Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

16/02/2017

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Jayne Bryant Bywgraffiad|Biography	Llafur Labour
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Eraill yn bresennol
Others in attendance

Yr Athro/Professor Peter Barrett-Lee	Cyfarwyddwr Meddygol, Ymddiriedolaeth GIG Felindre Medical Director, Velindre NHS Trust
Dr Helen Baker	Cyfarwyddwr Cyswllt (Gofal Eilaidd), Deoniaeth Cymru Associate Director (Secondary Care), Wales Deanery
Yr Athro/Professor Peter Donnelly	Deon Ôl-raddedig Dros Dro, Deoniaeth Cymru Interim Postgraduate Dean, Wales Deanery
Dr Amanda Farrow	Pennaeth yr Ysgol, Coleg Brenhinol Meddygaeth Frys Cymru Head of School, Royal College of Emergency

	Medicine Wales
Martin Jones	Cyfarwyddwr Gweithredol y Gweithlu a Datblygu Sefydliadol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Executive Director of Workforce and Organisational Development, Betsi Cadwaladr University Local Health Board
Dr Philip Kloer	Cyfarwyddwr Meddygol, Bwrdd Iechyd Lleol Hywel Dda Medical Director, Hywel Dda Local Health Board
Dr M Sakheer Kunnath	Coleg Brenhinol Pediatreg ac Iechyd Plant Royal College of Paediatrics and Child Health
Yr Athro/Professor Keith Lloyd	Coleg Brenhinol y Seiciatryddion Royal College of Psychiatrists
Dr Phil Matthews	Dirprwy Gyfarwyddwr Meddygaeth Teulu / Pennaeth yr Ysgol Hyfforddiant Arbenigol ar gyfer Meddygaeth Teulu, Deoniaeth Cymru Deputy Director of General Practice/Head of Specialty Training School for General Practice, Wales Deanery
Dr Evan Moore	Cyfarwyddwr Meddygol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Medical Director, Betsi Cadwaladr University Local Health Board
Dr Martin Rolles	Cadeirydd y Pwyllgor Sefydlog Cymreig, Coleg Brenhinol y Radiolegwyr Chairman of the Standing Welsh Committee, Royal College of Radiologists
Dr Robin Roop	Is-lywydd, Coleg Brenhinol Meddygaeth Frys Cymru Vice President, Royal College of Emergency Medicine Wales

Sharon Vickery	Pennaeth Uned Gyflawni a Staffio Meddygol Adnoddau Dynol, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Head of HR Delivery Unit & Medical Staffing, Abertawe Bro Morgannwg University Local Health Board
Dr Toby Wells	Ysgrifennydd, Coleg Brenhinol y Radiolegwyr Secretary, Royal College of Radiologists

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Claire Morris	Ail Glerc Second Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk
Sian Thomas	Clerc Clerk
Dr Paul Worthington	Ymchwilydd Researcher

Dechreuodd y cyfarfod am 09:29.
The meeting began at 09:29.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Dai Lloyd**: Bore da a chroeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. Rydym ni mewn ystafell wahanol y bore yma, ond, wrth gwrs, mae'n ddigon hawdd ymgynefino â'r sefyllfa wahanol. A allaf i estyn croeso i fy nghyd-Aelodau? Mae gennym ni ymddiheuriadau oddi wrth

Dai Lloyd: Good morning and welcome to the latest meeting of the Health, Social Care and Sport Committee here at the Assembly. We're in an alternative room this morning, but, of course, we will get used to our new surroundings. May I extend a warm welcome to fellow Members? We received apologies from Angela Burns today as she's

Angela Burns heddiw. Nid yw hi'n gallu bod yn bresennol. Fe allaf i bellach egluro bod y cyfarfod yma yn ddwyieithog. Gellir defnyddio'r clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2? A allaf i atgoffa pawb i ddiffodd eu ffonau symudol ac unrhyw offer trydanol arall a allai ymyrryd â'r offer darlledu yn y gornel wrth ein hochr ni? Hefyd, nid ydym ni'n disgwyl larwm tân y bore yma. Os bydd yna larwm tân yn canu, mae'n golygu bod yna rhywbeth mawr o'i le a dylem ddilyn cyfarwyddiadau'r tywyswyr i adael yr adeilad. Felly, dyna bob peth o dan eitem 1.

unable to be with us. May I further explain that this meeting will be held bilingually and headphones can be used for simultaneous translation from Welsh to English on channel 1, or for amplification on channel 2? Can I please remind everyone to switch off their mobile phones and any other electronic equipment that they may have that could interfere with the broadcasting equipment in the corner there? We're not expecting a fire drill this morning, so if you do hear a fire alarm, then it does mean that something's amiss and that we should follow the instructions of the ushers and leave the building. So, that's item 1 dealt with.

09:31

Ymchwiliad i Recriwtio Meddygol: Sesiwn Dystiolaeth 6—Coleg Brenhinol Meddygaeth Frys a Choleg Brenhinol y Radiolegwyr
Inquiry into Medical Recruitment: Evidence Session 6—Royal College of Emergency Medicine and the Royal College of Radiologists

[2] **Dai Lloyd:** Eitem 2 ydy'r parhad efo'r ymchwiliad i recriwtio meddygol. Hon yw sesiwn dystiolaeth rhif 6. O'n blaenau ni'r bore yma mae tystion o Goleg Brenhinol Meddygaeth Frys a Choleg Brenhinol y Radiolegwyr. Felly, a gaf i groesawu i'r bwrdd, felly, Dr Robin Roop o Goleg Brenhinol Meddygaeth Frys Cymru; Dr Amanda Farrow, hefyd o Goleg Brenhinol Meddygaeth Frys Cymru; Dr Toby Wells o Goleg Brenhinol y Radiolegwyr; a hefyd Dr Martin Rolles o Goleg Brenhinol y

Dai Lloyd: Item 2 is our inquiry into medical recruitment, and this is evidence session number 6. Before us this morning, we have witnesses from the Royal College of Emergency Medicine and the Royal College of Radiologists. So, may I welcome to the table, Dr Robin Roop from the Royal College of Emergency Medicine Wales; Dr Amanda Farrow, also from the Royal College of Emergency Medicine Wales; Dr Toby Wells from the Royal College of Radiologists; and also Dr Martin Rolles from the

Radiolegwyr.

Royal College of Radiologists.

[3] Rydym ni wedi derbyn eich tystiolaeth ysgrifenedig gerbron a diolch yn fawr iawn am hynny. Mae'r cwestiynau wedi'u paratoi yn seiliedig ar beth rydych chi eisoes yn sylfaenol wedi'i ddweud wrthym ni. Felly, gyda'ch caniatâd, awn ni'n syth i mewn i gwestiynau, ac mae'r cwestiynau cyntaf o dan ofal Caroline Jones.

We've received your written evidence, and thank you very much for providing that. The questions have been prepared based on what you have already provided us with. So, with your permission, we will move immediately to questions and the first questions are from Caroline Jones.

[4] **Caroline Jones:** Diolch, Chair. Good morning. In terms of the medical workforce in emergency medicine, clinical oncology and radiology, where do you think the key pressure points are and how can they be tackled?

[5] **Dr Wells:** To clarify, sorry, the question was—

[6] **Caroline Jones:** Regarding the medical workforce in emergency medicine, radiology and clinical oncology, where do you consider the key pressure points to be and how can they be tackled?

[7] **Dr Wells:** In clinical radiology, which is what I represent, the key—the only—pressure point is the absolute shortage of radiologists. There are just not enough radiologists to do the work. The number of complex scans being requested has increased 10 per cent year on year for the last five years, whereas the workforce has only increased between 1 per cent and 2 per cent. So, mathematically, there's a shortage.

[8] In terms of solutions, it's very difficult. We've come up with various options. We've tried our best to recruit from overseas, but there's an international shortage of radiologists. Wales is no worse off than the rest of the UK. The number of radiologists per capita is similar to every other area. It's slightly better than East Anglia and slightly worse than London. But there's no radiologist sitting around anywhere that we can poach, so recruitment is limited. We've had to outsource a lot of work to private companies because there is no other solution. The only long-term sustainable solution is to increase training numbers.

[9] **Caroline Jones:** Okay, thank you.

[10] **Dr Roop**: From the Royal College of Emergency Medicine point of view, we know that our population is rising and attendances to emergency departments are increasing as well. The case mix of people who attend emergency departments is also increasing in terms of the over-65s who need to be seen more frequently in emergency departments. That's one of the pressure points. We find that we need to have the appropriate staff levels within departments to deal with these more complex patients who have different needs. We are also in a position where our numbers are not sufficient to deal with these pressures.

[11] **Dr Rolles**: I think it's about bodies on the ground essentially. I think the situation is the same. I think there's an added dimension that hasn't been mentioned, which I think is generalisable possibly, in that we are particularly vulnerable in the south-west and the north, where recruitment is difficult and the departments are small, and there's an added requirement to provide a service to a rural, geographically distributed population. So, there's a loss of economies of scale that one might find in a large department and there are extra requirements. So, the metrics in terms of staffing numbers per million population, which have generally worked out for places like the English midlands, where you've got a relatively consistent high-density population, really don't apply to rural Wales.

[12] **Dr Farrow**: May I add to that? Just to reinforce what Robin said, for emergency medicine, staffing is an issue and, again, mirroring what Martin said about oncology with north Wales and west Wales, in particular. I work for the Wales Deanery as part of my role, so I'm the head of school for emergency medicine. So, I deal mainly with training, and we have very good training, but we actually have a very small number of training posts, so we do rely on a lot of non-training doctors, and that's where the problem is with staffing. But also currently a big pressure point for us would be the crowding that is facing all emergency departments on a daily basis, which has a very negative impact on, you know, burnout and stress to staff, including nursing and other staff. So, that has to be tackled to make sure that emergency medicine people can function and work in good, supportive environments as well. So, I think staffing is a problem, but also it's getting the system correct.

[13] **Caroline Jones**: Okay, thank you. What do you consider to be the influencing factors on where doctors choose to study, train and work, and how do you think this information can be substantiated?

[14] **Dr Farrow:** So, we had a survey done recently by our trainees, and, actually, a lot of the reasons they choose to stay in Wales were because of family reasons and work-life balance. And if we manage to get them into a training programme, then generally they stay in Wales as consultants. So, it's attracting them in the beginning and, obviously, retaining them, but a lot of choice is for reasons that aren't necessarily due to the medical side of things, so it's often the family work-life balance. There are a number of doctors who want to work in north Wales and live in north Wales, but there are also a lot of doctors that want to work in south Wales, and therefore don't want to have to rotate during their training programme. So, we've got two separate training programmes now, really—one for south Wales and one for north Wales.

[15] **Dr Roop:** Being a small country as well, we have a lot of district hospitals, and there was this sort of homely-type environment, so the experiences that these doctors had in these units made them want to stay and become really loyal to the units that they were working in. So, you do have to give these doctors a very good experience as well, so that's why there have been attractive schemes in different parts of the country, and that keeps people in.

[16] **Caroline Jones:** Thank you. Anyone else?

[17] **Dr Rolles:** Just to echo those comments, there's a definite sort of a—. If we train people and they live here for at least five years, there's a reasonable chance they'll settle down, but it has to be recognised that people are free to move around and there is a national and international market for jobs. People who are high-calibre, which is what we want here, will tend to look everywhere. So, there's a diffusion back across the border. We've also got to ask, 'How do we attract people from England?' because we're not just looking at indigenous trainees. And there are a number of issues that I don't think have necessarily been enumerated here, but if you're someone who's lived and trained in the home counties, there's almost a Socratic question, 'Why would I want to go and work in Wales?' I think we have to get back to those basics, and we've got to work very, very hard really to get people to want to come here. I mean, the attractions are obvious for some of us, but not for everybody.

[18] **Caroline Jones:** Okay, thank you. We've received evidence about the length of time it takes to recruit and appoint medical staff. Do you think there's a need for more clinical ownership and involvement in the

recruitment process, and would that help to address the sort of time delay, do you think?

[19] **Dr Wells:** It wouldn't address the time delay; there's a fixed amount of training time that can't be adjusted. And I don't think there's an awful lot we can do to recruit people from outside Wales to come to Wales. In radiology, everywhere is so short of radiologists that you can phone up any department and say, 'I'd like to work there', and they will give you a job. And it's very hard to attract someone from an area to another area, because they've set down roots. It's a five-year training scheme, people buy houses and have kids, and they're in school, so why would you want to come to another area? And if you're recruiting from abroad, why would a Polish radiologist choose to come to Wales, much as I love it? They know London better. They get paid a little more in London, and they would choose to go to London rather than Wales.

[20] **Caroline Jones:** But the cost is so much higher in London, isn't it?

[21] **Dr Wells:** I know, and to me it's an obvious choice, but coming from Poland, nobody's heard of Swansea and everyone knows London, and they're just as short of jobs in London, unfortunately.

[22] **Caroline Jones:** Okay.

[23] **Dr Roop:** Coming back to your question on more clinical ownership of these recruitment schemes, there is quite a lot of ownership from the clinicians in terms of—we are the ones who can direct what we expect from that post. As a college, and our head of school, and the school of emergency medicine in Wales, we plan exactly what type of training scheme we would like to have for our trainees. So, there's a lot of clinical engagement into identifying how the jobs are done.

[24] **Caroline Jones:** Thank you.

[25] **Dai Lloyd:** Julie, you had a supplementary.

[26] **Julie Morgan:** Yes. It was just on what Dr Wells said about if you were a radiologist, and you contacted any department—in the UK I presume you're talking about—you'd be able to get a job.

[27] **Dr Rolles:** Almost.

[28] **Julie Morgan**: Almost, yes. [*Laughter.*] How does Wales actually compare with the other departments? Are we worse off or are we—?

[29] **Dr Wells**: In terms of numbers or in terms of attractiveness?

[30] **Julie Morgan**: In terms of numbers.

[31] **Dr Wells**: The number of radiologists per capita in Wales is 3.8 per 100,000, which is almost bang on the average for the UK. In East Anglia it's down to 3.2 and in London it's up to nearly 5. But we're bang on average. The problem is the distribution. All of our 3.8 are in south-east Wales, and in Llanelli they haven't appointed a UK-trained radiologist for 22 years. Again, because our training scheme is based in Cardiff currently, most people set up their lives in Cardiff, and then it's hard to attract them to somewhere they've never been.

[32] **Dai Lloyd**: Dawn.

[33] **Dawn Bowden**: Thank you, Chair. I was just wondering whether you have particular problems around recruitment in rural areas, and if that is mirrored with recruitment in rural areas in England.

[34] **Dr Wells**: To some extent. King's Lynn was the classic example—no-one worked in King's Lynn, in the far corner of north East Anglia. They couldn't recruit for upwards of 10 years, and that department was failing, and then they built the Norwich Radiology Academy and shifted their training scheme to be centred near there, and now they have no problems with recruitment, because these radiologists set up their lives in the south-east, away from London, and that solved their issue.

[35] **Dawn Bowden**: Okay. That's fine. Thank you very much.

[36] **Dai Lloyd**: Symudwn ymlaen at yr adran nesaf. Rhun.

Dai Lloyd: We will move on now to the next section. Rhun.

[37] **Rhun ap Iorwerth**: Bore da i chi i gyd. Nid ydw i'n gwybod ai 'adran nesaf'—mae popeth yn llifo i mewn i'w gilydd mewn difri, ond os allwn ni drio manylu ychydig bach mwy ar rai

Rhun ap Iorwerth: A very good morning to you all. I don't know if it's the 'next section' as such; everything seems to flow into each other, if truth be told, but if we can

o'r meysydd sydd wedi cael eu crybwyll yn barod. Pa opsiynau sydd yna ar gael sydd wedi cael eu hystyried neu, o bosibl, ddim wedi cael eu hystyried yn ddigon eto ar gyfer cymell rhai i ddod i gael hyfforddiant yng Nghymru ac i weithio yng Nghymru? Rydw i'n eich gwahodd chi i fod mor agored eich meddwl ag y gallwch chi fod—popeth o gymhelliad ariannol, er enghraifft, i gyfleoedd ymchwil ac yn y blaen. Beth ydy'r foronen yna a allai wneud Cymru fod yn neilltuol wahanol pe bai'r ymdrech yn cael ei wneud go iawn?

try and focus a little on some of the areas that have already been mentioned this morning. What options are there available that have been considered, or perhaps haven't been considered in enough detail yet, in terms of incentivising people to come to train in Wales and to work in Wales? I would invite you to be as open-minded as possible in terms of all the options, from financial incentives, for example, to research opportunities and so on and so forth. What is that carrot that could make Wales a particularly attractive place if the effort was put in place?

[38] **Dai Lloyd:** Design your own recruitment policy.

[39] **Dr Roop:** For emergency medicine, we do have a restriction in terms of having to follow the national guidance on consultant contracts—that's for one. So, we do have that part we have to stick to, although we can still be a little bit inventive in terms of things that you can do to attract, from the trainee's point of view all the way up to consultants.

[40] One of my colleagues, my equivalent in Scotland, needed to attract people into his posts, and they were moving from the south of England, and there was a husband and wife team, so they had two people. They had a house that was on the market and so the chief exec said, 'Well, we'll pay the mortgage while you all get settled.' So he had to take probably a small hit for a bigger gain, and those people stayed with him, and they managed to get their house sold. So, you have to be a little bit inventive. If you've found the correct person for your post, then you need to make sure that you can look after them and be able to give them something in return. It's not always all about money as well. It's about making sure that they have a work-life balance, as Amanda was saying, because one of the big parts of emergency medicine at least is it has to be a sustainable job, because we don't want doctors, by the time they're in the middle of their 40s, to be burnt out—then you've lost another good 20 years of medical practice, emergency practice, from those doctors. But you also need to ensure that they feel valued within their departments, and part of the morale in emergency departments, again,

comes back to if you have departments that are congested all the time. So, it's a full-system problem that we're dealing with. You have to have departments that are actually working like emergency departments and not like wards.

