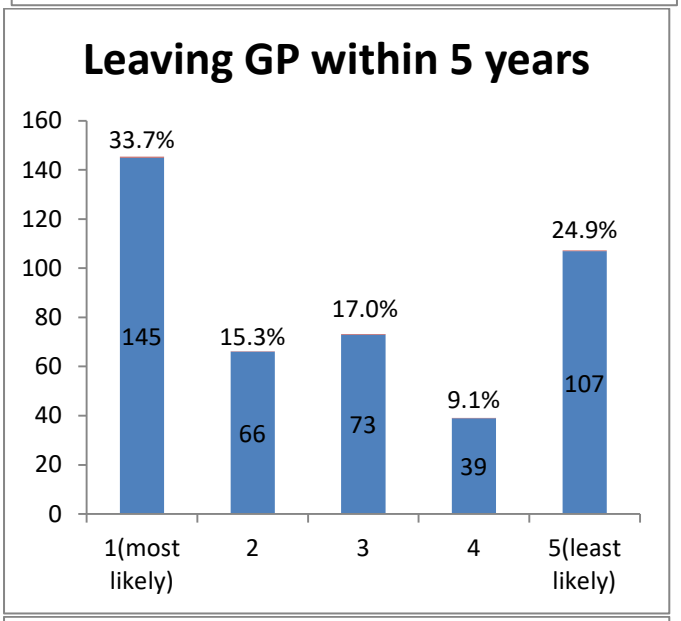


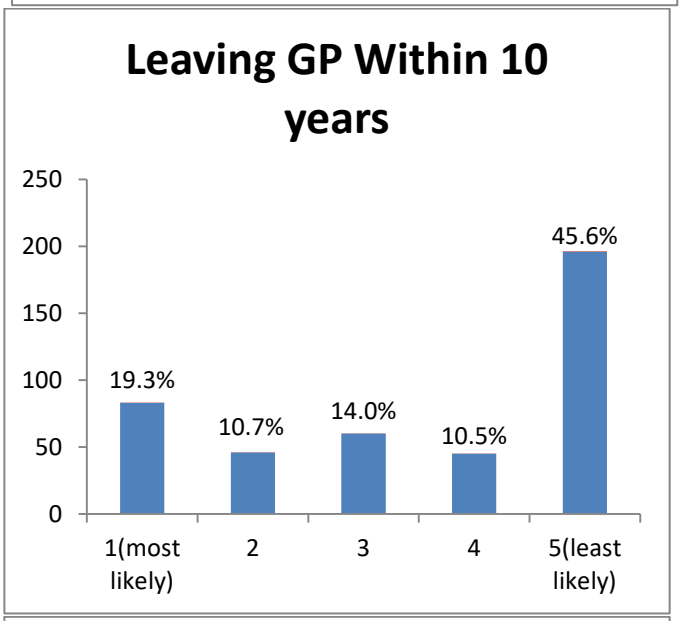




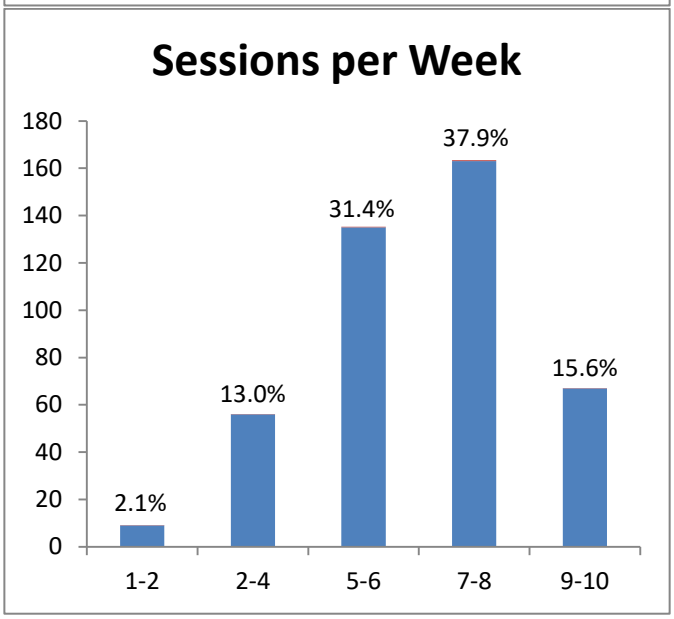

Welsh Medical School
Yes
44%
No
56%

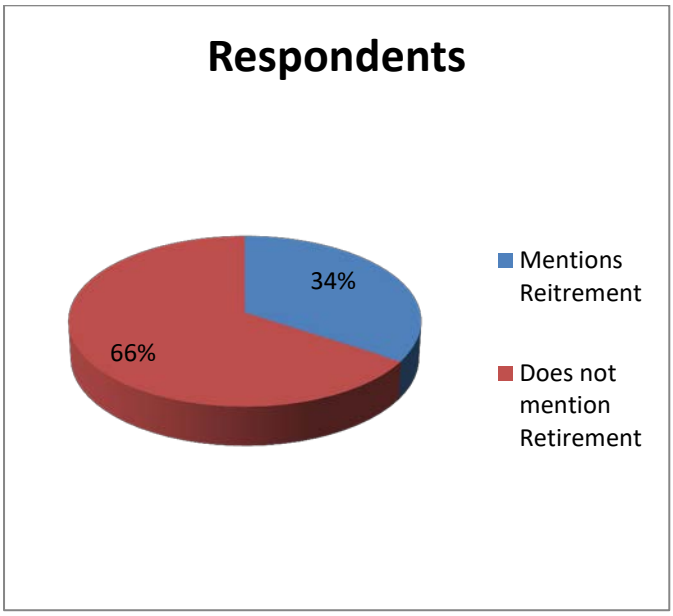

Considered Leaving Wales
No
49%
Yes
51%

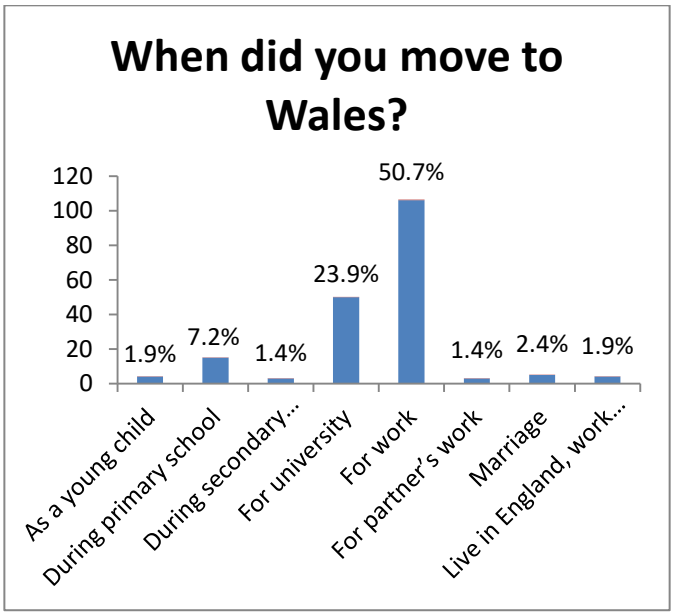

Leaving GP within 5 years
160
140
120
100
80
60
40
20
0
33.7%
145
15.3%
66
17.0%
73
9.1%
39
24.9%
107
1(most likely)
2
3
4
5(least likely)


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


Recommend a GP Career
No
39%
Yes
61%


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


Respondents
34%
66%
Mentions Reitrement
Does not mention Retirement


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

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

Llywodraeth Cymru
Welsh Government

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

Dr Dai Lloyd AM
Chair of the Health, Social Care and Sport Committee
National Assembly for Wales
Ty Hywel,
Cardiff Bay
Cardiff
CF99 1NA

31 January 2017

Dear Dai,

Public Health (Wales) Bill

Thank you for your letter on 24 January and for forwarding copies of the additional evidence the committee has received from the Royal College of Physicians and the Children's Commissioner for Wales.

Detailed consideration was given to the most appropriate age restriction for intimate piercing throughout the development of the Bill and the issue was also explored in depth during scrutiny by the previous Assembly.

In reaching the decision to set the age restriction at 16, a broad range of factors were taken into account. These included the views of stakeholders and the evidence submitted in response to Welsh Government consultations, as well as consideration of other types of activities, which are subject to restrictions at the ages of 16 and 18, and the full range of protections for children and young people provided under the United Nations Convention on the Rights of the Child (UNCRC). In particular, our approach intended to protect children and young people from harm without disproportionately trespassing on their rights to express themselves and make decisions about their own lives.

The committee's inquiry into the Bill has resulted in a number of stakeholders expressing a strong preference for raising the proposed age restriction for intimate piercing to 18, for a range of reasons. I have also noted the call from the Children's Commissioner for Wales, in her most recent letter to the committee for further consideration of information and evidence in this area. I have therefore instructed my officials to re-examine the evidence, particularly that which has recently emerged.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

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

Due to the complex and detailed work involved, this will take several weeks to complete. My intention is to consider the conclusions the committee reaches on this finely-balanced issue as part of its stage one review of the Bill and outline the Welsh Government's position when the general principles of the Bill are debated by the National Assembly.

I look forward to receiving the committee's report on the Bill's general principles shortly.

Kind regards,

Rebecca

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

Document is Restricted