



Health, Social Care and Sport
Committee

Medical recruitment

June 2017



National Assembly for Wales
Health, Social Care and Sport Committee

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The Committee was established on 28 June 2016 to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters, encompassing (but not restricted to): the physical, mental and public health and well-being of the people of Wales, including the social care system.

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South Wales West



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Chair's Foreword

Concerns about the recruitment, retention and sustainability of the NHS workforce in Wales are well-publicised.

We heard, as part of this Committee's first inquiry into winter preparedness, a strong and consistent message that sufficient service capacity and enough staff are vital components in any effective healthcare system. We therefore agreed that, over the course of this Assembly, we would review the sustainability of the health and social care workforce. This inquiry into medical recruitment is the first in a series which will consider issues relating to the broader workforce.

We are concerned about the low and declining numbers of Welsh-domiciled students applying to medical schools across the UK. Despite some improvement during the 2017 application round, the number of applicants from Welsh domiciled students is still considerably lower than other parts of the UK. Also of particular concern is the low number of Welsh domiciled students securing places at Welsh medical schools. This is especially concerning in light of the evidence we heard that there is a tendency for students, once qualified, to remain in the area where they studied initially.

We believe there is a clear case for increasing medical school capacity within Wales if we are to address the current recruitment and retention issues. This must include agreeing a clear plan to develop more opportunities for undergraduate medical education in North Wales.

We heard about the importance of engaging with schools at a much earlier stage. There is a clear need to take the message out to schools across Wales that medicine is a career that pupils can aspire to, and that it is a realistic and achievable aspiration for students from all communities.

There are a number of factors that influence the recruitment and retention of medical staff. We heard about the importance of a good work/life balance for staff and their families, including good access to schools, communities, social life and stability of trainee placements. We welcome the Welsh Government's commitment to attract and train more healthcare professionals in Wales, particularly the recent Train, Work, Live campaign, which promotes the broader concept of what NHS Wales and Wales as a country has to offer. However, there is still further work to be done to address the wide range of factors that could attract new medical staff to Wales and retain the existing workforce.

Recruitment and retention is a key issue for the future of the NHS in Wales. I trust that the evidence we have gathered and the recommendations we have made will contribute towards delivering the long term solutions that are needed.

Dr Dai Lloyd AM, Chair

Conclusions and recommendations

Recommendation 1. The Cabinet Secretary for Health, Well-being and Sport should agree and publish by September 2017 a clear action plan and timeline for establishing the new single body [Health Education Wales]. Page 13

Recommendation 2. The Welsh Government should work with the Deanery (or any successor body) and the medical schools in Wales to secure a sustained increase in the number of Welsh-domiciled students applying to medical schools within Wales. Page 39

Recommendation 3. The Welsh Government should work with the Deanery (or any successor body) and medical schools in Wales to develop a programme of support and advice on medical schools admissions and interviews for pupils in Wales. Page 40

Recommendation 4. The Cabinet Secretary should discuss and agree plans with the medical and clinical schools in Wales that will enhance and develop undergraduate medical training in Wales. This plan should include an increase in undergraduate medical school places, and an increase in the percentage of Welsh-domiciled students securing those places. Page 40

Recommendation 5. The Welsh Government should set out a clear plan to develop opportunities for undergraduate medical education in North Wales. This should include a new centre for medical education in Bangor. The Cabinet Secretary should announce a decision within the timescales he has set for 'summer 2017'. Page 40

Recommendation 6. The Welsh Government should work with the Deanery (or any successor body) and medical schools to develop proposals to increase time in general practice, as a key part of both the undergraduate curriculum and trainee doctor foundation training. Page 41

Recommendation 7. The Welsh Government and Deanery (or any successor body) should develop and agree proposals for an increase in the number of training places, targeted at key pressure areas. This should be accompanied by the greater devolution of powers for flexible deployment of this training capacity, especially in GP training. Page 41

Recommendation 8. The Welsh Government should:

- seek appropriate amendments to regulations to enable Post-F2 doctors to work as locums in general practice;
- continue discussions with the UK Government on performers list regulation with the aim of enabling doctors to be on the performers list in both England and Wales. Page 41

Recommendation 9. The Welsh Government should work with Welsh medical schools, local health boards and the Welsh Deanery (or any successor body) to develop a joint action plan for rural medical training and education, drawing on experience and best practice from elsewhere, both nationally and internationally. Page 50

Recommendation 10. The Welsh Government must focus on robust long term workforce planning by commissioning work which involves the key stakeholders in NHS Wales, Welsh medical schools, medical students and medical trainees to develop a comprehensive, all-Wales evidence base in respect of recruitment and retention. This would serve to inform recruitment strategies and campaigns. Page 50

Recommendation 11. The Welsh Government should ensure an evaluation is undertaken of the scope, reach and impact of the Train, Work, Live campaign, with a focus on outcomes achieved and lessons to be taken forward. These lessons should inform an on-going annual recruitment campaign for doctors. Page 53

Recommendation 12. The Welsh Government should provide an update to the Committee by the end of 2017 (and annually thereafter) on the impact of the GP Incentive Scheme, and examine and undertake work to

identify potential options for other financial or similar incentive schemes to attract and retain potential and practising doctors. Page 54

Recommendation 13. The Welsh Government should work with key stakeholders to develop options for ensuring the delivery of a single, national point of access for detailing current medical vacancies within Wales. Page 57

Recommendation 14. The Welsh Government should collate and publish the numbers of medical vacancies within Wales in order to inform long term and robust work-force planning strategy. Page 57

Recommendation 15. The Welsh Government should continue dialogue with the UK Government to emphasise the importance of quickly clarifying the ability of EU nationals to continue and commence working in the UK. Page 60

Recommendation 16. The Welsh Government should continue dialogue with the UK Government to seek assurances about the ability of EU nationals to work as medical professionals in Wales in the future. Page 61

01. Background

The purpose of the inquiry

1. As part of our programme of work on the sustainability of the health and social care workforce, we agreed to undertake a focused inquiry on medical recruitment. This piece of work followed on from the Fourth Assembly Health and Social Care Committee's inquiry on the GP workforce.
2. The intention of the inquiry was to seek views on:
 - the capacity of the medical workforce to meet future population needs, in the context of changes to the delivery of services and the development of new models of care;
 - the implications of Brexit for the medical workforce;
 - the factors that influence the recruitment and retention of doctors, including any particular issues in certain specialties or geographic areas;
 - the development and delivery of medical recruitment campaigns, including the extent to which relevant stakeholders are involved, and learning from previous campaigns and good practice elsewhere;
 - the extent to which recruitment processes/practices are joined-up, deliver value for money and ensure a sustainable medical workforce.

Engaging and gathering evidence

3. The Committee was keen that this inquiry heard from a wide range of organisations and individuals, across the spectrum of involvement in training, education and recruitment. We carried out an initial, broad piece of evidence-gathering to help understand the key workforce issues across the health and social care sector, which was designed to help inform our approach to looking at workforce issues throughout the Fifth Assembly. This included a **consultation during summer 2016** and an **online survey** targeting those who work in health and social care in the public, private and voluntary sector, conducted by the National Assembly's Outreach Team. This resulted in 856 responses.
4. From 6 October to 18 November 2016 the Committee ran a consultation focused specifically on medical recruitment and **received 33 responses** representing a range of stakeholders, including health care organisations from across Wales, professional bodies, universities and individual clinical staff. In addition, we heard oral evidence from a number of witnesses. The **schedule of oral evidence** sessions is published on the Assembly's website.
5. The Committee also visited Cardiff University on 13 October 2016, where we saw some of the facilities used in training future clinical staff, including the **Clinical Skills Centre and Clinical Simulation Suite** which provides realistic clinical environments in which students can develop their technical skills and practice safe and effective patient care. We also heard about the University's work on inter-professional education and had the

opportunity to talk to students about their experience of training and what had influenced their decision to train in Wales.

6. During the formal evidence sessions we heard evidence from a specially convened panel of trainee doctors from across Wales, from both General Practice and a number of different hospital specialties. One member of the trainee panel, Dr Huw Lloyd Williams, also produced a **report for the Committee**¹ which presented the views of trainee doctors from across Wales in Emergency Medicine on their undergraduate and postgraduate medical training.

7. The written submissions the Committee received also included a **report**² from Dr Heidi Phillips, Director of Admissions for the Swansea Graduate Entry Medicine Programme (GEMP). This report set out details of all the GEMP students, tracking where they came from and onward through application, medical school and into the workforce. It also contained the results of surveys of current Swansea medical students, to gauge their impression of remaining in Wales and working in General Practice, as well as the results of an e-questionnaire to GPs across Wales concerning their perceptions of General Practice.

8. The Committee would like to thank all those who have contributed to its work.

¹ Written evidence MR29

² Written evidence MR28

02. The current structure of medical education and training in Wales

Undergraduate medical education

9. Undergraduate medical training in Wales is provided currently by two medical schools: at Cardiff University and Swansea University. This is dealt with in more detail in Chapter 3.

Postgraduate medical education

10. The Wales Deanery delivers postgraduate medical and dental education and training for Wales. It supports, commissions and quality assures the education and training of nearly 23,000 trainees, dentists and dental care professionals and contributes to continuing professional development for secondary care doctors and general practitioners (GPs) for Wales. This includes a remit to develop innovative models of education and training delivery, building training capacity, and facilitating the delivery of a GP and hospital appraisal system.

11. The Deanery provides a wide range of activities underpinned by the General Medical Council (GMC) approved quality management framework, and runs over 50 specialty training programmes.

12. Funding for the Deanery is provided by the Welsh Government and the Deanery works in partnership with Local Health Boards (LHBs) and NHS Trusts in Wales. The importance of the Deanery to healthcare services in Wales was summarised by Professor Robin Williams in evidence to the Committee:

“They have a very difficult job to do, because on the one hand, there are the health bodies who need workers and then, on the other, there is a need to provide the right education for students.”³

The Williams Report / Health Education Wales

13. Professor Williams led the work that produced Health Professional Education Investment; Report on the single set of arrangements (2016) (The Williams Report). Commissioned by the Welsh Government, this report recommended combining the management of the NHS Wales functions for strategic workforce planning, education commissioning, organisational change and role design, workforce intelligence, NHS Wales’s careers and widening access to the workforce into a new single body - Health Education Wales. This would involve combining the existing Deanery and the NHS Wales Workforce, Education and Development Services (WEDS).

³ RoP, 2 February 2017, paragraph 25

14. The review recognised the significant work required to set up the new single body, including Chief Executive and board appointments, and avoided setting out a rigid timeline, which it acknowledged was for the Welsh Government to determine. However, it proposed that Health Education Wales be established in shadow form from 1 April 2017, if possible, and be implemented fully from 1 April 2018.

15. Professor Williams outlined the support received from stakeholders for quick implementation of the proposals⁴ and said that he understood that a Project Director was now in place⁵. The Cabinet Secretary for Health, Well-being and Sport confirmed that he expected Health Education Wales to be up and running by April 2018 but with some form of shadow body in place before then.⁶

16. The Cabinet Secretary set out some of the advantages he believed that Health Education Wales could bring:

“I think it will actually allow us to use our ability to plan our whole workforce in a different way, in a more joined-up way, rather than having different streams looking at things separately, and that’s been part of our challenge.”⁷

“I wouldn’t want to try and pretend to you that Health Education Wales means there will be more money, but I think we’ll be able to make smarter and better use of it in the way that we plan our whole workforce, not just the medical part of it.”⁸

17. This point was echoed in the evidence given by Professor Stephen Riley, Dean of Cardiff University Medical School:

“I think trying to bring everything under one roof, one umbrella, is an important way to go. As you’ve heard in other evidence, trying to have a joined-up approach, an all-Wales approach, to the recruitment, retention and funding of healthcare is important. We’re increasingly recognising that the inter-professional nature of healthcare delivery, and trying to co-ordinate that centrally, is something that I think is important.”⁹

18. Professor Williams also set out the importance of the new body working closely on workforce planning, training and education with all the key organisations; education providers, royal colleges and regulators, as well as having the confidence of both the Welsh Government and Local Health Boards (LHBs):

⁴ RoP, 2 February 2017, paragraph 8

⁵ RoP, 2 February 2017, paragraph 12

⁶ RoP, 15 March 2017, paragraph 8

⁷ RoP, 15 March 2017, paragraph 5

⁸ RoP, 15 March 2017, paragraph 6

⁹ RoP, 9 March 2017, paragraph 4

“It’s crucial that the chief executive of this body sits with the other chief executives of the health boards in Wales, so that the workforce issues and commissioning and training is there right from the beginning, so that the chief executive can listen to the needs of the health board, the way they’re thinking for the future, and can respond early.”¹⁰

“It’s got to look at the pipeline, I think, of health-related people coming through, right from the schools. And there’s a lot that can be done at that level—at every level, in fact. I would have thought that would be one of the tasks of the new body.”¹¹

Our view

19. It is clear from the evidence we heard that the new single body proposed by The Williams Report offers significant opportunities for improved and more integrated planning, commissioning and delivery of medical education and training right through from schools and University Medical Schools into LHBs and General Practice. However, we are concerned that there appears to be no information about any tangible progress in establishing the shadow body.

Recommendation 1. The Cabinet Secretary for Health, Well-being and Sport should agree and publish by September 2017 a clear action plan and timeline for establishing the new single body [Health Education Wales].

¹⁰ RoP, 2 February 2017, paragraph 32

¹¹ RoP, 2 February 2017, paragraph 70

03. The medical workforce: current and future capacity

Undergraduate medical education in Wales

Current provision in Wales

20. There are currently two medical schools providing undergraduate medical education in Wales: **Cardiff** and **Swansea**.