09:45

[41] **Rhun ap Iorwerth:** On the idea of paying a mortgage for somebody to make the move easier, that was an ad hoc situation. Are there structured, strategic things that could be offered in Wales that become the norm that makes Wales stand out, be it that kind of financial incentive or jobs for spouses or whatever it might be?

[42] **Dr Roop:** I think there are good ideas around the country, in the UK, in terms of—some people have been given golden handshakes, all sorts of things, and just getting them going and making sure that you can—. If you can keep them for a fixed period—you have to be with us for this fixed period—it would help a lot with your further recruitment, because once you have a stable workforce, more people come in.

[43] **Rhun ap Iorwerth:** Okay. Any thoughts from you?

[44] **Dr Farrow:** Can I—?

[45] **Rhun ap Iorwerth:** Yes, please.

[46] **Dr Farrow:** So, we don't have a problem recruiting junior doctors to specialty training posts within emergency medicine, but our rotas are made up of a number of different sorts of junior doctors, which include GP trainees. The problem with GP recruitment has an impact on our actual rota and therefore the experience of our doctors. But we have had 100 per cent recruitment to our actual specialty training posts for a number of years, so we don't have a problem recruiting them. We actually do retain most of our specialty trainees, but I'm talking about very small numbers, so, as an actual workforce, we're all having to look at other opportunities with developing other roles like advanced nurse practitioners, so having a mixed workforce to make sure there's enough different types of staff to staff around the country.

[47] But emergency medicine in Wales has raised its profile in the last few years with the introduction of initiatives within Wales like the emergency medicine retrieval and transfer service, the EMRTS, which has, actually,

positively recruited consultants to come and work from outside Wales. So, it's hosted by Abertawe Bro Morgannwg University Local Health Board. They may work in England as a consultant in anaesthetics or critical care and emergency medicine, but they're actually employed and work some shifts on the helicopter, which has enabled quite a lot of networking and raising the profile. Also, we have our first professor of emergency medicine who was employed in the University Hospital of Walesa couple of years ago, and we have now—from that, one of our trainees has been working on developing a BSc. So, we're looking at other options to try and raise the profile within Wales. So, I think, we do recruit people, we do retain them, but we need more money to get more posts to be able to get more people to meet the numbers better. I'm aware that they have introduced a financial incentive for GP training this year in some areas of Wales, and it would be interesting to see if that does have any impact on increasing the numbers attracted to GP.

[48] But I think we're very open to trying to introduce some flexible working. So, we also have a medical education Fellow who works in emergency medicine who's been involved in some research with the college, so we're looking at supporting any ideas for creating more interesting training posts as well.

[49] **Dr Wells**: We have a slightly different, but related, problem. Again, we don't have a problem with recruiting people to train in radiology. There are nine applicants per place, and if they train locally, they usually stay here. So, we have the problem of not having trainees because there aren't enough posts. But we have another problem in that the NHS is competing against other sectors for radiologists' time, and a lot of our radiologists work for outsourcing companies and can get paid a lot better sitting at home doing reporting. So, at the age of 60, we need to try and keep our radiologists and stop them retiring and having an easy life working for an outsourcing company and, equally, if anyone's got any extra spare capacity, we'd rather they did extra sessions for the NHS than for an outsourcing company. The only way to do that is to make it a better job, working in the NHS, be that doing some sessions from home with homeworking, which Gwent have tried, or, somehow, making it more attractive to stay in the NHS. For a lot of us, the patient contact is what keeps us working for the NHS, but we need to promote better the benefits of working for the NHS because a lot of people see staying at home and working for an outsourcing company as an attractive alternative.

[50] **Dr Rolles**: I don't disagree with anything anyone says at all. I think

we've got to distinguish between trainees and fully qualified consultants—they're two different things. Trainees are much more likely to stay in Wales, if they've been here, and put down roots. So, it's an important thing, but you've got to accept that you start your training on a scheme that is normally five years, but certainly for oncology, it's now seven to eight years because of postgraduate research and things like that. 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.

[51] **Rhun ap Iorwerth:** I just wanted to press you on that, if you've got more to add, because a number of you made that suggestion in your submissions—

[52] **Dr Rolles:** But that's not a quick fix, that's a strategic thing. So, you're looking at half a decade or a decade down before you—. Even if we start now, it's a long-term strategic thing, but it's probably worth while and it's a stable strategy long term. The second thing is: how do we get qualified consultants? There isn't a single way of doing this. It's a multifactorial thing, and you've got to just keep—. There are marginal gains here and there. So, Wales can be promoted as a place to live and work—that's one thing. The advantages of working in NHS Wales, as opposed to NHS England—there's been a bit of a distinction there—are pretty clear for a lot of us who work here. That can be played up and, you know, 'Why come across the border?'

[53] The other thing is opportunist headhunting. You don't just put an advert out in the *British Medical Journal* and see who applies. You've actually got to identify people who might come along, and start working on them before they get there.

[54] **Rhun ap Iorwerth:** I think as a committee we realise there is no quick fix and that we're looking into the medium term, but I wonder, if we were able to increase training places—and you all seem to suggest that you wouldn't have a problem filling those places; so it would be just a matter of building that capacity in whatever way—if that strategy was in place now, which wouldn't actually deliver trainee doctors for a number of years, would that in itself be an attractive proposition for medics who wanted to come to Wales? Because, okay, maybe they're still struggling, like the rest of the UK now, but, you know, what they've got to plan— 'In five, six, seven or eight

years' time, I'll be working in an NHS that is properly staffed and has a strategy.'

[55] **Dr Rolles:** I don't think there's any doubt about that. Actually working in an environment where you are training and have trainees—there's a chance to speak and to develop the sort of ethos of the system, and it's a chance to get more research done. It makes the whole thing much more attractive. It takes it beyond just being a jobbing doctor, which, actually, is one of the disadvantages that Wales has, especially in the smaller units. It's just working very hard to sort of do the bread-and-butter work. There's got to be a bit more than that to make it attractive.

[56] **Dr Wells:** That is exactly what we're looking to do in radiology, and this is why we proposed this radiology academy that I wrote about in our written evidence. That's a step change in how attractive it is to work as a radiologist in Wales. It instantly becomes an attractive place to work, and will not only increase training numbers but it will attract other people to come and work and teach in an academy.

[57] **Dr Farrow:** Just one thing to say: the Welsh consultant contract is actually a very supportive reason to work in Wales—the sort of recognition of the need for SPA sessions—that's our supporting professional activity sessions—versus the direct clinical care. In England, there has been a huge drive to reduce the number of SPA sessions, which is an absolutely essential part of our workload for looking after trainees. So, within the Wales Deanery they're trying to push professionalising education. So, having dedicated time where consultants have time to spend with the trainee doctors makes the environment much more useful. It makes the training better. So, I think the Welsh consultant contracts is an excellent thing. The more we promote it and maintain it is to attract consultants from England.

[58] **Dr Wells:** I trained in England and moved to Wales partly because of that—the 3:7 ratio of SPAs to DCCs is very attractive. The pay scale points are lower in Wales than in England. Starting off as a consultant in Wales, you start off a couple of thousands less well off than in England, which does put people off, for a small amount of money. Perhaps that would be worth looking at, but promoting the SPA thing is a good plan.

[59] **Dai Lloyd:** A wyt ti wedi gorffen? **Dai Lloyd:** Have you finished?

[60] **Rhun ap Iorwerth**: I could go on and on.

[61] **Dai Lloyd**: Yes, we're aware of that, Rhun, but I've got a committee to run. Julie.

[62] **Julie Morgan**: I wanted to ask about—. There's obviously links with the north-west of England for the clinical radiology and the clinical oncology training. Does that mean there are problems of retaining staff in Wales because of those links?

[63] **Dr Wells**: Yes, it does, absolutely, because they're exposed to the north-west of England, where there is also a shortage of radiologists, and a lot of people are tempted to stay there because it's a better work environment—more research, bigger hospitals, more specialties. But, you can also sell north Wales as an attractive place to live. But we can't do anything about that. Because of the geography of Wales, they will always have to go to north-west England to do some of their training.

[64] **Julie Morgan**: Right. So, would you say we lose quite a lot of people that way?

[65] **Dr Wells**: I don't know the figures. There are only two radiology registrars in north Wales. So, percentage wise, if both of those went, obviously, you'd lose a 100 per cent. I don't know the figures, but it is a significant problem and the recruitment is as bad in north Wales as it is in the south-west of Wales.

[66] **Dr Rolles**: And for clinical oncology, historically there's been one clinical oncology trainee in north Wales who's Welsh—under the Welsh deanery—but is de facto part of the Mersey team, so really rotated and trained largely in Liverpool with some work in Rhyl and other places. That's gone up to three. Hopefully, that will provide some exposure, but we've got to just accept reality. These guys—their peers are in Liverpool and the Wirral.

[67] **Dr Wells**: There's a threshold factor where a department gets so short that, beyond that threshold, they will struggle to ever recruit again because they're so short it's such a miserable life working there, and we need to prevent that from happening in north Wales.

[68] **Julie Morgan**: Thank you. You've mentioned the Welsh consultant contract. Obviously, there's been a lot of publicity and issues about the

junior doctors contract in England. Have you seen—or do you anticipate that having any effect on recruitment to Wales?

[69] **Dr Wells**: Well, it's been resolved, but when the issues were going on, a lot of people were looking—. We recruit nationally for registrars in radiology and I still have links in England and I know that a lot of people thinking about applying to radiology pushed Wales up their preferred first choice of place to come and train, purely because of the uncertainty and the way that junior doctors felt they were being treated in England, and Welsh doctors were being treated much better. That worked very well in our favour.

[70] **Julie Morgan**: So, you think we did get—

[71] **Dr Wells**: We didn't get any more numbers, because we've still got the same numbers and we always fill them. So, it didn't make any numerical difference, but it did help to make Wales more attractive.

[72] **Julie Morgan**: Right, thank you. The other question I wanted to cover was the impact of Brexit and how you see the impact of Brexit on how we function in Wales.

[73] **Dr Rolles**: My view is that one of the great joys of working in a national service is that it's cosmopolitan. It's a very good international organisation, it recruits internationally and it contributes internationally to knowledge of medicine in the world. My colleagues are international in west Wales, and everywhere I've ever worked, and it's a pleasure and a delight. And they're not just there to do their jobs; they're there because they contribute to the development of the service and the expertise and they bring a huge amount in.

[74] So, if you think about—. The great concern about Brexit is we have a very major EU component to the NHS workforce in the UK. It's going to likely affect the UK, and what affects England is likely to affect Wales more severely. 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?

[75] There's also a question really about—. It's not just about can we recruit and are there going to be visa problems or bureaucratic hurdles; it's about the general atmosphere. If people start to feel unwanted or that it's less friendly, then they're less likely to stay.

10:00

[76] **Dr Roop**: One of the things about emergency departments is that we have very big teams and we work in a team fashion, so we value all of the people within our teams. A fair percentage of our workforce is from outside of the UK and whilst there may be a little bit of uncertainty around what's happening with them, we're still going to try to support them because it will be—. If we can keep our people, we will still be able to recruit more in. Like Toby was saying, if you don't have a stable workforce within your department, you can never really recruit in again, so good makes good, basically.

[77] **Julie Morgan**: So, you're having to make efforts to make sure that people are valued.

[78] **Dr Roop**: Yes.

[79] **Julie Morgan**: Finally, I think, Dr Wells, you mentioned the radiology training academy and you said that in your written evidence, but are you able to fund—is that going to be funded?

[80] **Dr Wells**: That's a good question. The business case has been submitted and it's been reviewed by scrutineers in Welsh Government and we've had positive feedback. They had some minor questions, which we've addressed. So, it looks very promising that we will have the capital investment to buy the building and fit it. The ongoing issue is of ongoing revenue, because we need extra money for consultants to teach there and for staff to run the academy and we will also need more trainees to work there. So, we've asked the health boards. The Welsh Government has told us that they can't fund the ongoing revenue. So, they've told us to go back and ask the health boards, which we've done and they're thinking about it, but, obviously, the health boards have got a shortage of capital. But they are now aware that radiology is a particular pressure point and it's impacting on everything else. So, hopefully, they will cough up the ongoing revenue, but then that still leaves us with the issue that we might have an academy that is well funded and with consultants to teach there, but no registrars to train there and that's up to the deanery to give us more trainees, effectively, with their limited and finite resources.

[81] **Dr Farrow**: Could I say something about the radiology academy?

[82] **Dai Lloyd**: Yes, carry on.

[83] **Dr Farrow**: I just think that it would be a benefit to a number of specialties, because obviously in emergency medicine we do a lot of radiological investigations. We have a number of doctors who would need training with that. We do use ultrasound and we have emergency nurse practitioners and there are lots of other specialties that do now use their own ultrasounds. So, I think that the radiology academy would have a huge impact on improving training for a number of specialties and not just radiology in Wales.

[84] **Dai Lloyd**: Okay. Lynne Neagle.

[85] **Lynne Neagle**: Thanks, Chair. Do you think we've got the actual structure of health service division right in Wales? Obviously, we've had some reconfiguration. It's always very difficult to take forward reconfiguration and I'd just be interested in your views on whether there's a need for more reconfiguration to ensure that we can staff the provision that we've got.

[86] **Dr Roop**: I had a college study day last Friday in north Wales, and some of my equivalents from Scotland and England came to this day. I mentioned to them the different health boards that we have in Wales and one of the things that they didn't know was where these places were, so they wouldn't know how to apply for a job. In terms of the reconfiguration, because of the multiple reconfiguration patterns that have happened in various health boards, and various areas as well, it does make it a little bit uncertain, even for fixed consultants within departments. They are not sure what exactly is happening with their jobs in terms of whether they're going to have to cross-cover sites or whether they're going to be on one site. That bit of uncertainty around reconfiguration can have an impact on how you recruit and then mainly how you retain people.

[87] **Dr Farrow**: I think there does need to be consideration for some areas in particular—say, west Wales for emergency medicine—because it's unlikely that the traditional model of how we staff departments in the south-east area of Wales would be mirrored successfully in west Wales because there isn't enough staff and it's not an attractive place for a whole number of people to go at the moment. Similarly, we don't have people doing specialty training in west Wales, so therefore, it's not on their radar for applying for consultant posts. I know they've changed the way that the department works

in Llanelli with upskilling GPs, who are providing a minor injuries service. I think in areas in west Wales and maybe some areas in north Wales, they are going to have to look at different workforce options. Within south-east Wales, we're already looking at different workforce options with emergency nurse practitioners and advanced nurse practitioners. So, I think one model fitting all departments in all areas of Wales isn't going to be the future; everybody is going to have to try and work out their population needs are and look at what services are available. So, some reconfiguration for—. You know, it's going to have to be different in different areas, I think.

[88] **Dr Rolles:** Can I just ask for clarification on your question? When you say 'reconfiguration', are you talking about the idea of health boards or the provision of local services?

[89] **Lynne Neagle:** I think it was more really about the provision of local health services, rather than the actual management structure.

[90] **Dr Rolles:** Okay. I think there's a dawning realisation that despite the intense wishes to keep local services local, some services cannot be provided in a traditional district general hospital model, where a bit of everything was provided locally. It doesn't fit modern practice for some things and, actually, that's obviously caused a lot of local angst—not in my specialty particularly, but it's pretty obvious, especially when you go to places like Withybush hospital or Aberystwyth. So, the point is that you've got to have a service that's sustainable; if you pretend it's not sustainable, it will collapse and then that's not good for that population. There have to be innovative ways of working, and some services need to be provided on a regional basis rather than on a county basis. And to some extent, that's been driven by lack of staff. We've actually found that we can't provide—. I can't send oncologists up to Aberystwyth because it's too far for them to drive there and back and do a clinic. From Swansea, that's sometimes a five or six hour round trip. They could see 60 patients in that time. It's a nice idea, but it doesn't work. So, you innovate; you have expert nurse-led clinics locally, you have a local physician or non-consultant grade to try and provide services. We've been doing teleclinics, and some patients come down to a centre. So, you know, it's changing the way we do things, especially for tertiary specialties. And you probably find the same for invasive radiology, don't you?

[91] **Dr Wells:** Yes. Radiology, in theory, should be able to solve this problem easily, because we can network. We should be able to transfer images between departments and get it reported wherever the radiologists

are. We can outsource to Australia, but I can't see images from west Wales, because they're on different IT systems. We cannot see their images, because there's been a woeful lack of investment into the IT infrastructure in Wales. We can't yet provide the networking solution. But another benefit of the academy is that, as part of that project, there's a bid for IT support that will allow better networking centred in the academy, wherever it may be, that should allow access to imaging from wherever so that sub-specialists can go to the academy and report the imaging from north Wales or west Wales from there.

[92] **Lynne Neagle:** So, are you saying—? I'm aware that Australia is used, from personal experience, which I found quite shocking, really. But are you telling me that we can have somebody in Australia looking at them, and not somebody in west Wales?

[93] **Dr Wells:** Yes, because the outsourcing company have invested in their IT infrastructure, so they can come in and set up a system where, somehow, they can see the images in Australia. But we have yet to manage it.

[94] **Lynne Neagle:** Okay, thank you.

[95] **Dai Lloyd:** Rhun, a oeddet ti eisiau dod nôl? Mae gen i gwpwl o gwestiynau os wyt ti'n—

Dai Lloyd: Rhun, did you want to come back? I have a couple of questions if you—

[96] **Rhun ap Iorwerth:** I was keen to ask a question about the national UK-wide selection process, and I've heard suggestions that, certainly in surgery, but maybe across the board, it's time to consider withdrawing from national selection in that it is a system designed to provide for the workforce in the NHS in England, and perhaps it doesn't really work for Wales, with problems as basic as difficulty in getting interviewers from Wales to go to London for the interviews because of problems with the reimbursements of costs—even at that basic level. Do you have any thoughts on the future of the national selection process? To give a little bit more context, we were at a meeting a couple of months ago held by the dermatologists, who were concerned that lots of people were using, from England, the very high standard of training that we have in Wales to get trained, yet never having an intention of staying in Wales, and that somehow, if we were able to have more control over that selection process, we might be able to tailor it more to our needs.

[97] **Dr Farrow:** For emergency medicine, we do have national recruitment

for speciality training at the ST1 level, which is hosted by the London Deanery but, actually, we have four sites that do the interviewing. So, we are linked up with the Severn Deanery and Peninsula and Wessex. So, we actually go to Bristol to do our interviews. So, we don't have a problem at all sending consultants for interviews because actually that's a day's trip. It's run very well locally in Bristol.

[98] **Rhun ap Iorwerth:** I'm not suggesting that's the main problem with it, but I'm just suggesting that it could be one.

[99] **Dr Farrow:** Yes. So, I think there is a benefit to the national recruitment from the point of view of maintaining a quality standard, but also it does mean that there are probably fewer consultants that need to go for a national process. So, it does work well for emergency medicine. For our higher trainees, that's hosted then by Yorkshire, which means a trip up to Sheffield, but that's only once a year. Again, we only have to send three people. If we were running our own interviews for that, we'd need to send more. So, I think it works for emergency medicine. I think the evidence, from the fact that most of the trainees we have that start off as an ST1 complete their training and stay as a consultant in Wales, shows that, for us, I think the national recruitment process works currently.

[100] **Rhun ap Iorwerth:** Just to clarify, if somebody wants to go into emergency medicine—and somebody from Wales who wants to go into emergency medicine—would they go into a recruitment process in Yorkshire?

[101] **Dr Farrow:** So, at ST4 level, which is a registrar level, we don't have that many people entering, actually, at that level generally anymore because most of them start off at the beginning, at ST1.

[102] **Rhun ap Iorwerth:** But at the lower level, then, somebody would go to Bristol.

[103] **Dr Farrow:** To Bristol.

[104] **Dr Roop:** Yes. So, at a lower level it's a national recruitment. So, if you were in Scotland but you had roots in Wales or you wanted to work in Wales for some reason, you'd go to the closest interview centre to you. So, that might have been in Sheffield. You do your interview and you're on a national grid, therefore, and then you get ranked. Then, where you're placed in your ranking, you get your top choice, your second choice or whatever. So, you're

all in one pot, really.

[105] **Dr Farrow**: So, where you get interviewed isn't to do with where you apply for a job. It's just the opportunity to be interviewed relatively locally. So, they have four centres for interview. But for the higher level, for ST4, because there are such small numbers, it's just in one place, which is Sheffield. So, everyone from the whole of the UK would go up to Sheffield. It's only once a year, though, and with very small numbers.

[106] **Dr Wells**: It used to be a big problem. We'd take radiologists—the first year SpRs in radiology—in Wales, and they clearly never wanted to be in Wales. They'd put down Wales as their third choice and got it because their first choice—London—was full. Then, as soon as anyone dropped off the training scheme in London, they would transfer back to London. We've recently made it more difficult to do that. There have to be very good reasons to transfer between training schemes, and that's reduced it to some extent. Since that change was made, the last two years of radiology registrars starting have all been Welsh born and bred and keen to stay in Wales. So, that has helped enormously. Whether it would help further having a separate recruitment process, I'm not sure.

[107] **Rhun ap Iorwerth**: Because Northern Ireland have their own, I think.

[108] **Dr Wells**: I don't know about Northern Ireland.

[109] **Rhun ap Iorwerth**: Is it the KSS system that they use?

[110] **Dr Wells**: I don't know—maybe.

[111] **Dr Rolles**: For clinical oncology, it's an analogous system. So, there's a national recruitment programme. I think there are two sets of interviews a year. People rank the places they want to work. Actually, lots of people put Wales as No. 1. Some of our local F2 pre-registrar, pre-trainees have delayed applying until they know that there are places coming up in Wales. So, that's a good thing. We've discussed whether or not Wales should pull out of this, whether it's not responsive enough. Scotland, I think, have withdrawn from the national scheme and are doing it themselves. I think that the overall conclusion from my colleagues that are actively involved in this is that Wales is probably a bit too small to do this and it risks becoming marginalised. One of the things Wales can't afford to do is to be seen as being too different in terms of training and outcomes. Because people will come here because they

want to be trained, and then they have to be marketable and competitive for jobs afterwards. They're less likely to come if they think they're going to get something that's different and will not equip them to apply for jobs elsewhere. Not that they want to go elsewhere, but you've got to be seen as being at a high standard compared to everybody else.

10:15

[112] **Dr Roop:** One of the things with emergency medicine is that we could probably recruit three times over. So, the people who want to come to Wales, we'd probably be able to fill our posts three times over if we had enough posts, very easily.

[113] **Rhun ap Iorwerth:** How do you create those training posts?

[114] **Dr Roop:** Head of school.

[115] **Dr Farrow:** By meeting with medical directors often.

[116] **Rhun ap Iorwerth:** What's the barrier to having more training posts?

[117] **Dr Farrow:** It's money. Well, I think there is currently a lack of a system for this to be dealt with. So, it's unclear—as someone who has to write updates on workforce to submit to the deanery to be submitted to the Government—exactly what the process is. So, a number of years ago, after Modernising Medical Careers, a number of posts were set up and a number of them were 50 per cent funded by the deanery, 50 per cent funded by the health board, and the health board pays the banding. Since then, essentially, it's been health board-funded posts that we've created, and that's by local negotiation.

[118] **Rhun ap Iorwerth:** Is the capacity there, or potentially there, to train more?

[119] **Dr Farrow:** Absolutely, yes.

[120] **Rhun ap Iorwerth:** So, the capacity is there. It's the funding more than anything.

[121] **Dr Farrow:** Yes.

[122] **Dr Wells**: 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.

[123] **Rhun ap Iorwerth**: I find your idea particularly interesting because you have what you perceive to be the answer. It may not solve everything, but this academy is a proposal, a strategic way forward. How close are other parts of the medical world in Wales to having that kind of proposal with—? I presume you have a price tag on that.

[124] **Dr Wells**: Yes.

[125] **Dr Farrow**: We have a very good training scheme. We, actually, in the GMC national training survey last year came out as the top in the UK for overall satisfaction for trainees. We had a number of positive outliers with regard to our access to education resources and training programme. So, we do have a very good training programme. Obviously, I think the academy for radiology is slightly different because of the way radiology works. You know, in emergency medicine, we're in an emergency department, all of us as a team are seeing patients—that's what we do. Whatever comes through the door, we deal with it. So, we provide dedicated training, we give a lot of support to our trainees, and we're quite innovative with the training. When there're changes in the college for exams, we then change the training. We do train our trainers, but I'm not sure a different strategy is needed similarly to the academy.

[126] **Rhun ap Iorwerth**: So, it's capacity and paying for the additional training. If we had 200 extra qualified junior doctors coming through in Wales every year—as they're the kind of numbers I think we're talking about with the kind of proposals for introducing community medical training in other parts of Wales, or increasing capacity in Cardiff and Swansea—are you confident that you would be able to turn those 200 in Wales into specialists across the board?

[127] **Dr Wells**: Only if we're given the money to train them.

[128] **Rhun ap Iorwerth**: Yes, of course.

[129] **Dr Wells**: If we were given the budget, then absolutely, yes.

[130] **Dai Lloyd**: And access to helicopters, obviously. [*Laughter.*] Dawn, you

had a question.

[131] **Dawn Bowden**: Well, I think most of it's been covered, actually, in Rhun's questions. But I'm just interested to see in the Wales Deanery's evidence that they were talking about—. They were pretty much operating in a buyer's market was the way they described it. They said that,

[132] 'due to less applicants than posts trainees are able to select and preference where they wish to work and live'

[133] at the moment. What would be the one thing that you think the Welsh Government or the NHS in Wales could do that would attract people to train, work, stay and live here, rather than go to work in the English NHS?

[134] **Dr Farrow**: I think that buyer's market relates to other specialities than ours. So, I think that's mainly GP core medical training. So, our three specialities, clearly—

[135] **Dawn Bowden**: They'd be different.

[136] **Dr Farrow**: They are slightly different in that we obviously manage to recruit and retain. I think it is about raising the profile of Wales. So, you know, raising the profile of the success that we have. Already, radiology and oncology and emergency medicine are doing very well, but it's getting the word out there as well.

[137] **Dawn Bowden**: So, how could that be done more effectively than it is now? What would you say?

[138] **Dr Roop**: One of things we need to recognise is that the new generation of doctors are different—from a different millennium, basically. These millennials, they do things and they understand things very differently. They need that support mechanism and structure and social media—all sorts of things. You need to engage with them at their level. What Amanda has done on her training programme is that she's ensured that she can reach out to these doctors properly, so that's why they enjoy the training programme that we have in emergency medicine. Our GMC survey, as she says, is the best in the UK. So, we know that once we get the trainees in, we can look after them really well, but what we need to do is to have trainees. But if you have 20 more trainees and you don't have enough consultants there to train them, then their training programme or their training experience isn't going

to be as good. So, if you put the current number of consultants to deal with a new bunch of 20 more people, they just won't be able to manage it. So, it has to be a seamless expansion as well. There must be top-level trainers as well as the trainees. So, it is a work in progress.

[139] **Dawn Bowden**: Does it go back further than that? Does it actually start with doing more to promote Wales in schools, perhaps, in terms of the place to—? If you're going to take this career choice, this is the place to be and to stay. All right, thank you.

[140] **Dai Lloyd**: Ocê. Pawb yn hapus? Diolch yn fawr. Diolch yn fawr am ateb y cwestiynau. Diolch yn fawr, hefyd, am roi o'ch amser gwerthfawr i ni bore yma, a hefyd am y dystiolaeth ysgrifenedig gerllaw. O leiaf rydym ni wedi rhoi cyfle i goleg meddygaeth frys, radiolegwyr ac oncoleg i gael y sylw haeddiannol ar eich llwyddiannau chi y bore yma. Felly, diolch yn fawr iawn i chi. Gallaf i bellach gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r dystiolaeth y bore yma er mwyn i chi allu gwirio ei fod yn ffeithiol gywir. Ond gyda hynny o eiriau, diolch yn fawr ichi am eich presenoldeb. I fy nghyd-Aelodau, fe wnawn ni dorri am egwyl fer rŵan o 10 munud, cyn i'r ail sesiwn ddechrau. Diolch yn fawr.

Dai Lloyd: Okay. Everyone content? Thank you very much. Thank you for responding to our questions and thank you for giving your valuable time to join us this morning, and for the written evidence presented as well. At least we have given the opportunity for the Royal College of Emergency Medicine and the Royal College of Radiologists to have due attention paid to their successes this morning. So, thank you very much. I can also announce that you will receive a transcript of this morning's evidence so that you can check it for factual accuracy. With those few words, I thank you for your attendance this morning, and I'll inform my fellow Members that we will now break for 10 minutes before moving to the second session. Thank you.

Gohiriwyd y cyfarfod rhwng 10:21 a 10:37.
The meeting adjourned between 10:21 and 10:37.

Ymchwiliad i Recriwtio Meddygol—Sesiwn Dystiolaeth 7—Coleg Brenhinol y Seiciatryddion a Choleg Brenhinol Pediatreg ac Iechyd Plant
Inquiry into Medical Recruitment—Evidence Session 7—Royal College of Psychiatrists and the Royal College of Paediatrics and Child Health

[141] **Dai Lloyd**: A allaf i groesawu'r Aelodau yn ôl i'r sesiwn nesaf o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon? Ac rydym ni'n symud ymlaen nawr i eitem 3. Rydym ni'n parhau gyda'r ymchwiliad i'r recriwtio meddygol. Hon yw'r sesiwn dystiolaeth 7, ail sesiwn dystiolaeth y bore. Ac o'n blaenau ni nawr mae Coleg Brenhinol y Seiciatryddion a Choleg Brenhinol Pediatreg ac Iechyd Plant. I'r perwyl yna felly, a allaf i groesawu'r Athro Keith Lloyd, sydd yma yn cynrychioli Coleg Brenhinol y Seiciatryddion heddiw, a hefyd Dr Sakheer Kunnath o Goleg Brenhinol Pediatreg ac Iechyd Plant? Croeso i chi'ch dau. Rydym ni wedi derbyn eich tystiolaeth ysgrifenedig ymlaen llaw, ac mae pobl wedi darllen pob gair yn fanwl. Mae gyda ni nifer o gwestiynau yn seiliedig ar y dystiolaeth honno. Felly, gyda'ch caniatâd, awn ni'n syth i mewn i gwestiynau, felly, ac mae'r cwestiynau cyntaf gan Dawn Bowden.

Dai Lloyd: May I welcome Members back to this next session of the Health, Social Care and Sport Committee? And we move on now to item 3 and we continue with our inquiry into medical recruitment. This is evidence session No. 7, the second evidence session of the morning. And joining us now are the Royal College of Psychiatrists and the Royal College of Paediatrics and Child Health. May I therefore welcome Professor Keith Lloyd, representing the Royal College of Psychiatrists today, and Dr Sakheer Kunnath from the Royal College of Paediatrics and Child Health? A very warm welcome to you both. We've received your written evidence, and Members will have read every word in detail. We have a number of questions based on that written evidence. So, with your permission, we will move immediately to questions, and the first questions this morning are from Dawn Bowden.

[142] **Dawn Bowden**: Thank you, Chair. Good morning. Can I ask you first of all to expand a little bit more? Because we've received your evidence, as the Chair has said, but can I ask you to expand a little bit more on where you believe the key pressure points are, and the barriers in terms of the medical workforce in your two areas of speciality, and, perhaps more importantly, what you think needs to be done to tackle that? Because I think it's easy to identify the issues—it's perhaps not so easy to identify the solutions, is it?

[143] **Dr Kunnath:** If I may start, from the evidence we have submitted, you may see that infants, children and young people aged between zero and 18 make up around 20 per cent of the UK population. Children represent around 20 per cent of the general practice population and they have a higher use of healthcare facilities. At some point, they may represent 40 per cent of the GP workload. I also draw your attention to one of the papers cited in the submission, that is, 'Improving child health services in the UK: insights from Europe and their implications for the NHS reform'. So, the opening statement here is that:

[144] 'The care provided by UK children's health services is inferior in many regards to that in comparable European countries.'

[145] And they have given a lot of evidence as to that. One of the graphs they have given is the mortality rate, and in that you get drops, even though, in 30 years, tremendous progress has been made. And there are so many other parameters. So, that is a basic point. Why this is happening, we do not know.

[146] The royal college did a rota vacancies and complaints survey in 2016 that showed there is a gap of 12.2 per cent in paediatric rota tier 1, which is the first on-call rota populated by SHOs and lower trainees. In tier 1, that is slightly worse than England. In tier 2, it is 13.1 per cent, which is better than England. But tier 2 is populated by higher-grade trainees and they are highly skilled people and they do manage the basic workload in the hospital, and that is impacting tremendously on the quality of care.

[147] If you go back 10 years, before the major visa rule change happened, the tier 2 rota used to be populated by a category of doctors—they are a known training category grade of doctors called staff grade and associate specialists. They used to make up the backbone of that category of doctors. On top of that, trainees used to come and go. They were—on one account, they were about 59 per cent foreign graduates, that's non-UK, non-EU graduates. So, that category of people is dwindling. There's no supply of that category anymore and now the rota is purely dependent on trainees and the trainee numbers vary.

[148] The study has also shown that 20 per cent of consultants are non-EU, non-UK trained and 5 per cent are EU trained. So, there's a lot of reliance on foreign graduates in paediatrics. It may be general in other specialities as well. So, the restriction of immigration, especially from outside the EU, and

now, post Brexit, from the EU, will have a big impact on the supply of—

[149] **Dawn Bowden**: Sorry, can I stop you there? Has it already had an impact or is it—

[150] **Dr Kunnath**: It has already had, when the visa rule changes happened 10 years back, for non-EU—

[151] **Dawn Bowden**: Yes, so that had an impact at that time.

[152] **Dr Kunnath**: Yes, so, on top of that, when Brexit happens, there'll be—I don't know what the outcome will be. It was somewhat mitigated by the recent arrival of EU doctors.

[153] I heard that Jeremy Hunt has promised that there'll be a 1,400 increase in medical students, but that will take at least a decade to reach that level of training, because medical school training itself is six years, and then there are two years of foundation training, and to reach the middle grade they need another four years. The total paediatrics training is eight years. Paediatrics has got the longest training. The paediatric workforce is also 70 per cent female, so that increases—most of them opt for flexible training and flexible working. So, that also will have an impact on the availability of doctors.

[154] **Dawn Bowden**: These were training places for England, yes?

[155] **Dr Kunnath**: It's in general.

[156] **Dawn Bowden**: Okay. Okay, sorry to interrupt you.

[157] **Dr Kunnath**: I am a community paediatrician. In community paediatrics, because of the problems in acute paediatrics, the community paediatric workforce has also dwindled over time. One of my colleagues told me that, in Flintshire, there used to be eight to nine whole-time equivalent doctors in 2002. Now, it's down to 5.8 whole-time equivalent. That is because the attention goes to acute care because the crisis is more acute and severe there.

[158] **Dawn Bowden**: Can I ask you what is it that you think has brought about this particular crisis, as you refer to it?

[159] **Dr Kunnath:** I don't have an answer to that, but what I can see in the middle grade rota is there was a dip in the foreign graduates and a lot of problems in recruiting.

[160] **Dawn Bowden:** So, that's been a factor.

10:45

[161] **Dr Kunnath:** Yes. Now, because, for the service to run, this has to be filled, what most of the health boards and trusts are doing is to fill by locum at huge cost, because these vacancies cannot be left alone, because it will impact service provision, quality of care, and, sometimes, it may end up closing the wards. Beyond finances, it has also impacted on the morale of the workforce. Trainees are dragged into providing service with less time for education and training, and, at times, consultants have to fill in this rota, decreasing morale among the consultant workforce, as well as their service during the day time being impacted.