21. Cardiff University offers a standard five year programme, along with a four year **Graduate Entry Medicine (GEM) programme** and a six year **Medicine with a Preliminary Year programme**. The latter is designed for students with high academic potential who have not met the specific requirements for the five year medical programme. The course is delivered in practical classes, lectures, the virtual learning environment and both hospital and community settings. The University also provides other related undergraduate courses, including Medical Pharmacology and Biomedical Sciences.

22. Swansea University offers a four year GEM Scheme. The Medical School also provides undergraduate programmes in Medical Sciences, Biochemistry and Genetics and, from September 2017, BSc Applied Medical Sciences. The University guarantees Medical Genetics, Medical Biochemistry and Applied Medical Sciences students an interview for their GEM programme, provided students meet the minimum entry criteria.

23. The medical school at Cardiff University works in partnership with the **North Wales Clinical School** at Bangor and Glyndwr Universities, with clinical placements at hospitals in both South and North Wales. Swansea University students have placements in Abertawe Bro Morgannwg University Health Board (UHB) and Hywel Dda University Health Board areas.

Criteria for admission to medical schools in Wales

24. The medical schools at Cardiff University and Swansea University – in common with other medical schools – set their own admissions policies and criteria. At Cardiff there are minimum academic requirements for their **undergraduate medical programme**, with applications being ranked initially according to overall certificated academic qualifications. Their admissions policy for undergraduate medicine states that:

“This means that not all applicants who have met the minimum academic requirements will proceed to the next ‘non-academic’ stage of the selection process; it will depend on their ranking, and consequently, the competition. Once academic ranking of all applications is complete, a cut-off point is decided.”¹²

25. Applicants to Cardiff who meet the minimum academic requirements and are sufficiently highly ranked academically are assessed on non-academic criteria based on their

¹² Cardiff University **Admissions Policy for undergraduate medicine**, page 10

personal statement and their referee's report. Non-academic requirements will also be assessed at any potential interview, and include:

- medical motivation and awareness of the career;
- caring ethos and a sense of social awareness;
- sense of responsibility;
- evidence of a balanced approach to life;
- evidence of self-directed learning and extracurricular activities.

26. However, Cardiff University recognises that work and non-academic opportunities can vary and is not prescriptive about how the criteria are demonstrated. Interviews are offered to those achieving the highest positions according to their academic and non-academic rankings. For the 2017 entry, applicants were required to attend multiple mini interviews (MMI).¹³

27. Applicants to Swansea who meet the minimum entry requirements¹⁴ are ranked based upon their GAMSAT scores¹⁵. The applicants who have scored most highly are then invited to attend the Selection Centre at the Medical School. At the Selection centre, candidates sit a short written assessment to try and identify those with the personal and academic qualities suitable for a medical career. Candidates then attend two separate 20-minute interviews looking at the candidate's personal statement. The interview process is designed to take account of the personal and academic qualities needed as a doctor:

- communication skills;
- problem solving skills;
- coping with pressure;
- insight and integrity;
- passion for medicine/resilience to succeed.

28. The candidates who score highest in the selection process will be offered a place at Swansea.

29. Admission to the Cardiff University and Swansea University GEM Programmes is based on both academic and non-academic criteria, assessed via application and interview. The Cardiff University GEM programme is available only to entrants from designated

¹³ The MMI process is based around ten 6-minute interviews focusing on exploring the personal qualities and attributes important in developing good doctors in the future.

¹⁴ **Courses and application details, Swansea Medical School GEM**

¹⁵ GAMSAT is a selection test for medical schools offering graduate-entry programmes open to graduates of any discipline; it evaluates the nature and extent of abilities and skills gained through prior experience and learning, including the mastery and use of concepts in basic science, as well as the acquisition of more general skills in problem solving, critical thinking and writing.

undergraduate Feeder Stream Courses in the Universities of Cardiff, Bangor and South Wales. The Swansea University GEM is open to graduates of any discipline.

Applications and admissions to medical schools: statistics for Wales and the UK

30. We heard concerns from a number of stakeholders about the low and declining numbers of Welsh-domiciled students applying to medical school, and the low number of such students subsequently studying at Welsh medical schools. We also heard evidence about individual cases involving Welsh-domiciled pupils who applied unsuccessfully to Welsh medical schools, but were accepted subsequently at medical schools in England.

31. A member of the trainee doctor panel, Dr Bethan Roberts, told us that she had ended up training in England because she was not offered a place in Cardiff. She said:

“As someone who had to go elsewhere to train, my form tutor was very angry about this and looked into the figures. I think the intake was under 20 per cent, that year, of Welsh-domiciled students.”¹⁶

32. In relation to this issue, the Cabinet Secretary told us:

“I wouldn’t be surprised if lots of Members have got those individual anecdotes within their constituency of people who are clearly bright, talented young people who don’t get an offer of a place in Cardiff but do get an offer in a medical school in a different part of the country. Part of the challenge for us to understand is that it isn’t that we would say that every person who wants to study medicine and gets over the bar to the entry criteria will get a place in Cardiff and Swansea, but it is about saying that we should not readily accept that everything is fine and we couldn’t do any better, and that goes back to the initial question. So, I recognise that, and I’ve had instances in my own constituency, with people saying, ‘Why should it be that my daughter, from a part of the city that isn’t a traditional entrance for medicine, who is predicted to get straight As, couldn’t even get an interview?’

So, I recognise that that’s a real feature in the story, and it’s really about ensuring that medical schools respond properly to that, in looking at their own admissions procedures, and understand that we expect them to do better.”¹⁷

33. Published data shows there has been a decline of around 14 per cent between 2015 and 2017 in the number of Welsh-domiciled students applying to study medicine for all UK medicine courses. This is compared with falls of around 5 per cent in England, 3 per cent in Scotland, just over 5 per cent in Northern Ireland and 5 per cent across the UK. There was also an 11.4 per cent fall in applications from the EU between 2015 and 2017, dropping by around 16 per cent between 2016 and 2017.

¹⁶ RoP, 2 February 2017, paragraph 256

¹⁷ RoP, 15 March 2017, paragraphs 34 and 35

Table 1: Applicants for all UK medicine courses, 2013-2017¹⁸

Domicile of applicant	2013	2014	2015	2016	2017	% change 2015-17
England	14,520	14,670	12,930	12,620	12,320	-4.8%
Northern Ireland	660	590	570	580	540	-5.3%
Scotland	1,160	1,170	1,060	1,050	1,030	-2.9%
Wales	670	710	660	570	570	-14.7%
UK total	17,000	17,140	15,220	14,820	14,450	-5.1%
EU (excluding UK)	1,990	2,110	1,940	2,050	1,720	-11.4%
Non-EU	3,130	3,490	3,230	3,240	3,040	-5.9%
All	22,130	22,740	20,390	20,100	19,210	-5.8%

34. The Royal College of Physicians (RCP) reported in *Physicians on the front line: The medical workforce in Wales in 2016* that only 30 per cent of Welsh medical school undergraduates were Welsh domiciled, compared with 85 per cent in Northern Ireland, 80 per cent in England and 55 per cent in Scotland, and the RCP report states:

“It is crucial that Wales makes a more concerted effort to attract its own students to medical school in Cardiff and Swansea... 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.”¹⁹

35. Martin Jones of Betsi Cadwaladr UHB stressed the value of more Welsh-domiciled students:

“... if you’re starting with a greater number of people who are predisposed to the idea of working within their local communities, then the likelihood of people coming forward must be higher. So, I think one of the big things must be about increasing the proportion of people who are going through a Welsh medical education, who are domiciled in Wales and who are Welsh-speaking, because to fulfil that need as well—that’s going to be really, really important.”²⁰

¹⁸ Data from UCAS

¹⁹ Royal College of Physicians *Physicians on the front line: The medical workforce in Wales in 2016*, page 12

²⁰ RoP, 16 February 2017, paragraph 363

36. Dr Trevor Pickersgill from the RCP echoed this evidence about students remaining in the area where they study initially:

“...the number of Welsh applicants to Welsh medical schools is going down and we really need to know why and reverse that, because, when you come to medical school here, you tend to stick, like you do wherever you go. And when the Welsh schoolchildren go to Newcastle or London or Scotland, they’ll probably stay there. Some will come back, but mostly they’ll stay there.”²¹

37. We heard from Professor Stephen Riley, Dean of Cardiff University Medical School, who acknowledged that the School wanted and needed to get more Welsh-domiciled students, and stressed their commitment to widening access. He indicated there were signs of improvement during the 2017 application round:

“Around 50 per cent of Welsh students will apply to Cardiff for an undergraduate place in medicine. For this year, it was 288 students out of about 570. Those figures have been relatively static over the last five years.”²²

“This year, we’ve interviewed 213 of that 288. So, by contextualising the Welsh students and those students who are from underprivileged areas, we’ve managed to increase the ability to offer interviews to students. So, we’re up to nearly 70 per cent of those who apply to us being interviewed. This year, we’ve been able to offer 130 places, of those 213. So, around 61 per cent of Welsh students who applied to Cardiff have been offered a place this year.”²³

38. Professor Riley linked the rise in the number of successful Welsh applicants this year to the Medical School’s use in this recruitment round of the multiple mini interview (MMI) and contextual data (also adopted by Swansea University) in applications. This looks at the broader details of a candidate’s background, including academic and socio-economic factors.²⁴

39. Professor Keith Lloyd, Dean of Swansea University Medical School, reported that it receives around 1,000 applications, it subsequently interviews around 300 prospective students for the 70 available places, and could take more students if they had more available places. We also heard that Swansea University Medical School was becoming increasingly popular, and therefore an increase in available places would be important in enabling sufficient places for Welsh-domiciled students as there would also be increased interest from outside Wales.²⁵

²¹ RoP, 8 February 2017, paragraph 18

²² RoP, 9 March 2017, paragraph 35

²³ RoP, 9 March 2017, paragraph 37

²⁴ RoP, 9 March 2017, paragraph 45

²⁵ RoP, 9 March 2017, paragraphs 57 and 60

40. Professor Robin Williams also stated that there was a need to look at the respective value of undergraduate and graduate entry to medicine, given that graduate entrants tend to be more settled and less likely to move.²⁶

41. A number of stakeholders argued for some system of positive action by Welsh medical schools in favour of Welsh-domiciled applicants. Professor Peter Barrett-Lee from Velindre NHS Trust, suggested that, for Welsh-domiciled applicants:

“...it would be good to see them actually get through to the interview stage because I think to give them a chance to talk about their experience of living and being born and brought up, or whatever, in Wales and what they can bring to that local medical school...What if they were to build in the postcode as part of that, and give those people a chance, at least at interview?”²⁷

42. The LHBs discussed the potential for the All-Wales Strategic Medical Workforce Group to consider quotas for medical education, but also sounded a note of caution about the implications in terms of employment legislation.²⁸ This caution was echoed by the Higher Education Funding Council for Wales (HEFCW) in its submission:

“Admissions to autonomous universities need to be transparent, and cannot favour Welsh-domiciled students and this needs to be taken into account in planning.”²⁹

43. Professor Riley from Cardiff University on this issue, said:

“I think the fairness, openness and transparency of the application process is something that we hold very dear...Within the rules of the game at the moment, we are doing all that we possibly can within the contextualised approach to get the Welsh students in.”³⁰

44. The Cabinet Secretary recognised the challenges faced by medical schools in Wales:

“I’d start off by saying that it hasn’t always been the mission of the two medical schools that we have to simply recruit the future NHS workforce for Wales...There are challenges there about how medical schools see themselves as well. They want the brightest and the best and we should want very high-quality applicants, but there is a challenge, I think, about ensuring that we do get more Welsh-domiciled students to be offered places in our two medical schools,

²⁶ RoP, 2 February 2017, paragraph 94

²⁷ RoP, 16 February 2017, paragraph 369

²⁸ RoP, 16 February 2017, paragraph 299

²⁹ Written evidence MR30

³⁰ RoP, 9 March 2017, paragraph 135

without compromising on quality, because I don't accept that you have to compromise on quality to do that."³¹

45. Alongside his acknowledgement of the progress made by both medical schools in Wales, the Cabinet Secretary also set out the need for further additional improvement:

"I think it's fair to say that, previously, we haven't had as much return as we would have wanted. I also think it's helpful to say that I think both medical schools recognise that...I think there's more they could and should do within their current envelope, let alone any potential for expansion, because this Government would expect that any further investment into those two medical schools, to expand the numbers of training places, would have to be on the basis that there would be more Welsh-domiciled students taking up those places."³²

"We need to have a system where we can encourage Welsh students to apply and be clear about our expectations for Welsh public funding and what that will deliver for the Welsh NHS. I expect there to be both more applicants and more students offered places without compromising on quality."³³

The Welsh Language

46. A number of stakeholders set out the need for adequate numbers of Welsh-speaking medical students and trainees, including HEFCW³⁴ who noted that, although Welsh universities had made some progress, a stronger focus was needed in this area to meet the needs of Welsh-speaking populations. Professor Peter Donnelly of the Wales Deanery told us:

"I think if you then move to the selection process for medical schools,[...] there has been a move in both medical schools to, for example, increase the opportunity for learning a range of modules in Welsh, and I think that's been a very positive step. I think the next step is to look at the selection entry criteria and how we can steer that target or whatever, but steer that towards enabling Welsh-domiciled students and Welsh speakers to come in."³⁵

47. The Welsh Government's 'More than just words' strategy (2012) aimed to strengthen Welsh language services in health, social services and social care. It, and the follow up strategic framework (2016), emphasise the need to increase the Welsh language skills capacity of the workforce of the health sector.