[162] **Dawn Bowden:** Okay. Because you talked about in your evidence, didn't you, that possibly the increased production of local trainees would be a longer-term solution—

[163] **Dr Kunnath:** It is a solution we can look for—

[164] **Dawn Bowden:** —but it's several years we're talking about, isn't it?

[165] **Dr Kunnath:** Probably a decade, to reach that middle-grade level.

[166] **Dawn Bowden:** Yes, to reach that. So, what would be the kind of immediate-to-short-term solution, in your view?

[167] **Dr Kunnath:** The royal college has embarked on a few strategies. Now the royal college is managing the ST1—not, as such, recruitment, but the management of interviews in regional clusters. That means that a candidate doesn't have to apply to each deanery and they need to attend a few interviews in a few clusters. So, that should improve ST intake.

[168] It has actually done some improvement, but I was told that, lately, in the last two years, ST1 application has gone down and, this year, there weren't enough candidates to fill all the seats, so they had to re-advertise for ST1. In an attempt to mitigate the situation, the royal college also has

embarked on a programme called a medical training initiative. This is to bring overseas doctors on a two-year contract on a tier 5 visa. I'm not sure how much impact this has made, but there have been problems with that as well. Two of my colleagues in Glan Clwyd Hospital had recently visited India and they reported that the response was less than satisfactory. Anecdotally, one of the reasons for that is that (1) it's a limited contract, and, second, the incentives are now fading. Decades back, there were a lot of financial incentives and training incentives. Now the situation in those countries has changed, the financial incentives are much less, and the training opportunities have increased a lot. High-tech hospitals have sprung up everywhere, so there is less incentive for people to come to the UK now.

[169] **Dawn Bowden**: Yes, sure. Okay. Can I ask you—

[170] **Dai Lloyd**: The psychiatrists?

[171] **Dawn Bowden**: Yes, the psychiatrists.

[172] **Professor Lloyd**: So, the Royal College of Psychiatrists is the professional and educational body that trains and support psychiatrists in Wales and the UK. We aim to do four main things, which are: improve standards of care, improve outcomes for people with mental health problems, promote understanding about mental health issues, and promote parity of esteem. That's very important and I'll come back to that later.

[173] There are about 250 consultant psychiatrists in Wales at the moment and about 590 people in training and non-consultant career grades. We have issues both with recruitment and retention, but are doing a number of things to try and address that. So, the specific issues that we have with recruitment are that the fill rate for our training slots—. So, every year, we advertise training slots in the different sub-specialties within psychiatry and the fill rate for those—the number of people who we actually manage to appoint into the scheme—is about 60 per cent. So, of the jobs that are available in Wales, about 60 per cent get filled. That's slightly below the UK average. This year, about two weeks ago, my colleagues in the deanery interviewed for what are called core trainee slots in psychiatry. Those are the jobs that you do after you've done your initial two years of hospital posts. There were 18 slots available, for which there were eight applicants. So, once you get through the training scheme in psychiatry and you become a consultant psychiatrist, people tend to be retained reasonably well in Wales and they tend to have high job satisfaction. The difficulty is getting the front end in.

Now, I'm back here in a couple of weeks to talk to you about medical schools, but I think there's an important aspect for—. If you want to address shortage in certain specialties across Wales, you have to address the whole pipeline, from outreach to schools, through to how different subjects are represented in the curriculum, through to a variety of initiatives and incentives to help retain people once they qualify and start to work here. And there are a number of things that we're doing to try and address that.

[174] **Dawn Bowden**: Because you talk in your evidence, don't you, about the profession of psychiatry actually having a stigma attached to it—you know, that it's not the most attractive of the specialties to go into, or perceived as not the most attractive?

[175] **Professor Lloyd**: I don't think so. [*Laughter*.]

[176] **Dawn Bowden**: No, no—I was just referring to what was said in your evidence about the perception of the profession.

[177] **Professor Lloyd**: Yes, I mean, psychiatry and mental health—. Well, it's broader than professional psychiatry—it's to do with the public perception of mental health and mental illness. We're roughly where cancer was 25 years ago. It's becoming easier to talk about mental health problems. One in four of us at any one time, in any one year, will have one. So, you know, we all know somebody who's been affected by mental health problems. For us, the issue is addressing that at student level. For my own medical school in Swansea, we actually have a higher proportion of people going into psychiatry than almost any other medical school in the UK, and that's because of the excellent people who are role models—my colleagues who do most of the teaching for that. So, the way you address that kind of stigma is by having good role models and people who want to show what an interesting career it is.

[178] My colleague here is a community paediatrician; I'm a community psychiatrist. The nature of medical practice is going to change. Psychiatry went through a process of deinstitutionalisation in the last century. Care in the community often didn't mean care by the community, but nonetheless we moved out of large hospitals. We're going to see the same thing happening with all medical specialties in the future. We're going to move away from a traditional twentieth century DGH-based model of care, I think, and psychiatry is particularly well placed to benefit from that, having gone through that process already, and that needs to be reflected in what training

has to offer.

[179] **Dawn Bowden**: Okay. Thank you for that. So, can I just ask you both whether you feel that doctors and LHBs have the information available to them to identify the factors that influence where doctors want to work, for instance?

[180] **Professor Lloyd**: So, there is a—if I just finish that one off, if I may—national campaign working around recruitment and retention at the moment, and it's excellent. What it does is it says, 'Wales is an excellent place to come and work because there are lots of fantastic things to do when you're not working', which is true. That's absolutely true—I couldn't disagree with that—but it doesn't promote the positive aspects of working in an NHS that's actually better than the NHS in England. We know that last year more junior doctors came to work in Wales into foundation posts from England than in previous years, and that's a—

[181] **Dawn Bowden**: And is that also true of training and study in terms of getting people to study and train here as well?

[182] **Professor Lloyd**: One of the problems for trainees at the moment is that because of the financial difficulties that many of the health boards face, study leave budgets are being curtailed. So, that makes it slightly harder for the trainees to undertake the kind of study leave that they need, and I'm sure my colleague would echo that. So, yes, the health boards do have the information they need. For psychiatry it's interesting, because about 10 per cent of each health board's budget is spent on mental health and learning disability services. About 1 per cent of the board's time is taken up with talking about it. So, maybe they don't—. You know, if you're having to fill the front end of the rota for emergency departments and things, you're going to pay less attention to things that appear less urgent, such as psychiatry, although there has been significant investment in some areas of psychiatry, like liaison, which does have a direct impact on bed utilisation in general hospitals and things. But more could be done around training, and that's where the college is taking an active role in trying to promote it as an attractive career.

[183] **Dawn Bowden**: Okay, thank you for that.

[184] **Dr Kunnath**: My colleague mentioned the study leave, but I don't think that is any better in England, so there shouldn't be much difference. There

are a lot of positives to working in Wales, in job satisfaction and all, because here you find a true public sector service, but there's no dichotomy between primary, secondary and tertiary care and there's no competition. So, that should add to positive things, but, somehow, that doesn't produce any results. That's why I'm a bit perplexed. That is because, probably, people outside Wales—I was trained in England, so until I came to Wales, I did not know all this. So, there's a large information gap. I don't know how this can—

[185] **Dawn Bowden**: So, you think, in terms of selling Wales as a place to work, as opposed to just a place to live, actually, NHS Wales should be talking more about what the Welsh NHS is like, what it looks like and how it feels—

[186] **Dr Kunnath**: Yes, and what the difference is like.

[187] **Dawn Bowden**: What the differences are and what it feels like to work in a true public service organisation, yes.

[188] **Dr Kunnath**: So, there are many people who are frustrated—

[189] **Dawn Bowden**: I think that's a fair point, yes.

[190] **Dr Kunnath**: —about this money flowing, patients and all that kind of stuff that is not here, but that's not well advertised. The other thing I find is a bit of connection and anxiety about children and education and all those things, because I know two of my colleagues—their families are in England and they commute in the week, and I do myself. So, those things are there, especially those people who are coming into higher posts, who are past their 30 to 35 years, with families. These are anecdotal things; I don't think there's any study that has been done about satisfaction of work-life balance.

[191] **Professor Lloyd**: If I may just come in on that—I'd absolutely echo what you said that more needs to be done on this being a good place to work and the virtues of the Welsh NHS. We saw that around the stuff around ambulance wait times and so on. We seem very reluctant to say what's good about working in Wales.

[192] **Dawn Bowden**: That's great, thank you.

[193] **Dai Lloyd**: Moving on, Jayne, you've got the next question.

[194] **Jayne Bryant:** Thank you. I think, Professor Lloyd, you put it very eloquently, because we've heard lots of witnesses saying things about the importance of a work-life balance, and I think we're realising we're perhaps concentrating on the life stuff, as Dawn has said. First of all, we've heard also more evidence around the benefits for more consultant involvement and ownership of the recruitment process. Do you think that's happening at the moment?

[195] **Professor Lloyd:** So, there's an opportunity to try and address that through health education Wales in the future. At the moment, I think there's a disconnect, certainly in our specialty, between training and service provision, which leads to overemphasis on the training aspect to the detriment of service provision. So, the way in which medical training, and certainly in our specialty, is organised, is it's quite hard—you don't have as much contact with trainees as you used to. There are opportunities to do that differently. So, the answer to your question is 'yes'.

[196] In south-west Wales, we have a thing called ARCH, which is A Regional Collaboration for Health, which is looking at different ways of delivering healthcare, and there's an argument about how much commissioning of training posts should be done nationally and how much should be done locally. I think, on balance, I'm in favour of doing it on a national basis, but there are problems if you're a trainee in south Wales, having to move to north Wales, or vice versa. It's very difficult, once you've settled and you have family, to be expected to move around the country for training slots, which, in some specialties, is necessary, because of the subspecialisms, but probably isn't for ours.

[197] **Jayne Bryant:** So, do you think doctors could be more involved in the process then and, perhaps—?

11:00

[198] **Professor Lloyd:** The deanery fills that role at the moment, and my colleague Ian Collings is the head of the school of psychiatry in the deanery, and he's very much involved with the selection processes. So, where the disconnect is between the local service needs and the training—let me give you an example. It's quite hard to fill the training slot in psychiatry the further west you go in Wales. I'll speak about the parts I know best. Sort of west of Swansea it's harder to fill the training slots—yet, you'll hear that from

other specialties as well. Yet, if we want to promote people to work in those areas we need to actually make them more attractive places to work and, actually, rather than take—. There's a balance: you can't have juniors working unsupervised, so the response is to take them away from the places where there aren't the consultants, which sets up a vicious cycle and makes it worse in the long term. We need a solution to that, which I think we can offer.

[199] **Jayne Bryant:** Brilliant, thank you. Talking about the need for a national approach, do you think there should be that national approach to workforce planning and recruitment, or do you think it should be done at a more—?

[200] **Professor Lloyd:** Well, workforce planning and recruitment should be done—. There's a national element to it because the workforce needs to be planned nationally. There are some things that can be done locally. I think the key thing is not to disconnect training and service provision, and to look at it across the different professions. Because if we're following the principles of prudent healthcare, then my colleague and I should only do the things that he and I can do best. If there are things that other people can do, who cost much less than we do, then they should do it. So, if you have an approach that is national, that is informed by both service provision and by training, and has everyone working at the top of their licence during their training and subsequently, it would be better.

[201] **Jayne Bryant:** Okay. Dr Kunnath, do you have any—?

[202] **Dr Kunnath:** Yes, I think the strategic planning should be at the national level, but there should be a lot of local involvement because the availability of service provision and the availability of the trainees and doctors is variable in areas—especially in north Wales, where geography is widespread. One of the problems, especially in north Wales, is the geography itself. Sometimes, doctors will have to travel between places that are far away. We have had a vacancy in paediatric audiology for a long time and we couldn't get that filled. The person who was assigned has to travel almost 60 miles, and that is unsustainable and that person has to withdraw. So, it may impact upon people who want to come into Wales as well. So, I don't know what the solution can be because the population is dispersed. It's not concentrated in one place, and you have to provide a service in the community; otherwise patients have to travel. I don't know whether there are any quick fixes for that.

[203] **Jayne Bryant:** Okay, thank you.

[204] **Dai Lloyd:** Rhun, mae'r cwestiynau nesaf gennyt ti.

Dai Lloyd: Rhun, the next questions are yours.

[205] **Rhun ap Iorwerth:** Diolch yn fawr iawn. Jest i fynd ychydig bach yn ddyfnach i mewn i gwpl o faterion sydd wedi cael eu codi yn barod, mi sonioch chi, Athro Lloyd, ynglŷn ag *initiatives and incentives*. Pa fath o *initiatives* ydych chi'n meddwl y gellid edrych arnyn nhw'n agosach? Rhai ariannol? Rhai datblygu arbenigedd? Beth?

Rhun ap Iorwerth: Thank you very much. If I could just dig a little deeper into some of the issues that have already been raised, Professor Lloyd, you mentioned initiatives and incentives, but what sort of initiatives do you think could be put in place or could be studied more closely? Are they financial incentives? The development of expertise? What are they?

[206] **Yr Athro Lloyd:** Nid wyf yn siarad Cymraeg da.

Professor Lloyd: My Welsh isn't particularly good.

[207] So, I'll reply in English if that's okay.

[208] **Rhun ap Iorwerth:** Wrth gwrs.

Rhun ap Iorwerth: Certainly.

[209] **Professor Lloyd:** Okay. So, what types of initiatives could be put in place? The Royal College of Psychiatrists is working with the National Centre for Mental Health, which is Wales's first biomedical research centre. It's one of the premier places for psychiatric research in the UK, if not the world. It's based in Cardiff and has links with both Bangor and Swansea. We're planning a number of educational initiatives with them—conferences and training events—aimed at making a vibrant community for trainees to feel engaged with. The location of training is important, as a second thing. There is an argument for, as I say, probably having a north Wales training scheme and a south Wales training scheme that are merged, so you just have one large scheme in the north and two in the south, probably—one covering south-east Wales and one covering south-west Wales. That would mean that people felt more part of their local community.

[210] We have found, from our medical school, that people are more likely to go into psychiatry if they had positive role models. So, we're doing a lot of work with schools. People are going into schools to talk about mental health,

which has other benefits, and they're doing things with school leaders about psychiatry as a career, explaining what it is. People don't understand that it's a medical specialty. I guess the other issue is that people ask questions about whether there are things that should be done with the pay structure. So, probably not. At consultant level, I don't think it's pay incentives that make a difference to people. There's parity at the moment between Wales and England, pretty much, on pay. The Welsh system of commitment awards is better than the English system for consultants. So, that's an incentive to retain people. But, essentially, you said, 'What sort of things are we doing?' It's about creating an environment where people feel engaged with the profession, passionate about it and are adequately supported.

[211] **Rhun ap Iorwerth:** And how could that be done in a way that—because, presumably, they're trying to do this in England as well.

[212] **Professor Lloyd:** Yes.

[213] **Rhun ap Iorwerth:** Everybody's in competition, in healthy competition, so how do you make Wales stand out? What are the tweaks that could be introduced, possibly, that could make Wales particularly attractive in these areas?

[214] **Professor Lloyd:** 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.

[215] **Rhun ap Iorwerth:** Yes, and I'll give you a chance to answer in a second as well. Financial incentives, in addition to salary, things like paying training fees that are—. You know, it is a burden on trainees [*Inaudible.*]

[216] **Professor Lloyd:** I think the solution is actually earlier in the pipeline, if 'pipeline' is the right word; it suggests something industrial, and it's not what I mean. But if you increase the proportion of Welsh graduates, or Welsh school leavers, going into Welsh medical schools and encourage them going into certain professions, then you have feeder courses for, say, graduate-entry medicine for the people who haven't got in the first time round. They're going to stick around, and they're more likely to put that—. You know, if they haven't got roots already, they'll put them down. You have to make the professions attractive for them to go into. So, if there's anything to

be done about pay structures, it's early on, around the time after people have just qualified, I think, because by the time they've decided on their specialty, they've made their choice.

[217] **Rhun ap Iorwerth:** Yes, but increasing the pool of undergraduates is key to that as well, because the more you have there—

[218] **Professor Lloyd:** Yes, and looking at ways—. You know, there are differences between the medical schools in terms of the proportion of people who stay in Wales or go to England, Australia or wherever, and all that needs to be taken into account.

[219] **Rhun ap Iorwerth:** Thank you. Some blue sky thinking from you as well.

[220] **Dr Kunnath:** Yes. The royal college have done some studies, for which they don't have the figures yet, but there's been quite a bit of a drop-out after graduation, and they don't know where they're going. So, what the Royal College of Paediatrics and Child Health have done is to engage with medical students. So, they are doing a lot of engagement work with medical students and foundation trainees to attract them into paediatrics, but that's in general, UK-wide, though. As far as Wales is concerned, there are a lot of positives for consultants to retain their jobs—job satisfaction, and for the trainees to come in as well, because, with the new contract in England, it will be more attractive for them to come to Wales. That has not had any results yet, but that's maybe something we can embark on.

[221] **Rhun ap Iorwerth:** It strikes me, from listening to you and from our earlier witnesses this morning, that the different specialisms have different issues they need to address. Attracting more people into your specialism is a particular issue. With emergency medicine, we were hearing this morning, 'No problem; it's the number of training places to meet the demand that there is out there'. What about the ways that the issues are cross-cutting and where there could be a Wales-wide strategy for increasing people right across the profession who either want to be recruited to come into Wales, or who want to come in to train in Wales? What are the things that are in common between you, where there could be co-operation?

[222] **Dr Kunnath:** I can't think of anything right now.

[223] **Professor Lloyd:** The recruitment campaign is absolutely spot on as far

as it goes about Wales being a great place to live. Let's celebrate the working environment as well.

[224] **Rhun ap Iorwerth**: And we have an NHS that has a different attitude to Jeremy Hunt's junior doctors, and what have you.

[225] **Dr Kunnath**: That needs to be promoted and advertised.

[226] **Rhun ap Iorwerth**: What about—and this is something we explored this morning as well—if we had an NHS in Wales that had a clear strategy on increasing the number of undergraduates, increasing training places, as well as developing excellence? Okay, that wouldn't deliver the people maybe for some years, because it takes time to train a doctor, but would the existence of that strategy in itself help you today to attract people here?

[227] **Professor Lloyd**: Yes. Yes, it does. People find that having a medical school, being linked to one, being involved in teaching and training, helps recruitment, retention and so on. My colleague Dean Williams, from north Wales, gave evidence here a couple of weeks ago, and he made that point about the value of having a centre of academic excellence, which actually does act as a focus for those kinds of training activities in a region. So, that is important.

[228] **Rhun ap Iorwerth**: Okay. And your thoughts?

[229] **Dr Kunnath**: My training colleagues have previously mentioned that having to go outside for tertiary specialist training might impact on them coming back. So, if those kinds of facilities are there, available locally, then more people could be retained.

[230] **Rhun ap Iorwerth**: Okay.

[231] **Professor Lloyd**: I can give you an illustration of that. I have a trainee at the moment who comes from west Wales. He is Welsh speaking. He's an excellent trainee. He went out to England to do his medical training and he's come back. He's applying for a consultant job in west Wales and they are very keen to appoint him there. I hope he'll be successful. If we had more people like that coming through the system, that would help as well. So, there's both a long-term gain and a short-term gain from the vibrancy of having those kinds of centres.

[232] **Dai Lloyd:** Okay. Caroline, you've touched on some of this issue with regard to people having to go for higher training in England, and possibly not coming back—have a go.

[233] **Caroline Jones:** Yes. There's concern at the moment that some trainees have to move to England for specialty training—neonatology, for example—and the concern is that once these people have gone, the chances are they may not come back. So, really, we need the training to take place in Wales. Could you tell me what your views are on this?

[234] **Dr Kunnath:** At the moment, there is provision for developing the neonatal service in north Wales, but most of our trainees rotating in north Wales have to have tertiary hospital experience in Alder Hey hospital. Those kinds of facilities are not available in north Wales. Equivalent services are available only in south Wales, but the rotation is different now. I don't know whether it is feasible to develop those kinds of services in north Wales. Depending on the population, I'm not sure, because you need to have that kind of population and case load.

[235] **Caroline Jones:** Yes, but anywhere in Wales?

[236] **Dr Kunnath:** Yes, but the problem is—

[237] **Caroline Jones:** Central.

[238] **Dr Kunnath:** Yes. Travel between south and north, which the trainees did not like very much, was the reason for developing a north Wales rotation with Mersey Deanery, and that was running successfully, and we are getting trainees from Mersey as well. Sometimes, Mersey trainees, if they can get good experience here, may choose to come here and take up the jobs.

[239] **Caroline Jones:** Yes. So, you think that it's a two-way sort of situation, really. But obviously we'd be in a much better and win-win situation if we did have those services because we could attract more people here, as well as retaining our people who would normally go to England for this specialty training. We'd have a sort of nucleus, then, of people from away, and retain our people here.

[240] **Professor Lloyd:** If I may—

[241] **Caroline Jones:** Yes, certainly.

[242] **Professor Lloyd**: We have some specialties that we can't provide in Wales at the moment for psychiatry. So, we don't have in-patient provision for eating disorders.

11:15

[243] We lack training in medical psychotherapy, and there are a couple of aspects of forensic training where people need high-secure psychiatric exposure, where they have to go out of the country. For psychiatry, it's probably not important for training purposes to provide all of those. But for eating disorders, medical psychotherapy and for perinatal psychiatry, it's important to provide those locally from a service point of view, which is a different point.

[244] **Caroline Jones**: Okay, thank you.

[245] **Dai Lloyd**: Julie, you're back on paediatrics.

[246] **Julie Morgan**: Just following that one point for a moment, what provision is there for mothers and babies to receive treatment?

[247] **Professor Lloyd**: The challenge for the mother and baby perinatal psychiatry services is the on-off demand nature of them. So, it's difficult to provide a—you need a very large population base to have a permanently used facility. There are services in Wales for mothers and babies, but not in-patient provision at the moment.

[248] **Julie Morgan**: Do you think that's something that will happen, because there used to be, didn't there?

[249] **Professor Lloyd**: There used to be; there were in Cardiff, yes. There is provision, but not beds at the moment. I think it's actually very important that mothers and babies receive the right kind of care because it's really important from the point of view of bonding and so on. Ideally, we would have those services. It comes down to cost, I think.

[250] **Julie Morgan**: Right, because I've been approached by constituents about this issue. Thank you very much.

[251] I wanted to ask some questions about paediatrics, and I know the

royal college is concerned about the staffing levels. We had a submission from Bliss, which says that over half of the neonatal units in Wales don't have enough staff to meet the minimum standards for quality and safety. And I was very pleased, with another member of the committee, Lynne Neagle, to visit the neonatal unit in the Heath earlier this week. I wonder if you could clarify whether it's a shortage of staff being there to be employed, or who could be recruited, in terms of both doctors and specialist nurses, or whether it's the absence of funding for those jobs that causes the issue, because that seemed to be one of the crucial issues.

[252] **Dr Kunnath:** A sub-regional neonatal unit is in the process of being established in Glan Clwyd Hospital. Staffing has been progressing, but there is also, of course, the number of minimum cases they need to have to retain the expertise level. So, I think that was the impediment in developing a tertiary neonatal centre. So, at the moment, we are collaborating with the tertiary neonatal set-up in England. How much staffing has been a problem, I'm not sure.

[253] **Julie Morgan:** Could you tell me about the Heath, for example? You don't know about the staffing there.

[254] **Dr Kunnath:** No, I don't.

[255] **Julie Morgan:** No, because I was not clear, after the visit, whether it was a lack of staff or a lack of funding for posts that was the issue.

[256] **Dr Kunnath:** In the Glan Clwyd sub-regional unit, I think that funding is available.

[257] **Julie Morgan:** Funding is available, right.

[258] **Dr Kunnath:** Yes. I can't be quoted, because that's what my impression is, because they are trying to staff—. But, from the nursing level, there has been a problem in finding—

[259] **Julie Morgan:** Nursing level?

[260] **Dr Kunnath:** Yes.

[261] **Julie Morgan:** So, in terms of attracting nurses to work in neonatal units, is that difficult to do, then?

[262] **Dr Kunnath:** It's beyond my knowledge. I wouldn't be able to answer that.

[263] **Julie Morgan:** Right. Thank you very much.

[264] **Dai Lloyd:** Just following on from that, isn't there an element, as well, of mismatch of where the cots are? Just to be sort of bold about it, it's not just staffing or medical recruitment, or nursing recruitment; it's actually the physical presence of cots. And, whether they're paediatric intensive care cots or special care cots, it's the same cot; it just depends how many nurses are around to staff it.

[265] **Dr Kunnath:** Yes, but there is an element of the number of the high-risk deliveries to become class 1, because, to maintain a minimum expertise level, you need a minimum number of high-risk babies to be delivered in the unit. So, I don't know if that has been established or not—at the moment, the tertiary centre is in Chester and there's a sub-regional unit—but this can be developed. And, even while developing that, there is a debate, actually, that the high-risk deliveries in Bangor have to be stopped and they have to be transported all the way to Glan Clwyd Hospital. That was close enough for—. The debate has been going on for some time but, at the moment, it has established. Hopefully, it will flourish.

[266] **Dai Lloyd:** Okay. Jayne, you've got the last question.

[267] **Jayne Bryant:** Thank you, Chair. Do you think the shape of the healthcare services should change to ensure there are sufficient doctors to staff current and future hospital doctor rotas? I think the RCPCH has made the case for whole-system change in paediatrics with fewer and larger in-patient units providing consultant-delivered care. Do you want to expand a bit on that and perhaps Professor Lloyd could also come in?

[268] **Dr Kunnath:** That actually is a royal college policy, because, especially for tertiary-level, high-quality care, that level of concentration is needed. But translating that into the Welsh context is a bit difficult because the population density is dispersed. But, without that concentration, the expertise will not be attained and that will impact the quality of care. But that will be at the cost of the population needing to transfer, arranging transport and so on. There should be a balance.

[269] **Jayne Bryant:** Yes, okay. Professor Lloyd.

[270] **Professor Lloyd:** It's an issue across all specialities, I think. The current models of care are unsustainable and, from primary care right through to tertiary and quaternary care, we need to have different models of care. 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. Hospitals are generally best avoided if you can possibly do it. We will need—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.

[271] **Jayne Bryant:** Thank you.

[272] **Dai Lloyd:** Ocê, hapus? Unrhyw gwestiynau eraill? Na. Pawb yn hapus. Felly, diolch yn fawr iawn ichi. Dyna ddiwedd y sesiwn. Diolch am eich cyfraniadau ac am ateb y cwestiynau mewn modd mor raenus ac mor aeddfed. Hefyd, diolch am y papurau y gwnaethoch chi eu cyflwyno cyn y cyfarfod. Diolch yn fawr iawn am hynny. Fe allaf bellach hefyd gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r sesiwn yma jest i wirio fod popeth yn iawn. Ond, gyda hynny, fe allaf gyhoeddi bod y sesiwn yma ar ben ac fe allaf gyhoeddi i fy nghyd-Aelodau y cawn ni nawr egwyl am chwarter awr. Felly, diolch yn fawr iawn i chi i gyd.

Dai Lloyd: Okay, happy? Any further questions? No, everyone seems content. So, thank you very much. That brings our session to a close. Thank you for your contributions and for answering the questions in such a polished and mature manner. Also, thank you for the papers that you prior to the meeting. Thank you very much for that. May I also inform you that you will receive a transcript of this session so you can check it for accuracy? But, with those few words, can I announce that this session is now at an end and tell my fellow Members that we'll take a quarter of an hour's break? So, thank you all very much.

[273] **Professor Lloyd:** Diolch yn fawr.

Professor Lloyd: Thank you very much.

[274] **Dr Kunnath:** Thank you.

Gohiriwyd y cyfarfod rhwng 11:23 a 11:41.
The meeting adjourned between 11:23 and 11:41.

Ymchwiliad i Recriwtio Meddygol—Sesiwn Dystiolaeth 8—Byrddau Iechyd Lleol
Inquiry into Medical Recruitment—Evidence Session 8—Local Health Boards

[275] **Dai Lloyd:** Croeso yn ôl i sesiwn ddiweddaraf Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. O dan eitem 4 ar ein hagenda'r bore yma, rydym ni'n parhau efo'n hymchwiliad i recriwtio meddygol, a sesiwn dystiolaeth rhif 8 y bore yma. O'n blaenau nawr, mae rhes o'r tystion diweddaraf, sef cynrychiolwyr o fyrddau iechyd lleol. Croeso i'r pump ohonoch chi.

Dai Lloyd: Welcome back to this latest session of the Health, Social Care and Sport Committee here at the National Assembly. Under item 4 of our agenda this morning, we continue with our inquiry into medical recruitment. We move to evidence session No. 8. Joining us now are our latest witnesses, who are representatives of the local health boards. So, welcome to all five of you.

[276] Rydym ni wedi derbyn tystiolaeth ysgrifenedig ymlaen llaw a diolch am hynny. Mae yna nifer o gwestiynau wedi cael eu paratoi gerbron yn seiliedig ar y dystiolaeth rydym ni wedi'i derbyn. Peidiwch â theimlo o reidrwydd bod yn rhaid i bob un ohonoch ateb pob cwestiwn, ond, wedi dweud hynny, a gaf i groesawu'n ffurfiol felly yr Athro Peter Barrett-Lee, Ymddiriedolaeth GIG Felindre, Sharon Vickery, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg, Martin Jones, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr, Dr Evan Moore, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr hefyd, a Dr Philip Kloer, Bwrdd Iechyd Lleol Hywel Dda. Croeso i bob un ohonoch chi ac, wedyn, heb fynd ymlaen ymhellach, awn ni'n syth i mewn i gwestiynau, ac mae gan Julie

We've received your written evidence and I'd like to thank you for that. We have a number of questions that have been based upon the evidence that we've received from you. Don't feel that each and every one of you has to respond to every question, but, having said that, may I formally welcome Professor Peter Barrett-Lee, Velindre NHS Trust, Sharon Vickery, Abertawe Bro Morgannwg University Local Health Board, Martin Jones, Betsi Cadwaladr University Health Board, Dr Evan Moore, again, Betsi Cadwaladr University Local Health Board, and Dr Philip Kloer, Hywel Dda Local Health Board? Welcome to all five of you and, without further ado, we'll move immediately to questions, and Julie Morgan has the first questions.

Morgan y ddau gwestiwn gyntaf.

[277] **Julie Morgan**: Bore da. Really, it's a general question to start off with. How effective do you think the LHBs and the deanery are in recruitment? Could you tell us if there is more flexibility being used in planning jobs? Are consultants being more involved in recruitment? What targeting is taking place about the way posts are advertised? Is there collaboration between you as LHBs and trusts to ensure that you make maximum use of those who are recruited? So, that's a whole range of things. Perhaps you could make a comment about part of it.

[278] **Dai Lloyd**: Whoever feels inspired to kick off.

[279] **Julie Morgan**: Yes.

[280] **Mr Jones**: I'll start. It's Martin Jones, director of workforce from BCU. In terms of the effectiveness, I think actually there's a lot of close working between the deanery and the health boards. I think there's a joint interest to ensure recruiting people through the training means, but there are also, actually, issues about non-training doctors as well—so the specialist doctors that are required for service work. 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 and, in terms of collaborative working with our consultants, there are many examples of consultants actually bringing forward innovative ideas about mountain medicine or the creation of year 3 foundation programmes to try to actually encourage doctors to stay in Wales.

[281] **Julie Morgan**: Thank you.

[282] **Dr Kloer**: I'll make a comment. Dr Phil Kloer, Hywel Dda medical director. I think there is a very close working relationship between the deanery and the health boards. The area that I think ourselves and the deanery are exploring at the moment is around rural health training, because 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 environment.

11:45

[283] Experience in the highlands has suggested that about 10 per cent of trainees, when asked, would like to experience their career in the future in a rural environment, and it's important I think that we give that 10 per cent of trainees that experience so that it captures their imagination and inspires them to come back and work in that rural environment. It's important, though, that we're able to provide the level of training that they require, so we wouldn't want to reduce the quality of their training just by putting them in a rural environment. So, it's a conundrum for us, but I do think we can make some steps on that in the future.

[284] **Ms Vickery:** I think, from a structural perspective, we have an all-Wales strategic medical workforce group, and there are a number of representatives from the health boards, but also the deanery sit on that group, and it's looking at the strategic medical workforce issues for Wales. So, the deanery is working hand in glove with us, really. There's a subgroup looking at psychiatry, a subgroup looking at surgical services, a subgroup looking at primary care. So, really, we've never worked so closely most probably with the deanery on specific areas where we know that we have problems.

[285] **Dai Lloyd:** And Peter. You don't have to touch the mike.

[286] **Professor Barrett-Lee:** Thank you. Just to talk from the Velindre perspective, particularly the cancer centre, I think it's really important to emphasise what trainee doctors are looking for. They're looking for a supportive environment and an educational environment. Of course, they want to look after patients and experience the service side, but I have a son who's a junior doctor and I know their main priority is a supportive environment and their education. There's a lot of pressure on them to get a lot of things done in their training. So, I think that's why we have to work very closely with the deanery and with our trainees, so that we understand exactly what their needs are. 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'.

[287] **Julie Morgan:** But you feel that closeness with the deanery. You feel

the closeness with deanery is there.

[288] **Professor Barrett-Lee:** I think it's really helpful, and it is there, and I echo what Sharon said, we've never worked so closely together. We should have done earlier, but we are doing it now and have been for several years.

[289] **Julie Morgan:** Thank you. Dr Moore, any comments at all?

[290] **Dr Moore:** From a Betsi point of view, we have an excellent relationship with the deanery and work very hard with them to understand what our essentially Cardiff-based students would need in order to spend time in north Wales. And, when they come up to us, the feedback that we get from them is absolutely excellent, both directly and through the deanery. So, they recognise the good training that we give. We're working hard with them to make that as attractive as possible for the junior doctors who come to us, and we're having good results with that and are pleased with the relationship.

[291] **Julie Morgan:** Thank you. There does appear to be a lack of clear and accessible data on medical vacancies available in one place. How do you think that can be addressed? Anybody got any ideas?

[292] **Dr Moore:** We certainly would know what vacancies we have, so I'm not sure that I understand the question.

[293] **Julie Morgan:** You don't think that that is true, that there's not available in one place all the medical vacancies that there are.

[294] **Dai Lloyd:** We've had evidence that says that, basically, it'd be nice to know all-Wales figures for the different specialties of what the vacancies are and where they are. They may well be collected on an individual health board basis, but where is the all-Wales situation? I think that is the basic tenet; I don't know. Peter.

[295] **Professor Barrett-Lee:** We do receive regular updates at the medical directors' meeting from the deanery who come and produce spreadsheets, both on where the vacancies are and where they may be expected to be, so there's always a projection as well, because there's a continual round every year, several times every year, of recruitment. So, we do, I think—. And then, individually, in our own organisations, of course, we know exactly where those gaps are every day in real, live time.

[296] **Julie Morgan**: So, you don't think this is much of an issue, really.

[297] **Professor Barrett-Lee**: I don't think the extent of the problem, and knowing about it, is an issue. I think we know where the problems are; it's how we address them, I think.

[298] **Julie Morgan**: Thank you. Do you think enough effort is being made to ensure that we have more students who live in Wales applying and being admitted to Welsh medical schools?

[299] **Ms Vickery**: Most probably, the answer to that currently is 'no.' We know, from looking at statistics, that a few years ago there were about 30 per cent Welsh-domiciled students, but that's fallen to about 10 per cent recently, and that doesn't compare well to some of the other UK countries. We know that the evidence suggests that if they train in Wales, they stay in Wales, and so, if you just go back to the structure that I talked about earlier, the all-Wales strategic medical workforce group, it's just setting up another sub-group. It's another area that we want to explore around access and medical sustainability, and that will very much be looking at how do we work with schools to attract schoolchildren and school students to be interested in medicine, to see it as a viable career, to prepare them for entry into the medical schools, potentially working with universities in Wales, as well. I think that group will toy with the concept of can they set quotas and will that possibly breach some elements of employment legislation. There's all of that work, then, to work through, but I think for you to take some assurance, it's on our agenda. It's going to be addressed, and I think it's an important issue for us to address.