³¹ RoP, 15 March 2017, paragraph 12

³² RoP, 15 March 2017, paragraph 13

³³ RoP, 15 March 2017, paragraph 18

³⁴ Written evidence MR30

³⁵ RoP, 16 February 2017, paragraph 463

48. The Cabinet Secretary also acknowledged that this was an area where there needed to be improvement:

“We recognise that the ability to speak Welsh is a real care need in both health and care, so we will need more doctors who have the ability to speak Welsh.”³⁶

The number of undergraduate medical places in Wales

49. The UK government has **recently announced proposals** to increase the number of student places at medical schools in England by 1,500. The intention is that the first 500 places will be allocated to medical schools and will be available to students in September 2018. As part of this, the Department of Health in March 2017 **launched a consultation** on the increases in medical training places, which includes proposals for expanding the supply of home-grown doctors and proposing that they serve patients in the NHS for a minimum term.³⁷

50. We heard from the Deans of both Welsh medical schools that they were in discussion with Welsh Government about the potential for increases in undergraduate places. Professor Keith Lloyd told us “if we don’t up our game, those students will go to England and may not come back”.³⁸ HEFCW also recognised this threat:

“We note that there are plans to increase medical school places by 25% (1,500) in England from 2018. Without an equivalent increase in Wales, we are likely to see undergraduates recruited over the border who may not return to Wales to practice.”³⁹

51. This view was echoed by a number of witnesses. Dr Evan Moore from Betsi Cadwaladr UHB argued that there was a need to either attract more doctors trained elsewhere or train more doctors within Wales.⁴⁰ Dr Philip Kloer of Hywel Dda UHB was clear in his view:

“There are thousands of applicants to our medical schools. The bottleneck is clearly at the medical school level.”⁴¹

52. HEFCW noted the planned increase in undergraduate medical places in England, and argued that:

“Without an equivalent increase in Wales, we are likely to see undergraduates recruited over the border who may not return to Wales to practice.”⁴²

³⁶ RoP, 15 March 2017, paragraph 25

³⁷ Department of Health, Expansion of Undergraduate Medical Education (2017)

³⁸ RoP, 9 March 2017 paragraph 170

³⁹ Written evidence MR30

⁴⁰ RoP, 16 February 2017, paragraph 355

⁴¹ RoP, 16 February 2017, paragraph 308

⁴² Written evidence MR30

53. Professor Robin Williams indicated that Health Education Wales could retain some of the funding it had available for commissioning education to ‘do new things’ to address the training issue at undergraduate and postgraduate level, perhaps looking at the potential of shorter courses.⁴³

54. The Cabinet Secretary acknowledged the calls for increased places within the Welsh medical schools, but noted that:

“I’m really clear that I think there’s more they could and should do within their current envelope, let alone any potential for expansion, because this Government would expect that any further investment into those two medical schools, to expand the numbers of training places, would have to be on the basis that there would be more Welsh-domiciled students taking up those places.”⁴⁴

55. We heard other evidence setting out the need to increase opportunities for medical student places in North Wales. This was linked to the recruitment challenges in North Wales and evidence that students often then stay to work where they have trained. We heard that there were a range of options for achieving more opportunities in North Wales, one of which was a North Wales medical school.

56. Dr Evan Moore, Medical Director, Betsi Cadwaladr University Health Board told us:

“In terms of a medical school in Bangor, which is the question that you asked us, I think we would be very supportive of anything that increases the supply of doctors to North Wales. There are a number of ways that that could be achieved, and certainly a medical school in Bangor is one of them.”⁴⁵

57. Professor Peter Donnelly of the Wales Deanery told us:

“I think the first thing to say is that, as Wales Deanery, we would very much welcome an increase in medical student numbers and intake in both medical schools and/or further developments in North Wales.”⁴⁶

58. Gareth Llewelyn representing the Royal College of Physicians told us:

“Well, we want more places available for students and the project to have a medical school in Bangor is one that we support. [...] perhaps that is something that Health Education Wales will look at as part of their portfolio.”⁴⁷

⁴³ RoP, 2 February 2017, paragraphs 77 and 79

⁴⁴ RoP, 15 March 2017, paragraph 13

⁴⁵ RoP, 16 February 2017, paragraph 357

⁴⁶ RoP, 16 February 2017, paragraph 500

⁴⁷ RoP, 8 February 2017, paragraph 104

59. In written evidence, Cardiff Medical School referred to the potential for locating medical schools in specific locations as a way of improving recruitment to those areas, saying:

“The South Wales Teaching Hospitals are at, or over, capacity but there is little justification for concentrating all our students in a secondary care location. A recent publication from a Community Based Medical School in the USA documents the recruitment potential of a rural located medical school (1). Graduates from these schools are more likely to adopt a rural practice or stay in health professional shortage areas. Investment in Wales for this type of approach might make a huge difference both in the ability to increase the number of medical students in Wales and educate them within the areas of need resulting in improved recruitment to these areas.”⁴⁸

60. Professor Dean Williams of the North Wales Clinical School at Bangor University outlined that there was a good degree of existing co-operation between Bangor University and the medical schools in South Wales, for example his role as undergraduate organiser for Cardiff medical school for the clinical placements up in North-West Wales. However, he pointed to significant recruitment difficulties in North Wales and cautioned against relying on current partnership working to address these saying:

“I’m wary that, if we hold on to things as they are, and hope that Cardiff will help us somehow, we’re going nowhere in the longer term.”⁴⁹

61. He went on to say:

“There wouldn’t be much of a change. The clinical placements would be the same. But I’m wary of how much workforce we’ll have left at this rate, and there’ll be no point in training, because we’ll have nothing to put them into.”⁵⁰

62. He also told us of the urgency of a decision on a proposed North Wales Medical School, with the additional undergraduate and medical training capacity that such a development could bring. He referred to developments in England and said:

“We know there was an announcement from Jeremy Hunt, wasn’t there, about increasing medical student training, and my concern is that if we keep on delaying things, we’ll miss the boat yet again.”⁵¹

⁴⁸ Written evidence MR13

⁴⁹ RoP, 8 February 2017, paragraph 282

⁵⁰ *ibid*

⁵¹ *ibid*

63. He also recognised that there would be a long lead in time for a medical school, if supported, and there were benefits in further developing existing partnerships and looking to enhance their focus on rural healthcare.

64. Referring to the possibility of a North Wales Medical School, Dr Huw Lloyd Williams said:

“I think you’ve got to look quite carefully there at whether or not there’s enough clinical placements available, because one thing you don’t want to do is to overload a department or overload a speciality with too many medical students, because the quality of the teaching would then reduce, and the quantity as well. But, that’s not to say that that can’t be done in North Wales, but I think that’s got to be looked at quite carefully.”⁵²

65. He also highlighted some other challenges for trainees based in North Wales, for example the additional travel expenses they need to fund from their study budget. He went on to say:

“There is some training provided in the North, but not as much. We [in South Wales] get regular monthly training, where they don’t. So they’ve had to go over to the Mersey deanery to have their training done there. I think that’s one of the issues that our North Wales trainees are finding.”⁵³

66. In written evidence, Dr Heidi Phillips suggested the potential development of academies across Wales in order to help with GP recruitment. She said:

“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.”⁵⁴

67. The Cabinet Secretary reported that he was expecting a recommendation on the North Wales Medical School proposal towards summer 2017, but that:

⁵² RoP, 2 February 2017, paragraph 251

⁵³ RoP, 2 February 2017, paragraph 201

⁵⁴ Written evidence, MR28

“I’m interested in what we would do in terms of having more medical school places available and what that would look like. I’m interested in whether that is likely to result in more people staying within the Welsh NHS and does that mean that a new medical school is the answer...”⁵⁵

Increasing the number of Welsh domiciled students at Welsh medical schools

68. We heard from a number of witnesses who all argued the case that a range of stakeholders need to have better engagement with schools and pupils within Wales to encourage those considering a career in medicine. Awen Iorwerth called for greater collaboration between agencies that provided information and advice to pupils in schools and more support for careers services in schools. She also suggested that medicine should be introduced as a potential career from primary school age.⁵⁶

69. Cardiff University and Swansea University Medical Schools emphasised the need to create and increase motivation for school children in considering careers in both medicine and other areas of healthcare. Professor Ian Weeks from Cardiff University reported that it has a very active programme of engaging with schools, including at primary level, and the **Science in Health Live initiative**, aimed at giving secondary school students an insight into the science behind medicine and the career opportunities in healthcare.⁵⁷ Cardiff University School of Medicine, in its written evidence, stated that:

“Continued work with Welsh schools and children to raise aspiration is necessary to ensure that we are able to recruit from all areas of Wales.”⁵⁸

70. In its written evidence, the Wales Deanery supported this point, highlighting some of the factors behind the fall in applications from Welsh-domiciled prospective students to study medicine:

“...because of entry requirements, the quality of education in schools and narrowed aspirations in some communities. It is clear that, in some schools, aspiring to attend medical school is not seen as achievable. There is a need to reverse this trend. There is some work underway with medical schools and local communities but this work would benefit from a Welsh Government policy position and further resources to ensure that access to medical school is open to all who have the ability irrespective of their background.”⁵⁹

71. Professor Peter Donnelly from the Wales Deanery followed this up in oral evidence, stressing the need for greater engagement with schools in Wales, which should perhaps include the development of health summer schools. The aim of this would be to encourage

⁵⁵ RoP, 15 March 2017, paragraph 45

⁵⁶ Written evidence MR16

⁵⁷ RoP, 9 March 2017, paragraph 137

⁵⁸ Written evidence MR13

⁵⁹ Written evidence MR06

pupils in Wales to see the potential of a career in medicine and healthcare generally, creating the opportunity of:

“...having a co-ordinated approach to informing schools, both the teachers, the headteachers, careers advisers and the students, about careers in health, not just medicine.”⁶⁰

72. We also received evidence which called for more support for schools to give pupils some experience in, and preparation for, medical school interviews. The Wales Deanery set out the value of supporting such preparation.⁶¹ Professor Robin Williams supported this view, saying that there was scope for such work to be undertaken, either by secondary schools or perhaps the new body, Health Education Wales.

73. Martin Jones from Betsi Cadwaladr University Health Board told us about work that was going in the UHB through the undergraduate medical departments and consultants on their own initiative:

“...there’s a range of work going on, engaging with schools, particularly around the medical agenda. There were four things that were shared with me by the undergraduate department in Bangor: they’ve got work going on with very young children about desensitising their attitude towards hospital and healthcare; they’ve got school roadshows going on in respect of people before they take their GCSE examinations so that they’re choosing the right type of GCSEs to support their journey onwards; they’re working with Communities First groups to help people in particular communities to see medicine as a particular career; they’ve got study days that are going on for year 9 to year 13 pupils, including the use of skills simulators; and they’ve got the Seren network where they’re working with post-16 children.”⁶²

74. The response from Dr Heidi Phillips⁶³ detailed collaborative work between Swansea University and Cardiff University on Selecting for Excellence, aimed at encouraging engagement with schools from across Wales, concentrating on those areas that are under-represented in medical school and university, and raising awareness of the career opportunities in the health service.

75. Dr Phillips also discussed a widening access work experience pilot project for aspiring medical students in which Year 11 and 12 pupils across Wales were offered a three day work experience placement with GPs in Wales. This succeeded in identifying pupils who were enthusiastic about medicine and General Practice. Dr Phillips called for expansion of this project, especially for harder to reach pupils.

⁶⁰ RoP, 16 February 2017, paragraph 461

⁶¹ RoP, 16 February 2017, paragraph 466

⁶² RoP, 16 February 2017, paragraph 312

⁶³ Written evidence MR28

76. The possible use of financial or other incentives to support and encourage Welsh-domiciled applications to medical school and future retention was raised. We heard from Craig Hatherley, a GEM student from Swansea University, who argued for the need to explore the options for incentives as a means of encouraging students to apply for, and remain in, training in Wales.⁶⁴

Medical workforce and training in primary care

Recruitment and retention in primary care

77. A wide range of stakeholders stressed the difficulties facing primary care in Wales in recruiting and retaining GPs. The Royal College of General Practitioners (RCGP) believed this posed a significant challenge in all types of GP posts across Wales, both in practices and out of hours (OOH) services. It stated that some GPs were choosing to leave practice due to increasing work pressures. It also highlighted the challenges facing primary care in rural practices - that these often have older patients with more complex healthcare needs who are without family support. Additionally, younger doctors often wish to work in more urban environments. The RCGP further noted that new models of care were developing with greater clinical input from other professions, but this could leave GPs dealing with a clinically more complex workload.⁶⁵

78. The BMA has previously stated that the NHS in Wales is **facing a GP recruitment crisis** “for which Wales is ill prepared”⁶⁶ and warned especially that too few GPs were in training in Wales. Dr Bethan Roberts, who took part in the trainee doctor panel, outlined concerns at the high number of hours GPs, including GP trainees, were needing to work.⁶⁷

79. We also received the results of a questionnaire sent out to GPs across Wales by Dr Heidi Phillips.⁶⁸ Key messages identified include excessive workload, the perceived lack of worth of GPs and consequent low morale. Although for some respondents, General Practice still provides the career that initially attracted them; the results show that:

“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.”⁶⁹

80. We heard about the increase in the number of directly managed GP practices across Wales. The Cabinet Secretary reported in April 2017 that LHBs were directly managing 18 general practices across Wales, compared with 10 in 2015,⁷⁰ and the possibility of more practices applying to LHBs for direct management, primarily as a consequence of recruitment difficulties.