[300] **Julie Morgan**: Why do you think the numbers have dropped?

[301] **Ms Vickery**: I don't know whether—. Anecdotally, I've heard that the entry criteria in some of the local schools can be quite stiff, and people apply to study in Wales, but perhaps they don't get places and then they go abroad. Peter was just talking earlier—his son applied for one university, didn't get in and then went to Southampton and has stayed in England ever since. So, clearly, it's something that we need to grab hold of, and it's going to be a fairly major plank of work now, going forward.

[302] **Julie Morgan**: Because we've been given examples of outstanding students who have been refused in Wales and then they've got places in

Cambridge—

[303] **Ms Vickery:** We need to unpick all of that.

[304] **Julie Morgan:** So, you're going to look at all that?

[305] **Ms Vickery:** Yes, definitely.

[306] **Julie Morgan:** Thank you.

[307] **Dai Lloyd:** Philip and then Martin.

[308] **Dr Kloer:** I think this is a really critical point for us when thinking about recruitment in Wales. I think there's a question, certainly, about the disparity between people with a Welsh postcode going to our universities compared with the numbers in, say, Scotland and England. We have very low numbers, as you've heard in evidence before and in our submission. I think there would be a variety of ways we could change that to help our residents get into medical school. I think it would have a really big impact on the likelihood of us being able to recruit to posts in the future. There are thousands of applicants to our medical schools. The bottleneck is clearly at the medical school level. As you go further up the scale as medical doctors, there are fewer and fewer applicants for posts until you get to consultants, where there sometimes aren't any applicants for a post. So, we know that there's an issue at the bottleneck at medical school.

[309] I think there's a second question as to whether we've got the number—which is related to the medical students—right in Wales, and whether we're actually training enough, because to train fewer medical students than we actually need is an issue. We know that medical students do leave Wales and we know there is a small drop-out rate as well. So, it is inevitable that we will have a medical workforce shortage unless we're drawing in huge numbers from other countries.

[310] I think, also related to this is how we attract people, not only into medicine, but into all health and social care professions in our schools. We're the biggest employer, and do we raise the profile enough of that in our schools and the fact that this is a really worthwhile occupation to go into? Across the spectrum, we need healthcare support workers, carers in the community, district nurses—all of whom will be important, because whilst we need doctors, we do need the whole team. So, I think there's a lot to this, but

trying to somehow ensure that we get more Welsh-domiciled students into medical school, I think, would be quite a quick win for us.

[311] **Dai Lloyd:** Okay. Martin.

[312] **Mr Jones:** I just wanted to share some of the work that's going on in BCU through the undergraduate medical departments and through consultants on their own initiative. I think 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—and I've got examples from both Bangor and from Glan Clwyd where they're working with students to give them some exposure to medicine and to have lectures on biological subjects that may help them with their A-level examinations. They're introducing them to medical students already in the system so that they can understand the application processes and how they can sharpen their skills and presentation processes; and they've had sessions with the coroner. So, I think there's a lot of work going on. I think the big investment there is the health service reaching out into communities and into educational establishments to try to ensure that pupils have got the best opportunity and the best platform to compete in a competitive process of gaining a place in medical school. One of the statistics that they particularly shared with me, which I thought was interesting, is that 33 per cent of applicants may actually get accepted for medicine, but of the cohort who had been working with Bangor—in the 2015 cohort—68 per cent of those had been successful. So, I think it shows—. There's been a tremendous amount of energy, enthusiasm and voluntary time given by clinicians to actually support that programme.

[313] **Dai Lloyd:** Great. Julie, did you want to come back?

[314] **Julie Morgan:** Thank you. A final question: how much do you think external factors will influence recruitment and doctors wanting to come to Wales, such as the junior doctor contract in England and Brexit?

[315] **Dai Lloyd**: Who wants to take on Brexit? There we are—Sharon.

[316] **Ms Vickery**: [*Inaudible.*]—junior doctor contracts.

[317] **Dai Lloyd**: Oh, junior doctor contracts. There we are; another big issue.

[318] **Ms Vickery**: In Wales we haven't been completely idle in terms of looking at the different contractual situation. Certainly for the last 12 to 18 months we've been working with our English counterparts whilst they've been going through their fairly tortuous journey. We listened carefully. We've learned a lot about the contract that's in operation in England. They advised us very strongly to sit and watch and learn whilst they went through their journey. So, we know a lot about the contract. We know a lot about the advantages and the disadvantages of that particular contract. Certainly over the last 12 months there's been a lot of fairly detailed modelling that's been going on behind the scenes, working with some of the intelligence that's been given to us by England. Obviously, I'm not a member of the Welsh Government, but I know that I'm working with my Welsh Government colleagues, and it's fair to say that there's a lot of consideration going on currently in terms of what we do in Wales. I think there's a sense that we need to do something in Wales, but we haven't yet made any of those decisions. I think, in terms of some of the intelligence that we picked up, that certain specialties—because some of the premium that they pay in England, and depending on the grade of the doctor—may be better off than some of the doctors here; but that's not absolutely across the board. I think, for you to take some assurance, that we've been looking, we've been learning and there's recognition that we need to be making some decisions about what we're doing in Wales.

[319] **Julie Morgan**: And do you think the lack of confrontation in Wales, basically, has been a plus in terms of—?

[320] **Ms Vickery**: Definitely. We've heard from our junior doctor colleagues, and from the BMA, that they were very pleased that the Welsh Government didn't decide to impose the contract as they did in England. I think that's a major selling point. Because one of the major lessons that we were taught by England was that, if Wales decides to implement that contract in that current format, the only way that it will be implemented successfully is to have positive junior doctor engagement. Without it, we would really, really

struggle to operate that contract. So, it is a big plus for Wales.

12:00

[321] **Dai Lloyd:** Okay, Martin, you had a—

[322] **Mr Jones:** It was on the question about the external factors and the issue—. I mean, Brexit is one issue, but I think the big question is that medical degrees are an international passport to work anywhere across the world, and British doctors are in demand, as are many other clinical specialties. Certainly, in some of the analysis we've done, we have doctors from 55 different countries working in the health board and they make up about 40 per cent of our total medical workforce. About 8 per cent to 10 per cent of that will be from Europe, with Ireland, Poland and Germany being countries that are particularly represented there, but many countries—Hungary. There are a lot from European countries and very large numbers of individuals from India and Pakistan, and they have served, actually, the Welsh health service enormously well over many, many years. So, the real issue is actually about how we ensure that the ongoing debate about what the position of the UK may be in terms of immigration does not destabilise the commitment of those people who have given many years' service to the health board. Certainly, I've been approached by individuals to ask for assurance and we're trying to provide whatever assurance we can in a climate where we don't yet know the full details. What we do know is, actually, that we are privileged to have doctors from all across the world providing high-quality services to the patients and population that we serve, and it's important that we actually keep those people content and work and support them properly.

[323] **Julie Morgan:** Would that be true of the other health boards and trusts, that staff have needed reassurances, as far as possible?

[324] **Dr Kloer:** Yes. Certainly, in Hywel Dda, I've had a number of EU doctors asking me for similar reassurance. I suppose it's in that period where we're unsure what the terms will be. It depends on those terms. If the terms were that those doctors were no longer able to work in our NHS, then that would be about 8 per cent to 10 per cent of our workforce that wouldn't be there, and that would give us an even greater problem. But, as has been stated, it's not just EU doctors; there are a lot of countries around the world whose—. We have multinationals making up a large proportion of our workforce. One of the factors that is important, sometimes, is the delay in obtaining visas.

That has had a significant impact on us at times because there are a number of steps to go through. So, anything that could be done to speed up that process would be helpful. 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.

[325] **Dai Lloyd**: Okay. Rhun on this.

[326] **Rhun ap Iorwerth**: Yes, just on that point in particular, obviously, 10 years from now we'll know what the implications are of leaving the EU. The question is that we need doctors now and we need doctors from the EU who are here now to stay and we need more to come. Is that insecurity something short term that is of real concern to you?

[327] **Dr Kloer**: I think the doctors that I've spoken to who currently work in Wales are—. My interpretation of what they've said is that they would be unlikely to leave. I think, as it stands at the moment, the concern for me is that it's difficult for them to persuade their colleagues to now come. I think that's the issue with the uncertainty.

[328] **Ms Vickery**: Just to say that in ABM there has been some extensive international recruitment over the last 18 months. We started with Europe—so that's just one thing to bear in mind—and we've now got, probably, more EU doctors than we would have had previously. So, that increases the risks for us. But what we've now done, because of the uncertainty around Brexit, is that we've moved our focus from Europe and we've been to Dubai and to India.

[329] **Dai Lloyd**: Any excuse. [*Laughter.*]

[330] **Ms Vickery**: It's fair to say that the quality of the Indian doctors—. There's been a recent initiative called BAPIO where we've worked with the royal colleges and gone out and we've—. That's another example of collaborative working. We went out as Wales—as opposed to individual health boards—and we were successful in recruiting 58 doctors. We could have recruited more, had we had more vacancies in the right specialties. We had 93 who were eligible to be employed. So, the quality of doctors in India was really, really, really good. 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.

[331] **Dai Lloyd:** Moving on: Caroline, you've got a couple of questions now.

[332] **Caroline Jones:** Diolch, Chair. Yes. The committee has evidence about the length of time it takes to recruit and appoint medical staff. What do you think can be done to get more clinical ownership and involvement in the recruitment process to help address this, really?

[333] **Professor Barrett-Lee:** I'm not sure exactly if you mean the process—the recruitment procedure—or if it's more about how we attract. I can answer both. One thing that I think we're all becoming more aware of, that we have a role—. All of us who are medically qualified, but also anybody, really, who works 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. So, that's one area.

[334] I think the other one is: there have been improvements to the actual recruitment system lately, and that hopefully will help. It really plays into what we've just heard from Phil. Because of safety issues, and because of getting the right people and making sure that all the things are done correctly, there are a lot of steps in recruiting people. And we also have to remember that the recruitees have a lot of choice nowadays, and we often find that we are let down at the last minute by people withdrawing. I would say it is quite an onerous task, to be involved in recruiting new members of staff, and anything, again, anything we can do to streamline it—. I do think medical engagement is important, because we can keep that pressure on and say, 'This is not just a recruitment process; we actually need this person desperately, so anything you can do to speed it up would help.'

[335] **Caroline Jones:** With regard to what you said about people withdrawing, have you any idea what percentage of people withdraw, and do you have an audit trail as to why?

[336] **Professor Barrett-Lee:** So, we are a small organisation compared to the local health boards, and we haven't kept, in the past, detailed statistics on this. But I looked at the last two posts that we were recruiting to, and some of the posts weren't completely permanent, and one aspect was the uncertainty over what the contract meant, and it was aligned to getting mortgages. So, I think that's something we need to look at. Again, why can't we work, perhaps, with mortgage companies? Why can't the Welsh NHS engage with the financial sector and say, 'Look; come on. You need to help

us too'? And there were a number, I know—. Sometimes it's just simply that they get another offer somewhere else. So, we haven't done a detailed analysis of that, and that may be something that's important as well.

[337] **Caroline Jones**: Okay. Thank you.

[338] **Dai Lloyd**: Martin, did you want to come in here?

[339] **Mr Jones**: I would comment on a number of those. Certainly, one thing the health service did some time ago was to actually move to a shared services partnership with back-office functions. That has tended to mainly work for non-medical staff rather than for medical staff, with the medical staffing function being quite a specialist area of employment, but increasingly, there is work being done, more, on a national basis on things like the GP trainee contracts. The GP trainees are now actually hosted by one employer, rather than actually multiple employers. Things like the DBS—the Disclosure and Barring Service. Checks for doctors are now being done through shared services, and shared services do have, actually, quite an ability to analyse every step in the recruitment process, and there's ongoing work to try to actually reduce the amount of time. I think the one thing—just thinking about it as we were speaking—that is different is that, clearly, across the UK there are different types of health organisations, and in the English system with foundation trusts, they don't seem to be actually dependent on the same rules of, for example, royal college advisers, and the amount of time it takes perhaps to actually organise interview panels. So, I suppose that's one thing that we could continue to enter into debate with Welsh Government on, about the regulations that we employ for consultant appointment panels, for the advisory consultant panels, and whether there's anything that could be done to actually make them easier to convene so that time isn't lost relative to other organisations that have less onerous arrangements for actually putting panels together.

[340] **Dr Moore**: We certainly would have examples, especially at consultant level, of people who—. So, when you come to the end of your training, you have a certain period of time during which you need to find a consultant post, and at the end of that you won't have a job. Obviously, there's a pressure on people at that point in their careers to get a job. And we certainly would be aware of people who we were hoping to appoint and lining up panels for, but due to various delays haven't been nimble enough, whilst more nimble organisations—. Some of the responsibility for that obviously lies within the health board and they have been able to appoint the person,

and once they're appointed, they're appointed often.

[341] **Dai Lloyd:** Sharon.

[342] **Ms Vickery:** Just really to be clear that, when we talk about recruitment for doctors in training, then, obviously, the deanery manage the recruitment there. So we don't have a huge amount of influence over that process except to say that we are looking. Martin just talked about the Disclosure and Barring Service. There is portability now with those checks, but it's over a three-year period, and we are looking now at extending the portability of other pre-employment checks because junior doctors find it really irksome that, when they rotate within Wales—different employers—they've got to go back through occupational health and those sorts of things. As Martin and Peter said, there have even been some introductions of different software and track systems; that's helping to speed the process up as well.

[343] **Dai Lloyd:** Good.

[344] **Caroline Jones:** And could you tell me if you think the health boards have a clear idea of what the future medical workforce requirements are, and what the target numbers for training places should be?

[345] **Dai Lloyd:** There we are. A starter for 10. [*Laughter.*]

[346] **Caroline Jones:** Don't all rush at once.

[347] **Mr Jones:** I think that there are a number of things there. The strategic medical workforce planning group has been doing work and has commissioned external work to look at the number of doctors in training, how the demography is changing in Wales, and how the need for different specialties may change. So that work is going on. I think the one thing that is often highlighted is that, with a five-year undergraduate degree and then possibly nine to 12 years for someone to qualify as a consultant, a lot of things can change in that time. So there is work now going on to actually try to bring the non-medical and the medical workforce planning into closer alignment, and that will actually take place in forthcoming years, because it is a multi-disciplinary team effort. There are many different clinical specialties that are working alongside doctors; there's the development of physician associate programmes, and actually how those contribute. So I think it's a continuing challenge. People are looking very carefully at how society is changing, they're looking at the age profile of the workforce we

have and what the attrition rates are, but one thing I'm sure about is that, in 15 years' time, things like the extent to which genomics and gene therapy and that are going to be used will be different to what we can imagine. We are endeavouring to plan based on what information we know, but that is an imprecise science.

[348] **Dai Lloyd:** Thank you. Philip and then Peter.

[349] **Dr Kloer:** I would say that that's quite a difficult question, I think. And it depends how far into the future you look because we've done some workforce modelling based on our current service models in the all-Wales group, but, clearly, looking at the demographic of the future, the over-85-year-olds, the amount of chronic disease, dementia, frailty and end-of-life issues that we're going to have, and the fact that it's all going to have to be very much community facing, the fact that, in our area, if we continue with the same model in primary care, we would need to recruit an additional 82 GPs over the next few years because of retirements. Clearly, it's not going to be based all on medical doctors; there's going to be a multi-professional workforce. I think, also, due to the advent of technology, at some stage we will have an electronic clinical record. At some stage, our public will increasingly have more access to their own records, and be able to make many more decisions about their care. And the future generation will not be happy to wait for ages; they will want to get their information on their phones. So, I suppose, to actually pinpoint exactly what the workforce model and the service model will be is difficult, but I think we can make enough assumptions that we do need to major on recruitment of a range of specialities.

12:15

[350] We're clearly not recruiting—. 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.

[351] **Dai Lloyd:** Okay. Peter.

[352] **Professor Barrett-Lee:** Just really to echo those points but to add another one. We've been looking at this with external consultants with regard to transforming cancer services in south-east Wales and the building of a new cancer centre. It's quite easy—relatively easy—to model the workforce requirements in the future based on what we do now or what we have done

in the last few years, because we know what we do now and we've got some figures. The big issue is: how do you predict what healthcare looks like, say, in oncology, which is one of the fastest moving fields? We've heard about genomics, but there are lots of other developments as well. How do we predict what it looks like in 10 years? I think that is difficult, but we have to try and make a best guess because otherwise we become paralysed, we can't do it, we can't think what's going to happen in the future, and then we do nothing. So, we have to, I think, accept that it may not even be a science, really, workforce planning; it may be an art. We just have to accept that and do our best and get the best information we can, but accept there are huge uncertainties.

[353] **Dai Lloyd:** Yes, good point. Moving on, Rhun, some of the issues have been covered, I think.

[354] **Rhun ap Iorwerth:** Mae ychydig o gwestiynau penodol gennyf i. Rwy'n meddwl bod yna gytundeb yma ein bod ni eisiau gweld rhagor o israddedigion yng Nghymru. Rydych chi wedi gwneud y pwynt hwnnw'n dda iawn. A gaf i ofyn i'r tystion o'r gogledd—rwy'n cymryd eich bod chi'n gefnogol iawn i ddatblygu addysg feddygol yn y gogledd, ym Mangor, mwy na thebyg—beth yw eich barn chi ynglŷn â'r tebygrwydd y gallwn ni symud ymlaen efo hynny yn gyflym? Pa gryfhau a fydd angen ei wneud yn y gogledd yn Ysbyty Gwynedd, er enghraifft, fel ysbyty dysgu, er mwyn i hynny ddigwydd?