⁶⁴ RoP, 9 March 2017 paragraph 146

⁶⁵ Written evidence MR09

⁶⁶ BMJ careers, 9 October 2014

⁶⁷ RoP, 2 February 2017, paragraph 328

⁶⁸ Written evidence MR28

⁶⁹ Written evidence MR28

⁷⁰ Written Assembly Questions tabled on 4 May 2017

Availability of training places in primary care

81. The Wales Deanery provides the **GP Training Programme** in Wales. It pointed to concerns around the number of training places for doctors in primary care:

“In General Practice the demand for services has increased substantially in the past decade but the target intake to the GP training programme for Wales has remained at 136 for the past decade whilst in England, the target number has risen from 2,400 to 3,250. Large increases in recruitment targets in percentage terms have also been applied in Scotland (target increased to 400 entrants per annum) and Northern Ireland.”⁷¹

82. We heard from Dr Rebecca Payne of the BMA that Wales needed 200 new GPs a year to qualify, noting that NHS Wales had relied on qualified GPs coming from England.⁷² The Wales Deanery also estimated the increase it felt was needed:

“An oft-quoted figure you’ve probably heard from elsewhere, from the GPC [General Practitioners Committee], is 180 to 190. Certainly, that would put us on a par with England, [...] Scotland have been a bit more ambitious and they are having trouble getting to that 400 figure, but they’re over 300 now.”⁷³

83. Both the Wales Deanery and the Cabinet Secretary noted that not all GP training places across the UK have been filled, although the Cabinet Secretary **reported in June 2017**⁷⁴ that 91% of GP training places in Wales had by that stage been filled, with 100 per cent of places filled in Ceredigion, Pembrokeshire and parts of North Wales. The Cabinet Secretary was clear in his views on the pressure for increased numbers of GP training places:

“I won’t say that we’re going to expand our number of GP training places unless, and until, we fill our current places—we have 136 available this year. But if we get close to—once we do fill those, we can have a different conversation in the future.”⁷⁵

84. However, we heard from Dr Sara Bodey of **GP Survival Wales** that GP trainee places in Wrexham - an area where she outlined GP practices were under significant pressure - have been oversubscribed, and they were having to turn applicants away:

⁷¹ Written evidence MR6

⁷² RoP, 8 February 2017, paragraph 208

⁷³ RoP, 16 February 2017, paragraph 522

⁷⁴ Ministerial Statement, 13 June 2017

⁷⁵ RoP, 15 March 2017, paragraph 39

“I think it’s a real opportune moment at the moment to try and increase the number of spaces available for GP trainees, while we have a short-term, potential increase in interest from across the border.”⁷⁶

85. In respect of this, the Cabinet Secretary has indicated his willingness to look at the options available, possibly with primary care clusters having a role:

“I have made it clear that I will want to be as flexible as possible where there are more applications than places available in areas where we experience difficulties recruiting.”⁷⁷

“I would always want to look at, if there is oversupply and if there are more people who want to undertake training than is available in those training practices, how we try and manage that. That’s actually got to be a solution that GPs themselves are part of, of course.”⁷⁸

Access to GP training and experience

86. A range of evidence⁷⁹ commented on the limited exposure undergraduate medical students and trainee doctors have to General Practice. In his evidence Dr Philip Kloer from Hywel Dda UHB stated that:

“...I think it’s important to make sure that, where we’ve got practices, or areas where we’ve got difficulties in GP recruitment, that we do get doctors in at a relatively early stage in their career to come and experience those GP practice areas.”⁸⁰

87. Dr Heidi Phillips set out the case for a Primary Care Academy:

“If we teach medicine through a primary-care lens, rather than the secondary-care focus, we will actually be exposing these students throughout their journey to primary care and seeing patients at the point of coming into the service. Then, they’re more likely to stay in primary care.”⁸¹

88. The Deans of the Welsh medical schools told us about their efforts to increase the exposure of undergraduate medical students to primary care, although they emphasized their aim of enabling students to train and embed students more firmly within local communities.⁸²

⁷⁶ RoP, 8 February 2017, paragraph 216

⁷⁷ Health Social Care and Sport Committee, **Paper 1**, 15 March 2017

⁷⁸ RoP, 15 March 2017, paragraph 80

⁷⁹ Written evidence MR6, MR13, MR21, MR26

⁸⁰ RoP, 16 February 2017, paragraph 413

⁸¹ RoP, 8 February 2017, paragraph 218

⁸² RoP 9 March 2017, paragraphs 93 and 94

89. We also heard evidence from Dr Sara Bodey⁸³ about the difficulties in being able to do post-training locum work in GP practices. We were told that current arrangements would exclude those who have completed F2 (2nd year of Foundation Training) who do not want to commit to a formal training programme but may be interested in seeking GP experience. Dr Phil Matthews from the Wales Deanery confirmed that addressing this would need statutory changes:

“You can only work in general practice if you are either a foundation doctor or doing GP specialty training or actually on the performers list or on the GMC register. So, there are all sorts of technical reasons why that would be difficult. I think hanging it on the term F3 is one way of looking at it.”⁸⁴

90. Representatives from the BMA, GP Survival and the Wales Deanery suggested that this was a key issue and it might be helpful to seek views on the potential for amending regulations to enable:

- doctors to be on a performers list in both England and Wales;
- trainee doctor access to locum posts in General Practice.

91. Responding to these views, the Cabinet Secretary indicated that he was “open-minded” and “happy to consider” options for enabling post-F2 trainees to undertake GP locum work.⁸⁵ With regard to the performers list issue, he stated that:

“On the point about GPs returning, we’ve done all that we can to make it easier for people to be based on both performers lists in England and in Wales. It’s not as easy as we’d like it to be, and it does require some co-operation from colleagues across the border.”⁸⁶

Medical workforce and training in secondary care

Recruitment and retention in secondary care

92. A number of witnesses highlighted a range of medical recruitment and retention issues facing secondary care. The Welsh NHS Confederation⁸⁷ reported a 10 per cent growth in the UK medical workforce between 2010 and 2016. However, despite the overall growth in the medical workforce they believed there was a supply – demand gap in a number of medical specialties in Wales.

⁸³ Written evidence MR26

⁸⁴ RoP 16 February 2017, paragraph 546

⁸⁵ RoP, 15 March 2017, paragraph 154

⁸⁶ RoP 15 March 2017, paragraph 151

⁸⁷ Written evidence MR21

Table 2: Medical and dental staffing numbers across Wales in all specialties (full time equivalent, excluding GPs), 2012-2015 ⁸⁸

Grade of doctor	2012	2013	2014	2015	2016	% change 2012-16
All grades	5,908.5	6,072.9	6,911.4	6,120.3	6,232.8	+5.4
Consultant	2,273.9	2,323.7	2,315.9	2,344.6	2,408.8	+5.9
Specialty Doctor	427	457.1	492.2	508.3	516.9	+21
Staff Grade	6.9	6.9	5.5	4.4	5.2	-24.7
Associate Specialist	356.3	334.3	305.6	282.2	267.4	-25
Specialist Registrar	1,832.4	1,887.4	1,832	1,995.9	2,071.7	+13
Foundation Trainee 1	330.5	331	379.2	345.6	341.7	+3.3
Foundation Trainee 2	337.5	377	339	335.5	335.7	-0.6
Senior House Officer	180.6	199.6	194.1	162.7	134.1	-25.8

93. The Welsh NHS Confederation reported that as at July 2016, all LHBs across Wales (excluding Powys) had significant medical vacancies: 154 consultant, 253 Specialty, Associate Specialist and Higher Grade Training doctors and 132 junior doctors. We were told that there remain trainee vacancies in every acute hospital rota in Wales. The RCP reported⁸⁹ that in 2016 NHS Wales was unable to fill 39.8 per cent of the consultant physician posts it advertised and that Wales currently struggled to recruit enough trainees to fill hospital rotas; 33 per cent of core medical trainee places were unfilled in 2016.

94. The Royal College of Emergency Medicine Wales (RCEM) in its document **RCEM Wales' steps to rebuilding emergency medicine** (2015) called for Welsh Government and LHBs to undertake an evaluation of the appropriate level of resourcing for emergency departments. The RCEM reported that many junior doctors in A&E were not necessarily training to qualify in that speciality. Out of the current 91 junior grade training posts in Wales, 41 places were occupied by F2 doctors⁹⁰, 39 by GP trainees and only 11 places were taken up by doctors who wished to train in emergency medicine. The RCEM stated that in 2015 only 61 per cent of higher specialist training posts in emergency medicine in Wales were being filled.⁹¹

⁸⁸ [StatsWales Medical and dental staff by grade and year](#)

⁸⁹ Written evidence MR14

⁹⁰ The Foundation Programme is a two-year training programme for doctors who have just graduated from medical school. In the second year of the Foundation Programme (F2) doctors are fully registered with the GMC. They still work under supervision but start to take on more responsibility for patient care.

⁹¹ RCEM Wales [Essential Facts Regarding A&E services \(2015\)](#)

95. We also heard evidence about current and upcoming pressure in a number of other specialties, including orthopaedics, pathology, psychiatry, radiology, clinical oncology and neonatology.⁹²

Table 3: Areas where Consultant recruitment presents as a pressure or for the other grades where four or more gaps appear per specialty across Welsh LHBs.⁹³

LHB and grade	Specialty
Abertawe Bro Morgannwg	
SAS/HT	Emergency Medicine (EM), Anaesthetics , Neonatology, General Surgery and Psychiatry
Cwm Taf	
Consultant	Pathology and EM
SAS/HT	General Medicine, Psychiatry and EM
Junior	General Medicine and General Surgery
Hywel Dda	
Consultant	Ophthalmology, General Medicine, Radiology, General Surgery and Anaesthetics
SAS/HT	Anaesthetics, EM and General Medicine
Junior	Anaesthetics and Orthopaedics
Aneurin Bevan	
Consultant	Acute Medicine and Anaesthetics
SAS/HT	Anaesthetics and Trauma and Orthopaedics
Cardiff and Vale	
Consultant	Occupational Health and EM
SAS/HT	EM and Intensive Care
Betsi Cadwaladr	
Consultant	Pathology, Radiology , Anaesthetics , EM and General Medicine
SAS/HT	Anaesthetics and General Medicine
Junior	EM, Orthopaedics, Anaesthetics and General Medicine

96. Alongside this, the Welsh Government NHS Wales Workforce Review showed an increase in agency and locum spend (not just at consultant grade) of 83 per cent from 2014-15 (£48million) to a figure of £88 million in 2015-16. However, it is difficult to be clear about

⁹² Written evidence MR8, MR21, MR22, M24, MR25

⁹³ Source: Welsh NHS Confederation. Note: SAS (Senior Associate Specialist), HT (Higher Trainee)

the precise LHB spend on medical agency and locum staff. Spending on medical and dental locum and agency staff is recorded by LHBs, although the figures are not published. Some reported figures suggest that during 2015/16, there was a 48% increase in medical staff, costing in excess of £53m. The Annual Accounts for LHBs show that, although some LHBs have managed to reduce their use of agency staff, there has been a continued rise across Wales in the overall whole time equivalent numbers of medical and dental agency staff used from 409 in 2015-16 to 450 in 2016-17.

Availability of training places in secondary care

97. Several witnesses told us that there are insufficient training places available in a number of key specialties. The RCEM argued that the number of A&E consultants will need to double over the coming years to meet demand and stressed that:

“There are too few senior and Middle Grade medical staff in A&E departments to deliver effective and efficient care alongside too little training places. Government and NHS Wales providers need to ensure that more trainee places are made available.”⁹⁴

98. Similarly, the Royal College of Radiologists (RCR) discussed the position of clinical oncology training within NHS Wales, arguing that the high numbers of applications to radiology registrar training in Wales meant the only sustainable solution was to increase radiologist training capacity and numbers:

“Again, it’s a real success story for Wales. It has very highly reputed training schemes, which are oversubscribed, but our outputs are about two consultants a year, which is not enough to fill our existing vacancies or our projected requirements or projected increase in workload. So, actually, if we could increase the number of trainees, it would be a good strategy.”⁹⁵

“In radiology, I think we’re at capacity as we stand, without an academy. That’s why we need an academy to increase our training numbers significantly.”⁹⁶

99. We heard that a business case⁹⁷ had been submitted to the Welsh Government for a **National Imaging Academy for Wales**, with the intention that the Academy would accept its first trainees in August 2017. We were told, however, that the Welsh Government had asked the RCR to approach LHBs about the revenue funding, and there were cost implications for Deanery funding of any trainees. The RCR reported that the Business Case was currently being considered by the LHBs.⁹⁸ The RCEM indicated the benefits the Academy

⁹⁴ Written evidence MR15

⁹⁵ RoP, 16 February 2017, paragraph 50

⁹⁶ RoP, 16 February 2017, paragraph 122

⁹⁷ Written evidence MR24 and MR25

⁹⁸ RoP, 16 February 2017, paragraph 80

could have for other specialties, and in oral evidence, representatives of the Wales Deanery also outlined that:

“...it’s been confirmed there will be an increase in the clinical radiology intake for this August. Now, it’s still not at the level, I think, that would meet the supply demand, but it’s a significant step towards that. It still doesn’t meet the requirements of what we’ve articulated in the business case for the national imaging academy, which is a yearly intake of 20.”⁹⁹

100. The Cabinet Secretary responded to the Imaging Academy proposal:

“We’re awaiting a business case. We would like to see it happen, and it would help us in a number of ways, both in terms of our capacity, as well as in delivering the sort of workforce we want...So, we don’t have any difficulty with the Royal College of Radiologists pushing that as part of the answer. It’s part of what I expect to see happening and coming through...”¹⁰⁰

101. In terms of the availability of training places, we heard from Julie Rogers, Director of Workforce and Organisational Development at Welsh Government, that the Welsh Government and the Wales Deanery had introduced a new system to advise the Cabinet Secretary. Rather than annually rolling forward existing numbers on an annual basis, they had brought together key interests to look at better matching the number of speciality training places to the needs of the service and particularly the shortage professions across Wales”.¹⁰¹

102. The Cabinet Secretary’s submission emphasised the critical importance of the medical workforce in leading clinical decisions, and stressed that the medical and dental workforce in NHS Wales had seen “consistent annual growth”. He also emphasised the Welsh Government’s commitment to developing a 10-year plan for the NHS workforce, noting that medical workforce supply needed to be considered at every level, including undergraduate students as well as foundation, core and specialty training:

“Planning the current medical workforce is a challenging process because of the complexity of the workforce, the long lead time to complete training, and the balance between maintaining current levels of service whilst developing new models.”

⁹⁹ RoP, 16 February 2017, paragraph 497

¹⁰⁰ RoP, 15 March 2017, paragraph 82

¹⁰¹ RoP, 15 March 2017, paragraphs 51 and 52

“...the process used to identify the NHS training places for 2018/19 onwards should aim to bring together the planning for medical, dental and non-medical training places into one streamlined process.”¹⁰²

Data on consultant vacancies

103. Welsh medical vacancy rates have not been published officially since 2011. The Welsh Government sets out that this was following a consultation with NHS workforce information managers who said that “the NHS staff vacancies publication was not very useful to them, and did not reflect the current staffing and recruitment issues in the NHS”.¹⁰³ Referring specifically to data on consultant vacancies, data acquired through **Freedom of Information** (FOI) requests by the BMA in March 2015 showed a vacancy rate of consultants across Wales of 6.8 per cent, although this varied between LHBs; for example Hywel Dda University Health Board had a 15.9 per cent vacancy rate. As a result, the BMA called for improved collection and availability of data around medical vacancies to enable improved understanding of the vacancy position and better workforce planning.

A workforce which can deliver changing service and care models

Supporting services, including new service models

104. We heard a strong and consistent message from a wide range of stakeholders about the need for changes in the delivery of services. This could have substantial implications for medical recruitment. These include that the centralisation of hospital services may impact on the numbers and mix of trainees and consultants in some hospital specialties. There is also the potential that the increased focus on community and primary care may require more doctors to train and work in these services. New services may require different education and training structures, possibly within a more multi-disciplinary environment. Changes in services may also change the nature and content of medical work and, more optimistically, tackle some of the existing medical workload pressures and concerns about medicine as a career.

105. The Welsh NHS Confederation argued that, in order to achieve service change, the Welsh Government must help facilitate long term workforce planning. They said that this should be backed by a strategic vision for health and social care in Wales and which also reflects the needs of local communities:

“As changes in demographics and our lifestyles have resulted in a dramatic rise in demand on the health and care services, it has become increasingly clear that a transformation in the way treatment is delivered is required if the NHS is to meet the needs of a future population. A sea-change in the way services are designed is vital. [...] With an ageing population and a rising number of people with complex

¹⁰² Health Social Care and Sport Committee, **Paper 1**, 15 March 2017

¹⁰³ **StatsWales: note on termination of vacancies data collection**

and chronic conditions, the workforce must be ready to evolve and respond to the challenges ahead.”¹⁰⁴

106. The Royal College of Paediatrics and Child Health (RCPCH) called for whole systems change in paediatrics including fewer, larger in-patient units,¹⁰⁵ and the Royal College of Psychiatrists argued for centralisation of services, supported by stronger primary and community care.¹⁰⁶ This call for service change was echoed by the Royal College of Surgeons in its response:

“There is a clear need for reconfiguration of services in Wales based on clinical need, particularly to address the sustainability of the current pattern of acute hospital services...prevarication on service reconfiguration in Wales has impacted recruitment at some hospitals in Wales.”¹⁰⁷

107. During this inquiry we have heard substantial evidence about the increasing role of the multi-disciplinary team (MDT) in future healthcare delivery, and the impact this may have on medical workload. Research by the Welsh Institute for Health and Social Care sets out the value of services provided outside hospital.¹⁰⁸ Looking beyond Wales, work by **the King’s Fund** has set out the need for increased focus on the primary care team. The Nuffield Trust has also published **Reshaping the workforce to deliver the care patients need** (2016) which argued that equipping the existing non-medical workforce – nursing, community and support staff – with additional skills is the best way to develop the capacity of the health service workforce overall.

108. The RCGP¹⁰⁹ and Royal College of Nursing (RCN)¹¹⁰ echoed this, identifying the need for different skill sets, but also a shift of focus of GP work onto more complex cases, with teams having an enhanced role in areas such as management of chronic conditions.

109. The Wales Deanery set out the need for changes in healthcare delivery in Wales as an element of addressing the medical recruitment issue:

“There is an imperative to move to, wherever possible, non-doctor focused or reliant service models. These need to be articulated within the new 10 year strategic workforce plan. In General Practice there will be opportunities for skill mix change and new attractive models of care whereby skilled NHS workers (i.e. nurse specialists, pharmacists,

¹⁰⁴ Written evidence MR21

¹⁰⁵ Written evidence MR08

¹⁰⁶ Written evidence MR22

¹⁰⁷ Written evidence MR23

¹⁰⁸ University of South Wales '**Best configuration of hospital services for Wales: A Review of the evidence'**(2012)

¹⁰⁹ Written evidence MR05

¹¹⁰ Written evidence MR09

physician’s assistants) undertake at least some of GP’s traditional roles.”¹¹¹

110. A similar view came from Dr Philip Kloer of Hywel Dda UHB:

“Clearly, it’s not going to be based all on medical doctors; there’s going to be a multi-professional workforce... There’s not enough supply of doctors. Even for the future workforce, even with all those changes, we will need more doctors, nurses and therapists in the future.”¹¹²

111. Professor Keith Lloyd from the Royal College of Psychiatrists also outlined his view about future models of care, arguing that there was a need for more undergraduate experience in primary and community care, as well as having an increased training focus on the multi-disciplinary team:

“The settings in which it’s provided and training need to alter to reflect that so we’re training the people who can work in the community more. [...] the most difficult and complex care will need to continue to be delivered in hospitals, but a lot should be delivered in the community and home settings, but we need the workforce in the right place with the right skills to do that.”¹¹³

112. Responding to this, the Cabinet Secretary was equally clear about the changed and multi-disciplinary nature of future healthcare, and the implications for doctors and their training:

“Doctors of the future will have to work in a number of different ways from the doctors of today. In particular, we will need more doctors to work as generalists across hospital and community boundaries.”¹¹⁴

“I think there’s now a greater recognition that, actually, it’s a good thing to have a multidisciplinary team, and they need to work in different models.”¹¹⁵

Rural medical education

113. The Committee also heard evidence about the need to increase undergraduate experience of rural healthcare. Swansea University Medical School offers a **Rural and Remote Health in Medical Education** (RRHIME) programme, which aims to increase the numbers of students and doctors practising in rural Wales.

¹¹¹ Written evidence MR06

¹¹² RoP 16 February 2017, paragraphs 349-50

¹¹³ RoP 16 February 2017, paragraph 270

¹¹⁴ Health Social Care and Sport Committee, **Paper 1**, 15 March 2017

¹¹⁵ RoP 15 March 2017, paragraph 112

114. Professor Dean Williams from the North Wales Clinical School set out to the Committee that:

“I think a medical school based on rural provision would be an excellent thing, a little bit like what they do in Scotland, where some of the students are told at the start, ‘You’ll be going into rural provision straight away’. So, either we need a game changer like that, or we need to start thinking about a rural school for rural North Wales.”¹¹⁶

115. Dr Philip Kloer also stressed the importance of attracting trainees into rural healthcare provision:

“... many of the trainees tend to spend most of their time in specialist centres, which means that there’s less footfall of trainees in more rural hospitals and, when trainees are in rural hospitals, they’re more likely to stay there or come back in the future if they’ve experienced that.”¹¹⁷

116. Similarly, Dr Llion Davies and Dr Bethan Roberts, speaking as trainee doctors, all noted some of the difficulties experienced in recruiting trainees to work in rural areas, as well as the issues it could pose in terms of access to training.¹¹⁸

117. At the same time, Professor Dean Williams from the North Wales Clinical School expressed concerns about the existing, and future, possible impact on more rural healthcare and recruitment of increased service centralisation.¹¹⁹ In particular, he had fears that increased centralisation of services may mean that some hospitals in North Wales could be unable to offer the complexity and numbers in terms of clinical workload needed to support clinical placements.

118. The Cabinet Secretary acknowledged the challenges posed by the rural nature of parts of Wales, but noted that there would also be those who were keen to train in rural areas. He also emphasized the need for sharing good practice whilst looking for solutions that suited individual local areas:

“Because if you work in rural healthcare in mid Wales, there’ll be other practices in mid Wales doing different things, and in North Wales, and actually at the top of the Valleys—there’s huge rurality there as well. So, this isn’t just a geographic challenge in one part of the country.”¹²⁰

Our view

119. In recent years there has been a clear trend of low and declining numbers of Welsh-domiciled students applying to all UK medical schools. This has been compounded by a similarly low and declining number of students from schools in Wales both applying to and

¹¹⁶ RoP 8 February 2017, paragraph 285

¹¹⁷ RoP 16 February 2017, paragraph 282

¹¹⁸ RoP 2 February 2017, paragraphs 262, 272,

¹¹⁹ RoP 8 February 2017, paragraph 284

¹²⁰ RoP 15 March 2017, paragraph 120

being successful in such applications to medical schools within Wales. This has implications for the future medical workforce in Wales. The trends in Wales compare unfavourably with the data elsewhere within the UK; the percentage of home-domiciled applicants in England, Scotland and Northern Ireland are all significantly higher than in Wales.

120. The messages we heard throughout our inquiry were strong and consistent: Wales needs to attract more of its own students to medical schools in Wales; we need to be clearer about why the numbers applying and applying successfully remain low and Wales needs to find ways of reversing those trends. The Cabinet Secretary for Health, Well-being and Sport told us “I think it’d be wrong to say I’m content with the current position, because it needs to improve”.¹²¹ This is a view that we share. There is more to be done.

121. The evidence we heard – both during the inquiry and as Assembly Members through the experience of our own constituents - about Welsh pupils failing to get into Welsh medical schools but being successful in England may be anecdotal. However, we have heard it often enough. It raises real questions and the issue cannot be ignored.

122. It is clear that both medical schools in Wales are aware of these trends, share the desire to attract more students from Wales and have made real and positive steps to tackle this issue. The developments on admissions processes, including the use of contextualised data and multiple mini interviews (MMI) are welcome, and the 2017 applications round has seen more encouraging figures for Welsh applicants to the two medical schools. This is to be welcomed.

123. We also welcome the commitment to increasing the number of Welsh-domiciled students from the Welsh medical schools and their real and increasing focus on outreach and engagement with schools. Nonetheless, we believe that there is a pressing need for a stronger policy lead from the Welsh Government on this issue.

Recommendation 2. The Welsh Government should work with the Deanery (or any successor body) and the medical schools in Wales to secure a sustained increase in the number of Welsh-domiciled students applying to medical schools within Wales.

124. We heard convincing arguments about the need for better support for Welsh-domiciled students so they are better prepared for medical school interviews. These can be daunting, with students competing against others who have had advice and maybe even training in how to deal with such interviews. This support needs to be available to pupils in Wales.

125. Enabling access is about more than admissions procedures. What is of equal, and perhaps greater importance, is engagement with schools at a much earlier stage. There is a clear need to take the message out to schools across Wales that medicine is a career that pupils can aspire to, and that it is a realistic and achievable aspiration for students from all communities.

¹²¹ RoP, 15 March 2017, paragraph 15

Recommendation 3. The Welsh Government should work with the Deanery (or any successor body) and medical schools in Wales to develop a programme of support and advice on medical schools admissions and interviews for pupils in Wales.

126. We heard arguments in favour of some form of positive action – to ‘build in the postcode’ - for Welsh-domiciled students in relation to applying to Welsh medical schools. Alongside this we also recognise the need to ensure that admissions procedures are fair, equitable and transparent and support high quality applicants. At the same time, we believe there may be scope for developing innovative approaches such as developing a medicine degree with Welsh culture alongside it, for which a Welsh language qualification or Welsh baccalaureate would be required.

127. Scotland has a well-established record of attracting a high number of successful applications to its medical schools from within Scotland. Some Scottish medical schools have made some use of bursaries targeted specifically at widening access to medicine and other subjects. Equally, Scotland maintains a policy of direct financial support to Scottish-domiciled students studying at universities within Scotland. This can provide a powerful drive for retaining and developing home-grown doctors. We heard arguments for the need to explore options for incentives which would aim similarly at attracting and retaining Welsh pupils and trainees within Wales, and Recommendation 4 sets out our views on this.

128. Medical schools in Wales must be able to recruit high-quality students to their undergraduate and graduate entry courses in medicine. However, these courses remain consistently over-subscribed. There is a clear case for increasing medical school capacity within Wales. This must include agreeing an approach to enhance opportunities in North Wales. Options for this could include expanding existing university provision, developing enhanced or new training and education partnerships or establishing a medical school for North Wales.

129. In respect of the position in North Wales, we are acutely conscious of a number of pressures: the need to agree a clear, achievable and timely way forward; the need to ensure the availability of appropriate training capacity and clinical placements; the potential time lag associated with pursuing the full medical school approach. Above all, it is clear that there is a need to address the recruitment challenges swiftly and sustainably.