Rhun ap Iorwerth: Just a few specific questions from me. I think there's agreement here that we want to see more undergraduates in Wales. You've made that point very strongly. May I ask the witnesses from north Wales—I assume that you're supportive of the development of medical education in north Wales, in Bangor, more than likely—what is your view on the likelihood that we'll be able to proceed with that swiftly? What will need to be done in north Wales, in Ysbyty Gwynedd, for example, as a teaching hospital, for that to happen?

[355] **Dr Moore:** I very much welcome that question. I think that, if we look at the issues that we have, and accepting that we don't have enough doctors in the UK, or in Wales for that matter, there really are only two things that we can do to tackle that: one is to attract more doctors in who've been trained elsewhere or, secondly, to train more doctors ourselves.

[356] One of the points I wanted to make in the last question is that no matter how many doctors we think we will need in 10 years' time, to some

degree, the number that we will train for the next 10 years is already set. So, the number of medical students that will churn out over the next five years has already started and is already done and is unalterable. The number of consultants or GPs that will create is now set for the next 10 years. That's done. I think that's a very important point to remember in all of this.

[357] 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.

[358] **Rhun ap Iorwerth:** Can I just stop you before you carry on? I chose my words fairly carefully in terms of developing medical training in Bangor. I think a full-blown medical school is something that we should have an eye on and we should aspire to, but there are things that we could do far sooner than that in having undergraduates in Bangor as part of a new community medical training scheme over there.

[359] **Dr Moore:** Okay, so we're very proud of the training that we currently give at Gwynedd hospital. It's received several awards and has good outcomes. We have a good relationship with Bangor University and some of the education that goes on there we're heavily involved with. Professor Williams, for example, is an employee of ours and of the university—I know he was here earlier in the week. We work very closely with them, offering placements, offering education, offering what training we can. Is that the sort of thing you're asking me or am I missing the point?

[360] **Rhun ap Iorwerth:** Yes, but that's already happening.

[361] **Dr Moore:** It is.

[362] **Rhun ap Iorwerth:** What we need to do is move forward and have undergraduates training and being Bangor-based medical students.

[363] **Mr Jones:** Just to clarify, we do have undergraduates in Bangor. They have tended to be from year 4 of the training onwards—there have been, actually, some expansions: we have people at year 3. I think the aspiration that many people have is to ensure that we have more people drawn into the Welsh medical education system from north Wales. The numbers from Wales are relatively small. I think, recognising that it's an international currency and that people can work out of anywhere in the world, if you're starting off with

students who have a strong compass about working in the communities from whence they came, even if they don't in the future—it's a lot for 17-year-olds and 18-year-olds to plan their career all the way forward—and 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.

[364] I think, actually, one of the things we've often found is a concern that, if people start their medical education in different parts of Wales and start building relationships and start actually getting settled in communities, it's always seen as a negative factor in terms of people coming back to north Wales. So, we would be really encouraged with anything that helps us increase the proportion of Welsh medical students, who are drawn from Wales and drawn from north Wales, who can have as much of their medical education within north Wales at local hospitals and can maintain the links with the community and can maintain their aspirations and dreams for the future by working as a medical practitioner within the communities from whence they came.

[365] **Rhun ap Iorwerth:** Which is why it's rather frustrating when we hear of A-grade students failing to be given an interview even for medical colleges in Wales—it's a story that we hear far too often. As a 'yes' or a 'no' or a nod or a shake of the head, or whatever, do you think that any student in Wales who wants to study medicine in Wales—any 16-year-old, 17-year-old or 18-year-old in Wales—should expect to be able to be offered a place in Wales?

[366] **Mr Jones:** Rather than actually guarantee, I think what I would like to see is a trajectory that shows an increasing proportion of Welsh undergraduates who are drawn from Wales because I think it is really important. It's quite clear that the proportion of people drawn from Wales are lower than other UK countries. We need to address that. There are bilingual and linguistic skills that we need to have and the cultural awareness, and I think increasing the proportion of Welsh-domiciled students would help in those respects.

[367] **Rhun ap Iorwerth:** Who's going to go further than that? [*Laughter.*]

[368] **Caroline Jones:** Two. [*Laughter.*]

[369] **Mr Lee:** I'll go a bit further. I'll go further and say that 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, because many of them—. I understand the university's problem; they get—. Medicine is a popular choice and there are lots of applications. They have a screening process, which is probably just based on academic achievement and a school report. What if they were to build in the postcode as part of that, and give those people a chance, at least at interview? I don't think we could guarantee someone a place, but we could perhaps say that we would have a very low threshold or high threshold, whichever way you put it, to interview Welsh students.

[370] **Rhun ap Iorwerth:** It would be good if that was a recommendation of this committee, I think.

[371] **Dr Kloer:** I would just very, very strongly support that. I think, yes, it's not just academic achievement, of course, that will get you into doing medicine, but I really strongly support the fact that we get people to interview who have the right grades and who have a Welsh postcode.

[372] **Rhun ap Iorwerth:** And that's an important thing to remember—nobody is thinking of letting people in with lower grades because you need people with high grades to be doctors.

[373] Moving on from that, the consensus on the need to have more graduates coming through the system in Wales—on recruiting people to then train in Wales, I know you say that it's the deanery and not yourselves directly, but also on attracting people to work in Wales, who've already trained, give us some ideas of the incentives that you think should be explored more on a Wales-wide level—financial incentives, paying training fees, or whatever it might be. I'll invite you to be as innovative as you like.

[374] **Dr Moore:** I'm not sure that financial incentives are the most important thing or even where you'd want to focus your efforts. I think the efforts where we've certainly seen results, certainly at Ysbyty Gwynedd, are around providing training schemes that give the training that junior doctors want—that give the breadth and touch their interests, as well as making them feel at the end of it that they will actually be prepared for the job that they want; some confidence in them perhaps that there will actually be a job at the end

of that that won't require another relocation of spouse and family around the country; security around tenure of employment and the mortgage implications that that has, and security of finances in doing that; things that make the rotation easier to do, whether that be geographical, so you're not moving around quite so much, or you're in a modest area of movement for a period of time; good support whilst you do the training; good access to trainers and resources for those courses that are laid on; and time off work or time off duties to attend those courses and to sit your exams, and to study for those exams. So, I think it's all those things. And those are the things that we have had some successes with and are proud of, and are trying very hard to do more with.

[375] **Rhun ap Iorwerth:** Any of those that you mentioned there are things that—I'll give you an opportunity in a second. Are any of those things that you mentioned there things that can be developed in Wales to make Wales stand apart from other parts of the UK that are also trying to recruit more people?

[376] **Dr Moore:** I don't think developing those things in Wales is a new thing or something that hasn't been happening or isn't ongoing. I can think of the Train Work Live scheme or work where you'd love to live—all those sorts of things have been doing that, and we've been having good success with that in the deanery. So, for example, being at all the BMJ fairs and conventions, and representing Wales in a positive light has achieved a lot of that. But it is the sort of thing that when you get success with it, it's worth redoubling your efforts and putting more effort into it, because you know you'll get the dividend. Do you want to add anything to that, Martin?

[377] **Mr Jones:** There is some work going on with incentives already, isn't there? Recently, Welsh Government have announced support for GP trainees in areas where there's a low percentage of take-up. So, all areas in north Wales have been designated as falling within that scheme, so that will then give people £2,000 towards some skills training and give them £20,000 if they fulfil their training in Wales and then stay for a year after. You've got the nurse bursary, again, which is providing some linkage for people to remain within Wales.

[378] We're trying to promote the work environment, and it goes with the Train Work Live. North Wales was identified in the top four in terms of Lonely Planet's interesting places to visit. So, we're trying to use and develop websites and materials that convey that not only is it a good place to work,

it's also a good place to live and bring up children and spend your life. So, we're working hard on that, and we're just on the cusp now of developing some websites that will carry that material and carry that branding in north Wales, because it's really important.

[379] **Rhun ap Iorwerth:** One of the problems identified by an earlier witness today was that perhaps 'good place to live' is an easy one to sell because of the natural environment and what have you. The 'good place to work' is the one where we have a challenge, and the incentive there surely is having that good-quality training—

[380] **Mr Jones:** I think particularly, though, it's not uncommon for professional individuals to be married or have partnerships with other professional individuals. We've certainly been able to recruit partners to north Wales, and creating that opportunity for people to relocate as a family has been important. We're having discussions with the universities about what opportunities there might be there, but I think there's a wider issue about the availability of quality jobs right across the sectors, because people will not just come as a health unit—they will have family members who will be working in different parts of society as well. So, making sure that the ambition that we all have for all parts of Wales—that we have vibrant economies and vibrant opportunities for employment—is important in terms of how we make ourselves attractive, because people don't locate as individuals—they quite often relocate as family members.

[381] **Dai Lloyd:** Amser symud ymlaen, a'r cwestiwn nesaf—

Dai Lloyd: It is time to move on, and the next question—

[382] **Rhun ap Iorwerth:** Roedd Peter eisiau dod i mewn yn fanna.

Rhun ap Iorwerth: Peter wanted to come in there.

[383] **Dai Lloyd:** Peter, sorry.

[384] **Professor Barrett-Lee:** I'll be very quick. If you are known as a department for having a low pass rate, then that's a very big disincentive for junior doctors. So, if you've got a high pass rate, it's a big incentive for them to come to you. So, it's really important to get your educational support right, but that word gets out there as well, so everybody will know what your pass rate is.

12:30

[385] **Dai Lloyd:** Good point. Dawn.

[386] **Dawn Bowden:** Thank you, Chair. I just wanted to pick up, really, on the confed's evidence around the changing shape of services, and I know it's something that's been talked about for a long time. The confed's evidence talks about—

[387] 'it has become increasingly clear that a transformation in the way treatment is delivered is required'

[388] and it talks about—

[389] 'A sea-change in the way services are designed is vital'.

[390] Can I see from any of you, really, whether you think that we do need that sort of change in the health service now in Wales, including, possibly, service reconfiguration, which we've started and which has stumbled in some areas? But would that in itself be sufficient to deliver the additional numbers of medical staff that we need, or are the two processes actually not connected?

[391] **Dr Kloer:** I think they're definitely connected, and they will be one really key factor. Going back to what I said earlier, looking at the challenges that we'll have in looking after the future population, our services aren't, at the moment, configured to deal with the future demographic, the fact that we have higher obesity rates, the fact that we will need to focus a lot more on preventative and proactive care in communities and, certainly, our GP practice, given the fact that it's unlikely we'll be able to recruit, as it stands, as many GPs as we need with the current model. As Evan said earlier, we've already fixed how many medical staff will come out of medical schools. We will have to have a multiprofessional model, and, in pockets, we can see those models developing. In Kidwelly, we've completely changed the model, where it isn't so traditional, where you go in and you'd see the GP first. Actually, you're rerouted to the physio when you have an issue, actually, that the physio's the best to deal with, or an advanced nurse practitioner, or pharmacist or paramedic. Every professional has a really key role to play. The doctor has, then, other roles. My feeling would be, hopefully, certainly in primary care, instead of us having the routine seven-to-10 minute appointment for every single sort of circumstance when somebody comes to

the GP practice, actually, we have a longer time for the GP to spend with patients, even though we may have fewer GPs, because the multiprofessional team will be around them. But that does mean we need to be able to recruit all those other multiprofessional staff. So, I think we can see the future emerging in primary care.

[392] I think in our hospitals, trying to get access to specialist opinion, where consultants are becoming more and more specialist, it's difficult for them to be in every single hospital across Wales. I suspect that the future will make much better use of telehealth. When you look at Kaiser Permanente, they have a default position where nearly all their specialist opinion is undertaken via telemedicine. If you have the right professional, not necessarily a doctor, sitting next to the patient, they can access that specialist opinion remotely, rather than taking a four-hour drive to see a specialist for a relatively short period of time. I think that will help us with our medical recruitment issues and reduce, perhaps, or, for a time, help us with the shortfall of doctors that we've got. But I don't think it will be the only thing; I think all the other factors are also important.

[393] **Dai Lloyd**: Martin.

[394] **Mr Jones**: I just wanted to add to that and include the—obviously, your interest today is actually around medical recruitment, but medics make up just over 8 per cent of our workforce, so there is a huge array of other clinical specialists. People who are looking to join us in the future will have their mind's eye on what their work experience will be, what it's going to be like working for an organisation. Critically, that does actually reflect how many peers and colleagues they have and, actually, how sustainable the service is, so the question of sustainability and the question of the extent to which we have robust medical teams, but also robust multidisciplinary teams so that people can understand how they can make a contribution, but in a sustainable way, so that they're not burnt-out, is really important.

[395] So, that change is—the NHS is littered with examples of where people are pushing the boundaries and developing new skills. That goes all the way up from healthcare support workers who are developing additional roles all the way through the professional groupings.

[396] **Dawn Bowden**: Can I just follow up on that? We hear quite a lot, actually, about pockets of good practice where these things are happening. To what extent are health boards actually sharing good practice? I know one

size doesn't fit all—I understand that—but if something is working really well in one area, we don't seem to see that replicated as a matter of course in other areas. It seems like everybody has to go through the same process of identifying their little pilots and pockets of good practice.

[397] **Mr Jones**: I think that there are a number of contributions trying to change that. There are Bevan exemplars, there are staff achievement awards, there are union achievement awards, which are celebrating success. I think some of that is about promoting what's going on and sharing it. We've recently introduced a new award in Betsi Cadwaladr University Local Health Board, the Seren Betsi Star, which is about celebrating individual contributions, where peers have nominated people. So, I think it's about creating a virtuous circle and promoting examples of good-news stories. There are a lot of good things going on.

[398] **Dai Lloyd**: Okay. Philip.

[399] **Dr Kloer**: Yes. I think there are a number of ways that we do share our practice. I think the question could be, 'Why haven't we implemented that model across our own health board, where we're very aware of it?' There is some winning of hearts and minds, because the clinicians are trying to get used to the fact of a different way of working, where patients are routed directly to physiotherapy or a pharmacist, and understanding that, and also for our public to get used to the fact that, actually, you've had a really valuable opinion if you haven't seen the medical practitioner. In fact, sometimes, actually that person was much better for the situation that you've come to the surgery for. So, there's winning hearts and minds, both in our staff and in the public, that we need to do over the next few years.

[400] **Dawn Bowden**: And that's not easy to do.

[401] **Dr Kloer**: No.

[402] **Dawn Bowden**: All right. Thank you very much.

[403] **Dai Lloyd**: Okay. Turning to primary care—Jayne.

[404] **Jayne Bryant**: Yes, thank you, Chair. I was going to focus on primary care. You've given some examples, but perhaps you can expand on what role health boards play in trying to attract more doctors to work in primary care.

[405] **Dai Lloyd:** Martin.

[406] **Mr Jones:** I'll give this as an example. Obviously, it's becoming a mixed economy in the sense that we still have general practitioners working under the GMS contract. We actually celebrate that. We are certainly not looking to move away from that model. We have had some examples, though, where the health board has actually introduced managed practices where we employ the staff ourselves. We've got schemes in north Wales now—the outstanding GP programme—where we know that general practitioners who are completing their training don't always feel confident about making that step into practising fully. We have been running a programme for a number of years now, where we're actually providing some additional support to people at the end of their training with a view to try to encourage people to come to north Wales. But, again, the same question there is that, actually, it's not just about the medical practitioners and that model; it's about creating a whole range of different healthcare professionals that can contribute. So, in Prestatyn, for example, we've recently taken on the responsibility for GP services as an employed model, where we're engaging a whole range of different clinicians and supporting that.

[407] **Jayne Bryant:** And that's been successful so far.

[408] **Mr Jones:** It has been successful. There are still some challenges. There are some differences in the way that we're currently exploring the differences between the rates of remuneration for a salaried GP as opposed to a consultant or somebody else in the normal workforce, because there is a discrepancy between the two. It appears that there are a number of clinicians who are content working as locums as opposed to in full-time positions. It's a career choice for some individuals at the moment. So, I think there are a number of things we're trying to do in terms of pay rates, opportunities and training opportunities. There are changes coming through in terms of taxation, with the IR35 that's coming through about the status of people to actually work as limited companies now. That may change things again to the future. So, we're working continuously to try to ensure that we have creative models and welcome people into primary care within north Wales.

[409] **Jayne Bryant:** You were saying that there are creative models. Is everybody else aware of those throughout Wales, or do you know much about other good examples?

[410] **Mr Jones:** I think there are a number of forums that exist. Each of the

directors of the health boards has peer groups. So, there are those opportunities where people do exchange information. I think there can always be improvements in terms of the extent to which people are sharing, actually, what's going on on the ground. But again, I think it's actually getting back to what I mentioned earlier—it's about creating those opportunities to celebrate success and actually positively promote what NHS Wales is achieving.

[411] **Jayne Bryant:** And what are your views about opening up more GP work opportunities for post-foundation-year doctors? Does anyone else have any opinions?

[412] **Dai Lloyd:** Philip.

[413] **Dr Kloer:** I think there's no doubt that increased footfall in general practices is likely to increase the number of doctors who'd think of a career in primary care, in the same way that increased footfall in Hywel Dda university health board will increase the likelihood that we'll get people coming to work with us. So, 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. So, I would certainly support that. Just going back to your other point, I think the future of GPs—. We have to recognise that the GPs coming out of training now are less likely to want to take on a partnership, they're nervous about that in the current climate for all sorts of reasons, and we have to look at other options for them. So, we're looking at portfolio careers, where GPs can do some GP work but can do some other work with us, either in the community or in the hospital, because there's plenty of value that they can give in those areas as well.

[414] **Jayne Bryant:** Great, thank you. We've had some conflicting issues around a sort of indemnity. Do you think it's impacting on the ability to recruit new doctors into primary care?

[415] **Dai Lloyd:** The cost of indemnity.

[416] **Jayne Bryant:** The cost of indemnity, yes.

[417] **Dr Kloer:** 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. I think it's actually sometimes an issue at the end of people's careers, because people think at a certain point in their career, 'Is there any point in paying that much indemnity for the money I'm getting?', because it's eroding into their salary. So, I think it's more of a factor, actually, at that end of the career.