Recommendation 4. The Cabinet Secretary should discuss and agree plans with the medical and clinical schools in Wales that will enhance and develop undergraduate medical training in Wales. This plan should include an increase in undergraduate medical school places, and an increase in the percentage of Welsh-domiciled students securing those places.

Recommendation 5. The Welsh Government should set out a clear plan to develop opportunities for undergraduate medical education in North Wales. This should include a new centre for medical education in Bangor. The Cabinet Secretary should announce a decision within the timescales he has set for ‘summer 2017’.

130. Turning to primary care, we recognise the very real current and forthcoming challenges in medical recruitment and retention. We welcome the Train, Work, Live initiatives. However, we believe there are a number of areas where further action is needed in order to address the serious recruitment and retention issues that we have heard about.

131. An enhanced focus on primary care during undergraduate and postgraduate medical training is essential, to give aspiring and trainee doctors more exposure to where the majority of healthcare is delivered and to a more multi-disciplinary care environment.

Recommendation 6. The Welsh Government should work with the Deanery (or any successor body) and medical schools to develop proposals to increase time in general practice, as a key part of both the undergraduate curriculum and trainee doctor foundation training.

132. It is clear that there is a need for an increased number of medical training places across Wales. There also needs to be an increased number of GP training places across Wales, with greater devolved abilities – perhaps to LHBs or primary care clusters – to redeploy unused places to other areas where demand exceeds supply. We also heard specific evidence around medical imaging, including the case for a Welsh Imaging Academy.

Recommendation 7. The Welsh Government and Deanery (or any successor body) should develop and agree proposals for an increase in the number of training places, targeted at key pressure areas. This should be accompanied by the greater devolution of powers for flexible deployment of this training capacity, especially in GP training.

133. There are two regulatory issues that we believe should be addressed, which could have the capacity to enable easier access to GP working for some trainee doctors and make it easier for doctors to return and work in Wales if they wish to do so.

Recommendation 8. The Welsh Government should:

- seek appropriate amendments to regulations to enable Post-F2 doctors to work as locums in general practice;
- continue discussions with the UK Government on performers list regulation with the aim of enabling doctors to be on the performers list in both England and Wales.

04. Factors influencing the recruitment and retention of doctors

Training experience and trainee workload

134. Evidence relating to Wales from the General Medical Council (GMC) National Training Survey for 2016, All-Wales School of Emergency Medicine (AWSEM) and the panel of trainee doctors was largely very positive in terms of overall trainee satisfaction, including the quality of training, clinical supervision, training and induction. The AWSEM survey showed that around 40 per cent of responses identified training opportunities as a factor of what made trainees want to work in Wales. Dr Zahid Khan took part in the trainee doctor panel, and said:

“The main reason for coming to Wales for training was that I had heard from a colleague, basically, that the Wales training is a bit more supportive in terms of training than England and Scotland.”¹²²

135. At the same time, the GMC Survey set out that 40.4 per cent of trainee doctors in Wales reported a heavy or very heavy workload (44 per cent in England, 38.3 per cent in Scotland), with 55.3 per cent in Wales reporting their workload was about right (England 52 per cent, Scotland 56.7 per cent). However, the Wales Deanery and the panel of trainee doctors cautioned that workload and training experience could, and did, vary between LHB area and specialty.¹²³

136. Dr Heidi Phillips’ written evidence¹²⁴ identified concerns about excessive GP and GP trainee workload. This was reiterated by Dr Sara Bodey and Dr Rebecca Payne in [oral evidence](#) to the Committee:

“General practice should be the best job in medicine. I think people are attracted to the idea of what it should be, but the reality is something different. Certainly, we hear from trainees that they don’t want to work as hard as their trainers do, and that’s the feedback at the end of training programmes. They have a look at what we’re doing and say, ‘I don’t want to do that.’ That’s one of the reasons that they often choose to work part-time.”¹²⁵

“...we need to see a shift of staff from the secondary care system into general practice. The problem is everybody’s stressed, everybody’s under pressure....That’s the reality. We are expected to see everybody.”¹²⁶

¹²² RoP, 2 February 2017, paragraph 144

¹²³ RoP, 2 February 2017, paragraphs 144, 153, 182, 193 and 199

¹²⁴ Written evidence MR28

¹²⁵ RoP, 8 February 2017, paragraph 134

¹²⁶ RoP, 8 February 2017, paragraph 156

137. Likewise, Dr Bethan Roberts argued the need to both focus on optimising the training and also to make sure that trainees were working within their contracts:

“So, it doesn’t matter what your contract says, you do what the GPs do, and that’s that, because, otherwise, you have no idea what it’s like to be a GP. So, I think there is a creep in how much service we’re expected to provide.”

“I think, probably, what needs to be fixed is how trainees are treated, particularly during their final year of training when it’s very intense, to make them more likely to want to work in independent contractor models or as salaried GPs”¹²⁷

138. Workload issues in hospital settings were identified as an issue for some trainees. BMA Cymru, the Royal College of Physicians and the Royal College of Surgeons¹²⁸ all identified the need to work in an environment with manageable workloads and rotas were manageable, with a focus on staff being seen as valued and supported. Professor Robin Williams noted the difficult balance the Wales Deanery had to maintain between supporting LHB service delivery and ensuring high quality training.¹²⁹

139. The reputation of a service is also key in attracting trainees. Professor Peter Barrett-Lee from Velindre NHS Trust summed this up in his evidence:

“We know what our needs are - they’re both educating them and running a safe, reliable and excellent service. We must understand that their main priority is their own education. The Deanery can help in always keeping that balance for us. If you have excellent support and education for your trainees, you will attract more, because the internet and their groups will echo that message around. If you don’t, then that message will be, ‘Be careful of this place; it’s not a supportive environment’.”¹³⁰

140. The accessibility of training was reported as a concern in some consultation responses, with difficulties securing study leave or access to CPD-accredited events, especially in rural areas.

141. Professor Donnelly of the Wales Deanery, however, emphasised the importance of ensuring that NHS Wales not only attracts but also keeps staff:

“...what we need to do is make sure they get a positive experience and increase the chances of retaining them, because I think our mantra has been that it’s about retention. Recruitment’s fine, but actually it’s about

¹²⁷ RoP 2 February 2017, paragraphs 322 and 328

¹²⁸ Written evidence MR14, MR20 and MR23

¹²⁹ RoP 2 February 2017, paragraph 25

¹³⁰ RoP 16 February 2017, paragraph 286

retention. What are we currently doing and what else do we need to be doing?”¹³¹

142. Responding to all the concerns around training experience and workload, the Cabinet Secretary told us that:

“...there's got to be a clear focus about the importance of primary care and the importance of primary care change, because if we don't choose to change primary care then change will happen to us and we'll be left firefighting, which is the wrong thing to do.”¹³²

Quality of life and work/life balance

143. The AWSEM survey¹³³ showed that over 30 per cent of trainees were attracted to Wales for issues around work/life balance, Welsh culture and community life, and proximity to leisure and the countryside, with 19 per cent attracted by access to housing. Around 35 per cent of the trainees indicated that family ties to Wales were also a factor. This was also noted in evidence from the panel of trainee doctors.¹³⁴ The potential for flexible working was also cited as being of key importance.

144. The importance of these broader factors in recruitment and retention was reflected by **Dr Charlotte Jones** from BMA Cymru:

“I think we do need to be cognisant of many people coming out of university these days with significant debts—why it's cheaper to live in Wales and you get a much better work-life balance [...] and also looking at opportunities for their partners and their children, because people are coming out of postgraduate schools with partners and children, and even from undergraduate schools. We need to make sure that there are opportunities for their spouses, good childcare, good schools, and that we're promoting what's available out there.”¹³⁵

145. Dr Zahid Khan told us:

“You are definitely looking for the working environment, like what sort of environment you are working in. Then, definitely, another factor is lifestyle—the work-life balance. You are definitely looking for work, but you want some social life as well at the same point.”¹³⁶

¹³¹ RoP, 16 February 2017, paragraph 556

¹³² RoP, 15 March 2017, paragraph 119

¹³³ Written evidence MR29

¹³⁴ RoP, 2 February 2017, paragraphs 171 and 294

¹³⁵ RoP, 8 February 2017, paragraph 14

¹³⁶ RoP, 2 February 2017, paragraph 157

146. Professor Donnelly from the Wales Deanery also observed that:

“...this generation of trainees has a very precise specification in terms of requiring high levels—and they should require this—of supervision, a positive learning experience, as well as more of a focus on work/life balance...”¹³⁷

Geographical factors

147. Several witnesses expressed concerns about the continued problems of recruiting and retaining doctors in rural areas, with many trainees having a marked preference for working in or close to more urban settings. This was highlighted especially by the panel of trainee doctors and in the surveys from the All-Wales School of Emergency Medicine and Dr Heidi Phillips.¹³⁸

148. The Wales Deanery submission also indicated that trainees, in general, prefer to live and work near cities rather than in rural areas:

“We are also seeing a cohort of trainees who are prepared to resign from training programmes rather than be placed in a location not of their preference.”¹³⁹

149. We heard from Cardiff University Medical School that the teaching hospitals in South Wales are at very near capacity, noting that “*there is little justification for concentrating all our students in a secondary care location*” and the potential benefits of a rural located medical school.¹⁴⁰ Professor Robin Williams believed that encouraging recruitment from rural areas should be a priority.¹⁴¹ Dr Bethan Roberts outlined one example:

“I know of someone who trained in Birmingham as an undergraduate, did her foundation years there, and was specifically attracted to Wales on the basis of a rural GP course that she went on. So, it is something that you can make quite a big deal of.”¹⁴²

150. We are aware of the growing difficulty in recruiting into GP Partnerships, particularly in the more rural and socially deprived areas of Wales. The Cabinet Secretary reported in April 2017 that LHBs are directly managing 18 general practices across Wales,¹⁴³ compared with **15 in January 2017** and 10 in 2015. There has also been a rise in the number of salaried/other GPs working in Wales to **403 in 2016**,¹⁴⁴ compared with 334 in 2015 and **284 in 2014**.¹⁴⁵ The panel of trainee doctors told us about reluctance amongst younger trainees

¹³⁷ RoP, 16 February 2017, paragraph 443

¹³⁸ Written evidence MR9, MR28 and MR29, RoP 2 February 2017, paragraphs 272 and 286

¹³⁹ Written evidence MR6

¹⁴⁰ Written evidence MR13

¹⁴¹ RoP, 2 February 2017, paragraph 72

¹⁴² RoP, 2 February 2017, paragraph 272

¹⁴³ Written Assembly Questions tabled on 4 May 2017

¹⁴⁴ Welsh Government report on GPs in Wales 2016

¹⁴⁵ [Welsh Government report on GPs in Wales](#)

to seek out practice partnerships, although we heard that there was not a belief that there needed to be a “big push” generally for salaried GPs in Wales.¹⁴⁶

151. On this point, the Cabinet Secretary’s written evidence sets out information about the **incentive scheme for GP Trainees** in hard to reach areas, under which trainees taking up a training place in specific areas in West and North Wales will be eligible for a payment of up to £20,000.¹⁴⁷

152. We also heard evidence that trainees (especially at the higher training level) may be required as part of rotation in the training, to undertake placements across Wales, or into specialist or tertiary centres in England, to gain specialist or sub-specialty experience; this has impacted on retention and recruitment in some specialty area. Dr Abby Parish, who spoke as part of the panel of trainee doctors, set out her position in neonatology:

“It’s because when we sub-specialise, a lot of the speciality jobs are either mixed with England or you have to go to England. This is a national process; I’m not going to have any choice. If other people are ranked higher and they want to come to Wales, then I’m not going to be able to stay....”¹⁴⁸

Terms and conditions of employment

153. The BMA welcomed¹⁴⁹ the Welsh Government reassurances that it would not impose a new GP contract in Wales. It felt this presented an excellent opportunity to promote Wales to junior doctors. Evidence from GEM students¹⁵⁰ at Swansea University Medical School and the panel of trainee doctors noted the outcome of a recent survey by the BMA Wales Junior Doctors Committee:

“...well over half of our respondents who said that the contract issue had been a significant factor in their decision to come and work in Wales.”¹⁵¹

154. At the same time, we heard from BMA Cymru that the new contract in England offered trainees a higher basic level of pay and that trainees in Wales were likely to be left without supplementary payments for additional or anti-social hours worked. Dr Adam Dallmann, a trainee Histopathologist, set out the significantly higher pay that English trainees in histopathology would receive, possibly more than £40,000 over the 5 years training.¹⁵²

¹⁴⁶ RoP, 2 February 2017, paragraphs 323 and 328

¹⁴⁷ Health Social Care and Sport Committee, **Paper 1**, 15 March 2017

¹⁴⁸ RoP, 2 February 2017, paragraph 181

¹⁴⁹ Written evidence MR20

¹⁵⁰ Written evidence MR28

¹⁵¹ RoP, 2 February 2017, paragraph 301

¹⁵² Written evidence MR02

155. The Cabinet Secretary recognised the impact on recruitment of the Welsh Government approach in not introducing a junior doctor contract saying “We took a deliberate decision, which I absolutely believe is the right one, not to impose a junior doctors contract”, but also noted that:

“...mobility between the four nations, broadly, is a good thing for us. Because, actually, we recruit and encourage doctors from England and other parts of the UK to come here as well, so having contracts that are not massively different is something of an advantage for us, but that doesn’t mean that we’ll simply do whatever England do.”¹⁵³

156. The Cabinet Secretary was keen to stress the importance of having a constructive and beneficial working relationship with institutions in England, especially with regards to the delivery of medical training:

“I guess that North Wales is probably the most helpful area to put that across - you know, going east and west and into North-West England for some of the speciality training. That’s been much more helpful for doctors in training themselves. ...I think there is real benefit for the Welsh system in having some of those where it seems to work, but it is about making sure that the landscape of the contract, that that doesn’t get in the way of what should be a sensible training relationship that works for both Wales and for England. It’s in our interests for doctors in England to be well-trained and content as well. We think there should be advantages to coming into Wales that don’t simply rely on saying that you’re being mistreated in England.”¹⁵⁴

157. At the same time, he also responded to concerns with regard to histopathology, and the potential salary differences with NHS England:

“What’s been interesting is, for example, that one of the areas where they’ve already got financial incentives, histopathology, which has been a problem for us, we think that we’ll get very near, if not completely, filling our own training places here. So, we need to understand why we think that is.”¹⁵⁵

Professional Indemnity

158. We heard concerns about the need to put in place a robust system of professional indemnity for all professionals working in primary care, as well as the high cost of GP primary care indemnity. It was suggested that this is an issue that could have a potential impact on recruitment and retention.

¹⁵³ RoP, 15 March 2017, paragraph 101

¹⁵⁴ RoP, 15 March 2017, paragraph 108

¹⁵⁵ RoP, 15 March 2017, paragraph 104

159. Dr Philip Kloer, Medical Director at Hywel Dda UHB told us:

“It’s certainly something that gets raised with me very regularly, the high cost of primary care GP indemnity. Certainly, the indemnity to work in primary care is much more than for a hospital doctor, from what I’ve been quoted. So, I do think it’s a real issue.”¹⁵⁶

160. Dr Charlotte Jones from BMA Cymru told us that the Welsh Risk Pool¹⁵⁷ “does not actually cover every aspect of indemnity.”

161. She explained that:

“...it looks after the organisation rather than the individual. It only covers clinical instances, so the other aspects of a complaint or a claim, such as around disciplinary proceedings, GMC proceedings, criminal proceedings, anything like that, or professional issues, it does not cover. So, therefore, it would give you some cover but not all cover. As we all know, when a complaint is made against the profession, it often covers an array of areas and, actually, if you have Welsh risk pool cover and additional cover, it may actually cause the GP or the doctor to fall in the middle there and be a little bit vulnerable to not having all aspects covered.”¹⁵⁸

162. Dr Rebecca Payne stated:

“...doctors have to pay for insurance to practice. My insurance costs me £120 a day. Now, I need that insurance if I’m going to go and do a locum for Isolde [Shore-Nye], but if I do a locum for a health board practice or work in the out-of-hours setting, I don’t have to pay that additional £120 a day. Now, what that means is if I’m offered work in a non-conventional setting, for example out of hours, [...] there’s a real incentive for me to not go and help Isolde, because not only is the insurance extremely expensive, it’s also very inflexible.”¹⁵⁹

Workload pressures

163. Another area we were told that was impacting on retention, particularly in general practice, was workload pressure and the increasing complexity of patient care. Dr Charlotte Jones, BMA Cymru, told us:

¹⁵⁶ RoP, 16 February 2017, paragraph 417

¹⁵⁷ The Welsh Risk Pool Services is a mutual organisation which reimburses losses over £25,000 incurred by Welsh NHS bodies arising out of negligence. The Welsh Risk Pool Services is funded through the NHS Wales Healthcare budget.

¹⁵⁸ RoP, 8 February 2017, paragraph 52

¹⁵⁹ RoP, 8 February 2017, paragraph 151

“The complexity is going up, the workload demand is going up significantly, as are the other challenges facing general practice and, actually, the whole of the healthcare system. What we need to do is to make sure that we address all the various pressures, so that’s the workload pressure that we’re facing, the recruitment problems that we’re facing and, of course, the resource issues. There’s a perfect tsunami here just waiting to happen.”¹⁶⁰

164. While Dr Heidi Phillips, representing GP Survival, told us that, according to a survey of Swansea medical students, general practice was not seen as an attractive option because:

“... they see what we see, which is a 10-minute revolving door, starting at 8.30 a.m. through to 6.30 p.m., with no protected time for education, no protected time for the expansion of other interests, and no protected time even for administration. It’s relentless. When you look at the other side of it, you see the GPs—our role models—who, from the evidence I submitted, are burnt out, exhausted, demotivated and demoralised.”¹⁶¹

Our view

165. We believe there is much for NHS Wales to be positive about in terms of the quality of training and the training experience it provides for doctors who choose to come here. We were encouraged by the feedback from the panel of trainee doctors, who reported some of the positive views from trainee doctors about their experience of training and working in Wales.

166. At the same time, there remain serious and significant challenges. In secondary care, alongside the very positive experiences, there are concerns from trainees about heavy workload and difficulties in ensuring that training time is protected when competing with the very real demands of service delivery. In an age of social media, good and bad experiences are able to be shared widely amongst doctors.

167. Equally, we heard clear messages about the pressures in terms of GP and GP trainee services. There appears to be no appetite for more widespread moves towards a Salaried GP service; however, amongst many of the current generation of trainee doctors there is an evident reluctance to commit themselves to the role of GP partner and full independent contractor status. This poses real challenges for the existing model and sustainability of primary care.

168. Developing new models of care will be a key part of tackling these workload and sustainability issues: we believe the pace, visibility and focus of this development needs to be stepped up, which will need strong and structured direction and leadership. Doctors must play a critical part in supporting change and providing leadership, but they cannot do this alone.

¹⁶⁰ RoP, 8 February 2017, paragraph 67

¹⁶¹ RoP, 8 February 2017, paragraph 132

169. We believe Wales has a real opportunity and obligation to develop and promote itself as a leader in developing rural and community-based medicine, in terms of both service models and medical training. We endorse further development of undergraduate and postgraduate education and training in rural healthcare, as a way of both meeting the distinctive needs of rural communities and enhancing the range of opportunities Wales has to offer.

170. It is essential that trainees working in rural areas are able to access and participate fully in training; the evidence suggests there are barriers which mean this is not always the case. The Welsh medical schools and local health boards need to work together with students and medical trainees to identify and resolve any difficulties. This may require funding and the Welsh Government needs to be part of discussions around the resourcing of solutions. Tackling rural recruitment difficulties is a pressing issue and requires prompt action.

Recommendation 9. The Welsh Government should work with Welsh medical schools, local health boards and the Welsh Deanery (or any successor body) to develop a joint action plan for rural medical training and education, drawing on experience and best practice from elsewhere, both nationally and internationally.

171. We heard support for the Welsh Government approach on the junior doctors' contract. Nonetheless, there were issues raised with us where doctors in Wales may be disadvantaged when compared with their counterparts in England – additional hours payments and histopathology were specific examples; we believe that work needs to be undertaken to ensure areas of potential disadvantage are addressed.

172. The evidence provided to us in the surveys undertaken by the All Wales School of Emergency Medicine and Dr Heidi Phillips have been both invaluable and informative. We believe they demonstrate the necessity of a good evidence base, harnessing the views of those students and doctors who have chosen to study and work in Wales on what Wales offers, and is able to offer, in terms of medical training and education.

Recommendation 10. The Welsh Government must focus on robust long term workforce planning by commissioning work which involves the key stakeholders in NHS Wales, Welsh medical schools, medical students and medical trainees to develop a comprehensive, all-Wales evidence base in respect of recruitment and retention. This would serve to inform recruitment strategies and campaigns.

05. The development and delivery of medical recruitment campaigns

173. We heard very positive responses to the recent ‘**Train, Work, Live**’ recruitment campaign. This initiative was launched in 2016 and aimed specifically at attracting increased numbers of medical staff – including trainees, senior hospital doctors and GPs – to live, work and train in Wales. The initiative also aimed at promoting jobs and the broader concept of what NHS Wales and Wales as a country had to offer. We heard that it represented strong LHB collaboration:

“There’s a lot of work going on with the ‘Train, Work, Live’ campaign to try to actually promote Wales as a unified brand in terms of recruiting doctors...”¹⁶²

174. However, we also heard support from the Royal College of Psychiatrists for an increased emphasis on the work of NHS Wales:

“The bit missing from the recruitment campaign is that it’s also a very good place to work because there are fantastic clinical services in some areas and there’s very good research going on. You know, it’s how we add that element to it really, I think, which is missing at the moment; celebrating work as opposed to leisure, which is also important.”¹⁶³

175. Similarly, Professor Peter Barrett-Lee from Velindre NHS Trust argued that:

“[Anybody working in the NHS]...has a role in promoting Wales and the Wales NHS when they’re outside of work. We think there may be some negative messages out there, and we could counteract those in our social interactions, probably, more—be more of a champion.”¹⁶⁴

176. At the same time, Dr Helen Baker from the Wales Deanery sounded a note of caution:

“...we already know from trainees and anecdotal evidence that there is a perception that Wales is different—Wales has a different healthcare setting and environment. Training, potentially, could be different in Wales. If we then move our recruitment system, and run a different recruitment system, we increase the perception that Wales is doing something different. Trainees are in a competitive market, and they do want to move around the whole of the UK and overseas, so if we were

¹⁶² RoP, 16 February 2017, paragraph 280

¹⁶³ RoP, 16 February 2017, paragraph 214

¹⁶⁴ RoP, 16 February 2017, paragraph 333

to go alone and hold a Welsh recruitment process, we'd increase that perception to trainees.”¹⁶⁵

177. Some responses argued for more stakeholder participation. The Royal College of Physicians called for more involvement from the professional bodies.¹⁶⁶ Aneurin Bevan UHB believed the campaign should be developed, working with local businesses to target more socially deprived or harder to reach areas.¹⁶⁷

178. We also heard evidence from some witnesses based in North Wales about the need for a very strong locally-focused and responsive approach,¹⁶⁸ involving a much more personalised approach - working to fit jobs round the individual needs of individuals.

179. Dr Linda Dykes provided evidence about her approach in recruiting to emergency medicine in North Wales, making use of social media but emphasizing:

“...we do have to work hard for each and every recruit. We are selling posts, and it's a buyer's market. We have to be realistic about that' [...] the first thing is you've got to make the job right.”¹⁶⁹

180. This was seen as critical to success and often involved direct networking and 'head-hunting' approaches to possible recruits.

181. We heard from the Cabinet Secretary that:

“The launch of the campaign has generated significant interest from qualified doctors and GPs to medical students. Since the launch, our marketing campaign has been running well and is actively promoting Wales as a great place to train, work and live using press advertising, digital advertising and social media. This has extended the reach of the campaign to wider audiences, both nationally and internationally, and has proved to be successful in reaching our target audiences.”¹⁷⁰

182. The Cabinet Secretary also emphasised the importance of taking on board, and rolling out across Wales, some of the lessons from the work being undertaken by Linda Dykes in North Wales, which was about understanding and targeting the message “looking at the job as well as looking at the opportunities to live somewhere else as well”, in addition to ensuring effective leadership in a team “...where people feel supported and that radiates out”.

¹⁶⁵ RoP, 16 February 2017, paragraph 557

¹⁶⁶ Written evidence MR14

¹⁶⁷ Written evidence MR12

¹⁶⁸ RoP, 8 February 2017, paragraphs 192-9

¹⁶⁹ RoP, 8 February 2017, paragraphs 110 and 180

¹⁷⁰ Health Social Care and Sport Committee, Paper 1, 15 March 2017

183. He told us:

“How we can make sure the job matches up with what people will expect, and to make it the best possible fit for the job, and then how do we say you've got all these other opportunities too.”¹⁷¹

Our view

184. NHS Wales is operating in an increasingly competitive environment in terms of recruiting doctors. There are an extensive and growing range of training and career opportunities for doctors throughout their career and throughout the UK, as well as beyond. In order to continue attracting and retaining doctors, NHS Wales must ensure it delivers effective, well-targeted, accessible and highly visible recruitment campaigns.

185. We welcome the positive feedback we heard during the inquiry about the Train, Work, Live campaign. The campaign emphasised what Wales has to offer in terms of work and the lifestyle outside work. Indeed, we heard clear messages, including from the panel of trainee doctors, through the surveys of trainees in Emergency Medicine and Swansea medical graduates and other witnesses about the broader social, lifestyle and family-related factors that attracted doctors to Wales. The focus on Wales as a unique and individual ‘brand’ has been well received, as has the overall approach of the campaign.

186. The Cabinet Secretary shared this very positive view, and also set out the intent to ensure this ‘Welsh-branded’ approach would be sustained. Further phases of Train, Work, Live are to follow: the nursing phase has recently been launched, with therapies being the focus in 2018.

187. In our view, this campaign and Welsh-focus is to be welcomed and supported. Nonetheless, the launch of these further phases should not mean a loss of focus on medical recruitment. It should not be about a single effort, but needs to be an ongoing and sustained initiative, targeting annually each new group of medical graduates and trainee doctors. The problems of ensuring adequate medical staffing in Wales are both real and continuing. They need real and continuing attention.

188. There is also a need to properly assess and evaluate the impact of Train, Work, Live. This evaluation must include data about the interest it generated and attracted, the social media profile and how that interest has been converted into doctors who want to train, work and hopefully build careers within Wales.

Recommendation 11. The Welsh Government should ensure an evaluation is undertaken of the scope, reach and impact of the Train, Work, Live campaign, with a focus on outcomes achieved and lessons to be taken forward. These lessons should inform an on-going annual recruitment campaign for doctors.

189. We noted that there is a £20,000 financial incentive offered for those choosing GP careers in specific areas of Wales experiencing particular difficulties in recruiting and

¹⁷¹ RoP, 15 March 2017, paragraph 127

retaining doctors into primary care. We see this as a pragmatic and practical initiative, and support the principle of linking such an incentive with a contractual commitment to a time working in NHS Wales. We look forward to seeing what uptake there is of this offer and whether there is evidence that it translates into doctors coming into and, more importantly, remaining within Wales. We will request that the Cabinet Secretary provides a future update to the Committee on the progress achieved.

190. We also believe that this initiative has the capacity to both set a precedent for the use of financial incentives elsewhere, and pose the question as to where such incentives could be most effectively targeted.

191. Supporting increased numbers of Welsh-domiciled students to take up places in Welsh medical schools may be one such possible priority area, if backed by a commitment to undertake further training within Wales.

Recommendation 12. The Welsh Government should provide an update to the Committee by the end of 2017 (and annually thereafter) on the impact of the GP Incentive Scheme, and examine and undertake work to identify potential options for other financial or similar incentive schemes to attract and retain potential and practising doctors.

192. The medical recruitment initiatives for emergency medicine pioneered in North Wales are innovative, responsive and effective. They make active use of social media and personal networking to target recruitment messages; working to tailor job profiles to remedy difficulties, maximise appeal and secure a better match with target groups of doctors; being clear about the 'product' both in terms of the work and lifestyle factors; and securing good clinical leadership. It is vital that good practice lessons are learnt, from this and other recruitment initiatives, and made use of locally and throughout Wales.

06. Recruitment processes and practices

Joined-up recruitment processes

193. We received a number of responses which emphasised that recruitment processes should be more joined-up, focusing on wider workforce issues, and not solely on medical recruitment. RCN Wales recognised that, whilst medical recruitment represented a 'key vulnerability' for NHS Wales, doctors should be considered as part of a multi-disciplinary team.¹⁷² The RCPCH expressed concerns that there was an absence of a central strategy to organise recruitment work in the area of paediatrics, with much of the work being done more locally.¹⁷³ Other submissions identified the need for robust structures to be in place whilst Health Education Wales was being established.

194. Strong arguments were also put forward for moving beyond the traditional recruitment and advertising methods. The approach taken by Dr Dykes in Bangor Emergency Department made significant use of social media, tailored and flexible websites enabling advertising to be swift and responsive.¹⁷⁴ Similarly, Public Health Wales has made increased use of more directly targeted campaigns, utilising social media and specific mail-drops to medical staff.¹⁷⁵

The advertising and administration of vacancies

195. We heard that GP vacancies were advertised in a variety of locations across Wales, including **NHS Jobs for salaried GPs**, via the **Local Medical Committee** in Cwm Taf, in conjunction with Betsi Cadwaladr UHB in **North Wales**, and the 'Train, Work, Live' website sets out information on **GP training**. However, the evidence suggests individual strands of information on vacancies are not drawn together in a similarly, more co-ordinated all-Wales approach.

196. The Cabinet Secretary argued strongly for the value of a nationally-led and structured campaign, using systems which enable real time management of the recruitment process and self-booking of pre-employment checks. NHS Wales Shared Services Partnership (NWSSP) has also assumed responsibility for the issuing of Certificates of Sponsorship to medical and dental trainees, avoiding the need for trainees to re-apply with each training rotation:

“The management of medical recruitment is the responsibility of the Welsh Deanery and the Health Boards/Trusts. However, it was recognised by the NHS in Wales that a safe and effective recruitment process provides opportunity for improved value for money and provides a better experience for those wishing to work within the NHS in Wales.”

¹⁷² Written evidence MR05

¹⁷³ Written evidence MR08

¹⁷⁴ Written evidence MR27

¹⁷⁵ Written evidence MR17

“NWSSP developed a Standard Operating Process (SOP) to manage the recruitment process for non-medical posts within NHS Wales. The SOP was developed to reflect the requirements of the NHS Employment Check standards whilst also reflecting the requirements of NHS Wales. Medical recruitment undertaken by the Health Board/Trusts and the Welsh Deanery mirrors the SOP so that the streamlined process is now used across Wales.”¹⁷⁶

Our view

197. We recognise that there has been progress achieved in some aspects of medical recruitment and the joining up of HR processes across NHS Wales bodies, to help ensure that effective support is provided to doctors choosing to train and work here.

198. It is crucial that NHS Wales plans ahead in terms of its workforce. We know it can take up to 10 years to fully train a doctor. A robust workforce planning process, that is regularly reviewed, is essential. The planning process should be underpinned by accurate evidence, including current vacancies, and good forecasting of future need of skills and numbers. It should be informed by both professional standards and the experiences of the current workforce. There is real value in the more uniform and centralised national systems that NHS Wales now has in place to support the management of recruitment, pre-employment screening and checks and support for doctors from overseas with visas and registration through the NHS Wales Shared Services Partnership and its Certificates of Sponsorship. These national systems are important; they have the ability to deliver a better employment experience to new medical recruits and remove the burden of sometimes unnecessary bureaucracy. We also welcome the opportunities such centralisation offers for ensuring improved efficiency and value for money.

199. Nonetheless, we remain concerned about a number of issues. One concern is the advertising of vacancies. In their evidence to us, LHBs maintained that they have a clear understanding of the medical vacancies in their local area. We understand that view; for LHBs they will have a clear remit for their own workforce planning and recruitment. To take just one example, Aneurin Bevan University Health Board’s website contains clear and accessible details of medical and other vacancies for their geographical area, both in primary and secondary care.

200. At the same time, there is no reliable and central point of access which provides - or links to - up to date national information on medical vacancies. This is the case whether it applies to GP, community or hospital vacancies throughout Wales. GP vacancies in particular are advertised and accessible through a diverse number of sources. We believe that local advertising is vital for LHBs. However, we also believe that national advertising, building on the current developments and stressing the distinctiveness and diverse opportunities throughout Wales and NHS Wales, can yield significant benefits. This could be taken forward by the Deanery, through Train, Work, Live or - in the future - the new Health Education Wales.

¹⁷⁶ Health Social Care and Sport Committee, [Paper 1](#), 15 March 2017

Recommendation 13. The Welsh Government should work with key stakeholders to develop options for ensuring the delivery of a single, national point of access for detailing current medical vacancies within Wales.

201. Alongside this, we consider that adequate and regular information is a vital component in understanding the extent of the medical recruitment challenge. It is also an important part of enabling good workforce planning and the effective targeting of key pressure areas and specialties within Wales.

202. We are concerned that there is no national system for recording and reporting the number and level of medical vacancies within Wales. We believe effective reporting is central in being able to measure and evaluate the extent of vacancies, the impact and outcome of local and national recruitment campaigns, enable the effective targeting of such local and national recruitment campaigns and better inform workforce planning for healthcare in Wales.

Recommendation 14. The Welsh Government should collate and publish the numbers of medical vacancies within Wales in order to inform long term and robust work-force planning strategy.

07. Implications of Brexit for medical recruitment

203. Concerns were expressed about the potential and very uncertain consequences of the United Kingdom leaving the European Union (Brexit) on health and social care staffing, including medical recruitment. **The Wales Deanery** expressed the hope that post-Brexit immigration rules would enable EU nationals to continue working in the UK or at least allow those currently working in the UK to remain. The Wales Deanery’s submission acknowledges that the impact on the relatively small current cohort of training grade doctors in Wales is likely to be limited, but notes that:

“If we cannot recruit and retain EU doctors in Wales we will need to look to other parts of the world or train more Welsh domiciled students and encourage them to undertake their postgraduate training here in Wales with comprehensive incentive packages.”¹⁷⁷

204. Dr Martin Rolles from the Royal College of Radiologists told us:

“It’s just a generalisation, but in terms of staffing shortages for UK-trained doctors, what affects the UK affects Wales and the peripheries more. Why would it be any different for EU or overseas recruits?”¹⁷⁸

205. This uncertainty was echoed by Dr Philip Kloer from Hywel Dda UHB:

“I think as part of Brexit also, our regulators, such as the GMC and others, are going to have to work out what their policies would be to EU nationals coming into our country.”¹⁷⁹

206. However, Sharon Vickery from Abertawe Bro Morgannwg UHB set out that potential changes were shifting some of their recruitment approaches towards areas such as India:

“But, just for you to be aware, I suppose we are, almost implicitly, taking some of the uncertainty around Brexit in order to drive some of our policy around international recruitment.”¹⁸⁰

207. We heard from Aneurin Bevan UHB, RCEM Wales, BMA Cymru, the Welsh NHS Confederation, and the Royal College of Surgeons of the value that medical and other clinical staff from the EU bring to healthcare in Wales.¹⁸¹ They called for clarity on the issue so that EU professionals are permitted to remain and that the UK is able to ensure a continuing pipeline of staff to the sector. The RCPCH noted that 18 per cent of paediatric

¹⁷⁷ Written evidence MR06

¹⁷⁸ RoP 16 February 2017, paragraph 74

¹⁷⁹ RoP 16 February 2017, paragraph 324

¹⁸⁰ RoP 16 February 2017, paragraph 330

¹⁸¹ Written evidence MR12, MR15, MR20, MR21 and MR23

trainees were overseas graduates, including EU nationals.¹⁸² The Welsh NHS Confederation noted that:

“Staffing levels in the service operate on very fine margins. [...] The current uncertainty as to the timetable for leaving the EU may potentially lead to staff looking for opportunities outside of the UK and for potential applicants to be deterred from applying.”¹⁸³

208. The RCP, **in their response**, summarised their concerns:

“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. [...] 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.”¹⁸⁴

209. In evidence from Cardiff University Medical School, Professor Ian Weeks highlighted concerns about continued access to research grants and programmes, the loss of which may impact on Wales’ ability to attract and retain high-quality research staff:

“...the other side of the medical school—talking about creating good doctors, excellent doctors for the future—is about the research side of things as well, because that does attract a lot of people to an area. I think Brexit is clearly going to impact on the research side of things and our ability to attract quality research, and this is causing a lot of issues for us at the moment.”¹⁸⁵

210. This concern has also been set out in a report from the National Assembly’s External Affairs and Additional Legislation Committee.¹⁸⁶

211. We heard these concerns echoed unreservedly by the Cabinet Secretary. He stated that he believed Brexit represented a “really big risk”¹⁸⁷ for the whole NHS, not just in Wales, and drew our attention to a BMA survey showing real concerns from EU nationals working currently in the UK:

“If numbers of them leave, well, there’s no guarantee we’ll replace them readily and easily because the impact of leaving the European Union isn’t just on recruiting European Union nationals; it is something also about how other doctors from outside Europe see this country as well, and whether they feel welcome. Because part of the

¹⁸² Written evidence MR08

¹⁸³ Written evidence MR21

¹⁸⁴ Written evidence MR14

¹⁸⁵ RoP, 9 March 2017, paragraph 182

¹⁸⁶ *Implications for Wales of leaving the EU* (2017), paragraphs 126-30

¹⁸⁷ RoP, 15 March 2017, paragraph 131

evidence also is that other doctors who are not originally from Britain don't feel welcome and valued either. I think we've been really clear as a Government that we value those people not just because they provide high-quality healthcare services, but actually they're a part of the communities that we live in, and they're a part of this country."¹⁸⁸

"So, I'm due to meet the BMA to talk specifically about this issue in the coming months, but I think it's incredibly difficult and it's done real damage to healthcare right across the UK, not just in Wales. We're going to live with this challenge for a period of time..."¹⁸⁹

212. However, the Cabinet Secretary also acknowledged the work that was going on within NHS Wales to build recruitment partnerships beyond the EU, including the relationship with the British Association of Physicians of Indian Origin (BAPIO):

"Yes, the relationship with BAPIO is incredibly positive... So, I would like to see a relationship that looks and feels like BAPIO with all of our doctors, including the doctors from the European Union, because they recognise that they're valued..."¹⁹⁰

Our view

213. The views we heard throughout the inquiry were very clear on the subject of exit from the EU. There were strong arguments from a range of stakeholders for an early and clear resolution on the ability of EU nationals to be able to work within the UK, particularly in health and social care. We heard that current uncertainties are already beginning to have an impact on the ability to recruit and retain medical and other clinical staff.

214. We agree with the Cabinet Secretary about the value of doctors from the EU and elsewhere working currently within NHS Wales, providing direct, high-quality care with and for our communities. They are valued not just because of the care they deliver, but because they are part of the communities we and they live in, and part of this country.

215. We recognise and support the Welsh Government's view that the position of EU nationals should be confirmed. We believe this will enable an unambiguous message to be sent about the willingness and ability of Wales to recruit and retain skilled staff from not just the UK, but from the EU and beyond.

Recommendation 15. The Welsh Government should continue dialogue with the UK Government to emphasise the importance of quickly clarifying the ability of EU nationals to continue and commence working in the UK.

¹⁸⁸ RoP 15 March 2017, paragraph 132

¹⁸⁹ RoP 15 March 2017, paragraph 137

¹⁹⁰ RoP 15 March 2017, paragraph 139

Recommendation 16. The Welsh Government should continue dialogue with the UK Government to seek assurances about the ability of EU nationals to work as medical professionals in Wales in the future.

216. At the same time, we acknowledge and welcome the relationships which NHS Wales is already developing beyond the EU, through initiatives such as the work with the British Association of Physicians of Indian Origin (BAPIO). This has the potential to enable NHS Wales to draw in skills and individuals from a wide variety of professional and training backgrounds, enhancing the health services which are delivered to our local communities. We would support the continued and enhanced development of such outward-reaching initiatives.