[418] **Jayne Bryant**: Thank you.

[419] **Ms Vickery**: I suppose just a few statistics, really, from me. In preparation for today—structurally within ABM we actually created a whole delivery unit just looking at primary and community services—I spoke to our unit medical director for primary care. He said that his wish list really—he's fairly new in post—would be to have an appropriate range of incentives, and he was definitely very clear about having indemnity paid for all the people working within primary care. I don't know whether you're aware, but currently all GP trainees, in terms of these cohorts, during their training have their indemnity paid as part of their incentives. Again, just picking up on some of the things that have been mentioned, in the BMJ careers fair last October the emphasis was on GP recruitment from Welsh Government. Now, it's almost impossible to prove a causal relationship between incentives and the increase in the number of applicants, but, after round one, there is a 19 per cent increase in the number of doctors now applying for GP training in Wales. So, just a few statistics for you to think about there, okay.

[420] **Dai Lloyd**: Okay, good. Time for the last question, and it's Dawn.

[421] **Dawn Bowden**: Yes, it's just to follow on from that, really, still on GPs. It's just a quick question about whether local health boards can clarify how the Welsh Government funding provided for GP clusters has been spent, and what impact that's had.

[422] **Dai Lloyd**: GP clusters—early days, not enough dosh.

[423] **Dawn Bowden**: Too early to tell?

[424] **Dai Lloyd**: Philip, or Mark.

[425] **Mr Jones**: I can't clarify the issue about the funding arrangements. I don't have the have the details to do that; we'd have to actually submit something outside, I think, if there was a specific question on that.

[426] **Dawn Bowden**: That's fine.

[427] **Dai Lloyd**: Okay. Philip.

[428] **Dr Kloer**: I think it's early days, but it's been really helpful to have GP leaders who have money that they can prioritise for the needs of their local population, because, when you look across the world, the general feeling from the King's Fund is that you should consider need based on about 30,000 to 60,000 population.

12:45

[429] Two of our clusters, just to mention them—one of them is looking at pre-diabetic care. It's early days to see the full evaluation on that, but the feeling is that we've been able to target things that we wouldn't ordinarily have previously targeted. Another area is to invest in some software that allows us to risk stratify our population in Carmarthenshire, where we have 700 Stay Well plans for those people in the population who are likely to become unwell at some stage, and then there's a really clear escalation plan for when they do become unwell. So, it has allowed us, I think, to do that sort of innovation in our clusters, which, for the local population, is really important. But yes, it's a relatively small amount of money, and it's early days.

[430] **Dai Lloyd**: Julie, you had a question, to finish off.

[431] **Julie Morgan**: I just wanted to ask for a bit information, going back to the discussion. The BAPIO initiative seems a tremendous initiative. How long do the doctors stay here, and what are the arrangements?

[432] **Ms Vickery**: They come in at tier 5, and so there has to be liaison—an agreement with the royal college and the deanery. They had all of that all sorted. They can only stay with us for two years. If you go back to the all-Wales strategic workforce group, there is a medical training initiative/BAPIO sub-group actually reporting into that group, so they were the people who planned the event, and, as I say, it's collaborative across Wales—we all work together. I think I alluded to it earlier that a number of our consultants, obviously, went out to interview, and they were staggered by the quality of the candidates out there.

[433] What we've been very clear about with all of the health boards—and

the BAPIO sub-group is continuing to do a piece of work around this, and around evaluation, in terms of this particular trip—is that if we get this right, it could establish a new training pipeline for Wales, and, anecdotally, some of the consultants actually said if we got this right, we could solve some of the recruitment problems for Wales, or we could solve the recruitment problem for Wales. So, how we treat those doctors, how we plan their training, their experience with us, is absolutely critical. And I think, in terms of the employers confederation evidence, it sort of alludes to the fact that, actually, increasingly, there are different generational issues here coming into play, and how we treat doctors, how they're valued, some of the values and behaviours that they see in organisations, sometimes play out in the GMC survey. And increasingly, if we don't treat those doctors properly and they don't feel they've had a good experience, then clearly they're not going to tell their colleagues then to come, and that pipeline will dry up. And that is absolutely key to taking to the BAPIO scheme forward.

[434] **Dai Lloyd**: Grêt. Diolch yn fawr. Mae amser y sesiwn ar ben. Diolch yn fawr iawn i chi am eich atebion dwys, manwl, doeth—a phob ansoddair arall: aeddfed, graenus. Diolch yn fawr iawn i chi. Gallaf i bellach gyhoeddi y bydd yna drawsgrifiad o'r sesiwn yma yn cael ei gyflwyno i chi er mwyn i chi ei wirio fe, fel ei fod yn ffeithiol gywir. Ond gyda hynny o eiriau, a allaf i ddiolch unwaith eto i chi am eich presenoldeb? Diolch yn fawr iawn i chi. Ac fe allaf i gyhoeddi i'm cyd-Aelodau fod yna doriad am ychydig ginio nawr, ac fe fyddwn ni nôl yn brydlon am 13:30. Diolch yn fawr.

Dai Lloyd: Great. Thank you very much. Our time is up. Thank you very much for your comprehensive, detailed and wise answers—and many other adjectives that apply: mature, polished. Thank you very much. May I now just inform you that there will be a transcript of this session sent to you so that you can check it for factual accuracy? But with those few words, may I thank you once again for your attendance? Thank you. And may I just inform fellow Members that we will now break for lunch, and we will return at 13:30? Thank you.

Gohiriwyd y cyfarfod rhwng 12:48 a 13:31.
The meeting adjourned between 12:48 and 13:31.

Ymchwiliad i Recriwtio Meddygol—Sesiwn Dystiolaeth 9—Deoniaeth Cymru
Inquiry into Medical Recruitment—Evidence Session 9—Wales Deanery

[435] **Dai Lloyd:** Croeso i sesiwn prynhawn y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym ni'n symud ymlaen rŵan i eitem 5, â pharhad i'n hymchwiliad ni i recriwtio meddygol. Hon ydy sesiwn dystiolaeth rhif 9.

Dai Lloyd: Welcome to this afternoon's session of the Health, Social Care and Sports Committee here at the National Assembly for Wales. We're moving on to item 5 and the continuation of our inquiry into medical recruitment. This is the ninth evidence session.

[436] O'n blaenau ni'r prynhawn yma mae cynrychiolaeth o Ddeoniaeth Cymru. Croeso i'r tri ohonoch chi. Fel rydw i wedi ei ddweud eisoes, rydym ni wedi cael tair sesiwn eisoes y bore yma ar yr un pwnc. Hon ydy'r nawfed sesiwn dystiolaeth, i gyd ar recriwtio meddygol.

Before us today we have representatives from the Wales Deanery. Welcome to the three of you. As I've already said, we have had three sessions already today as part of the same inquiry. This is the ninth evidence session on medical recruitment.

[437] Felly, o'n blaenau ni mae'r Athro Peter Donnelly, deon astudio ôl-raddedig dros dro, Dr Phil Matthews, dirprwy gyfarwyddwr meddygaeth teulu a phennaeth yr ysgol hyfforddiant arbenigol ar gyfer meddygaeth teulu, a hefyd Dr Helen Baker, cyfarwyddwr cyswllt gofal eilaidd.

So, we have Professor Peter Donnelly, interim postgraduate dean, Dr Phil Matthews, deputy director of general practice and head of the specialty training school for general practice, and also Dr Helen Baker, associate director for secondary care.

[438] Rydym ni wedi derbyn tystiolaeth ysgrifenedig ac, yn naturiol, mae fy nghyd-Aelodau wedi darllen pob gair mewn manylder aruthrol ac mae gyda ni gwestiynau wedi'u seilio ar hynny i gyd. Felly, gyda'ch caniatâd, fe awn ni'n syth i

We have received written evidence and, naturally, my fellow Members will have read every word of that in great detail and we have questions based on that evidence. So, with your permission, we'll go straight to questions. The first two questions

mewn i gwestiynau, felly. Mae'r ddau gwestiwn cyntaf o dan ofal Dawn Bowden.
come from Dawn Bowden.

[439] **Dawn Bowden:** Thank you, Chair. Good afternoon. For the purpose of the record, as much as anything else, and for my benefit, can you just explain in a bit more detail what the deanery's role is, especially in supporting effective medical recruitment and retention?

[440] **Professor Donnelly:** Yes. Perhaps if I—. If it would help if I described the role of the deanery and the constructs around it and some of our activities and responsibilities—so, the Wales Deanery is a single deanery for the whole of Wales. We are directly commissioned by Welsh Government and our remit is around medical and dental training. So, it is a narrow remit, but that is it.

[441] In essence, there are a number of obligations that we're given each year by Welsh Government. Central to our activities and our deliverables is the quality management of training programmes across all specialties in Wales. That is dictated by, and we're accountable to, the regulators. Primarily, that's the GMC, the General Medical Council, who have set standards for medical undergrad and postgrad training across the UK, but also the GDC, for dental training.

[442] In addition to that, one of our responsibilities is the management of those training programmes as well as the commission and allocation of training posts across Wales. Now we do an awful lot more—what we describe kind of around that—in terms of support, including recruitment and, I think, importantly, retention. I think that's been a focus for us: what's the product that Wales is offering in terms of medical and dental training?

[443] We can recruit and have—the recruitment campaign that we've been involved with recently is very positive. But, actually, it's about retention and what is the experience within each of those health boards, within each department, within each general practice, and 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, which I think we all recognise within this generation. So, that's a kind of summary of where our roles are.

[444] **Dawn Bowden:** And what would your assessment be of, in general

terms, how effective you've been as an organisation in achieving those aims?

[445] **Professor Donnelly**: If I perhaps focus on the quality management, because that is a core activity, our quality management process is regulated, in essence, by the GMC, and I think the feedback we've had from the GMC over a number of years is that we are described as an exemplar in terms of risk-based escalation process, which, essentially, means that we triangulate data from various sources, including the trainee GMC survey, plus health boards, and then work with health boards. So, a lot of our work is working with health boards and general practices to address any training issues that arise so that we can nip those in the bud and we can move on very quickly so that trainees get a positive experience.

[446] In terms of recruitment, we're part of that all-Wales recruitment process and have been for a number of years. A number of things that we've introduced, I think, have helped. One in particular is the education contract, which is a contract between the trainee—each trainee in Wales—the local education provider, which, in Wales, is the health board trust, the medical director and clinical director level, and ourselves. So, it's a kind of tripartite education agreement. What that means for trainees is that they are empowered to feed into us on a live basis, if there are any issues around training, which we can work on quickly with the health boards and practices to rectify so that the trainees see that we're actually managing that, and actively managing it.

[447] **Dawn Bowden**: Okay. In terms of the recruitment processes themselves, do you have a view on whether the LHBs perhaps try to take on too much themselves locally and whether maybe it'd be better if there were more of a national approach to that. What's your view on that?

[448] **Professor Donnelly**: I guess you do need to separate, or we need to separate out, recruitment of trainees, which, typically, is administered by royal colleges centrally, so, there's national recruitment, as opposed to the recruitment of so-called—so-called—non-training grades within health boards, which each health board will do individually. I think there is an argument and we've had many conversations—. In fact, we've just come from a conversation with a health board, where, clearly, if there was a more co-ordinated approach across those health boards in terms of recruitment to non-training, i.e., there was less of a feel of competition between the health boards, then Wales would be better served and I think a flow of service provision—. I guess that—

[449] **Dawn Bowden**: A more joined-up approach, really.

[450] **Professor Donnelly**: Yes, I think that more collaborative approach, yes.

[451] **Dawn Bowden**: Just one final question, Chair, if I may: do you have any clear idea of the factors that might make doctors want to stay and train and work in Wales—what might be the factors that would keep them here?

[452] **Professor Donnelly**: Helen, if you perhaps would want to talk on that.

[453] **Dr Baker**: We know from various evidence sources that geography, and trainees who have built roots and established roots in a particular area, is one of the key factors to their decision making in terms of their recruitment. We've recently—because we're in the middle of our recruitment round at the moment—run a survey of all of those trainees coming to interview with us to find out exactly what are those key factors, and the vast majority have indicated that it's important that they've got somewhere where their friends are, their family is, and it's a geographical location that is known to them.

[454] Second to that, then, is the quality of training that is on offer and that is the second factor that they will look at. They're also looking for opportunities to enhance their training and enhance their knowledge and understanding. So, a lot of trainees want experience of research opportunities, which we deliver within the Welsh Deanery through our Welsh clinical academic track programme and other programmes that we've got.

[455] They also want increased opportunities to undertake and gain teaching qualifications. We've got a number of fellowship programmes that are run with the health boards in terms of delivering that, but that is something that we're working on at the moment, and we want to develop further. So, those are additional incentives and areas that they'd like us to focus on in their training.

[456] **Dawn Bowden**: Did you find—is it generally families or people that are in relationships, partnerships, that tend to want to stay here and stay together? Because I was explaining to the Chair earlier on that I was talking to a number of students thinking of going into medicine recently in my constituency. They were all young single men and women, 18, 19 years old, who couldn't wait to get out. They'd spent their whole lives in Merthyr Tydfil. They wanted to go and see the big, wide world. So, it's that kind of wanting

to keep people here, but there's an incentive for them to go out and see the big, wide world, isn't there?

[457] **Professor Donnelly:** Yes, perhaps—[*Inaudible.*]—I had the same conversation with some medical students in Cardiff uni just last week, really, where there were some Welsh-domiciled, who said, 'I've been here all of my life; I want to go somewhere else'. And, of course, I was saying, 'And you're going to come back, aren't you?' And I think that's where we need to set the conditions, whereby we want them to go out, actually, because that cross-fertilisation is so important within health. We're talking about medicine here, but, actually, it's important across health. So, I do think that, as Helen was saying, there's a whole range of issues in terms of Welsh-domiciled and Welsh people going to medical schools, but really it's a numbers game in part, but it's also about the quality of training, the quality of lifestyle. But then we have to remember that if you're a school-leaver medical student, when you qualify you're 23, 24, and they are a different generation, they do have different expectations, and that work-life balance, which is real. As someone who trained in Powys for three years—and they had to prise me out of Powys, because I would have stayed there—I would go, 'Well, why wouldn't you want to work there?', but I'm of a different generation. So, I think it's in Wales—across the UK this is in an issue, but I think, in Wales, the trick for us is marketing, marketing the product but making sure that that product is as fit for purpose, in fact, fitter for purpose, i.e. that we provide what we call the 'curriculum plus'. We have the curriculum, which is very clinically orientated, but we need to wrap around that those other experiences to make them fit for purpose to be a GP or a consultant, or—. And I think that's the trick for us to get that, because we are—I use the words 'in competition' with England, but what I mean by that is that our general flow, if we lose trainees at whatever level, it's into England. There's fewer to Scotland and fewer to Northern Ireland, and we are losing some abroad, et cetera, or to career breaks, but it's generally that flow. So, I think it's us positioning ourselves so that we're able to maximise the opportunities. And I think that will require a cultural shift in terms of just the interaction of the education providers, the health boards and, say, ourselves and the GMC. It's about that prioritisation of training as a solution for wider recruitment. If we can get the training right and that positive experience, it's such a positive benefit across the piste, really.

[458] **Dawn Bowden:** Thank you. Thank you, Chair.

[459] **Dai Lloyd:** Y cwestiynau nesaf **Dai Lloyd:** The next questions are

gan Julie Morgan. from Julie Morgan.

[460] **Julie Morgan**: To carry on with the issue about the Welsh-domiciled students and the fact that we understand that the number at medical school in Wales has actually fallen, I don't know if you could give us any reason for that.

[461] **Professor Donnelly**: Obviously, our remit is outside of the medical school remit, but I guess we would have a view. I do think this is quite a complex issue, and I think you probably have to start with the pathway of individuals from schools, and the approach of careers advisers in schools and the approach of teachers, and that kind of expectation. And, actually, I think it is about understanding of the health agenda. I'm aware of individuals, family members, who have been in school in Wales who ask me advice about medicine, and they clearly haven't been given perhaps the most accurate advice. So, I think there is an opportunity, if we think of this pathway, of us, of Wales—when I say 'us', I mean Wales—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.

13:45

[462] We have had conversations recently about—. Well, we have a whole range of simulated health facilities across Wales, some superb simulated hospitals, and, of course, through August, the real, unsimulated hospitals are quieter and there would be an opportunity for us not to just do roadshows, but to get schoolchildren in to rehearse, practice and play—because learning through play is very important, within, sort of, summer schools, for example. So, a health NHS Wales summer school for schoolchildren and for the teachers, et cetera, to pull in.

[463] I think if you then move to the selection process for medical schools, and I think we'd be the first to say we're not directly involved and wouldn't understand that completely, 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.

[464] Having said that, I think there's almost a leap of faith with this. I think

our view—actually, I'm speaking for myself now, so my personal view would be we do need to do that. It's very difficult with a multifactorial environment for us to test that in a controlled sense, but it does seem intuitively the right thing to do. But, having said that, a medical student said to me this week, 'I've been here all my life, I want to leave and come back.' So, it's complex, but I think it would be a step in the right direction.

[465] **Julie Morgan**: We do hear a lot of examples—they are anecdotal, but a lot of anecdotal evidence—of Welsh students who want to go to medical school here and seem to have outstanding grades and who may be living in places where, say, coming to Cardiff would be a great move forward in the great wide world, and who don't get in. As we said, the percentage of those students seems to be shrinking in the medical schools. So, it does seem that you are saying, really, that perhaps we ought to look at some form of mechanism to ensure that there is sort of a group where the issues of Welsh speaking or Welsh domiciled could be considered.

[466] **Professor Donnelly**: Yes. I think the anecdote is repeated, and it isn't a criticism of the medical schools where—in fact, anything we're saying isn't really criticism; it's more observation. But I would be aware that there are very—well, actually, I'm not aware of any schools within Wales—I don't know every school, clearly—that would provide coaching, for want of a better word, to practice the selection process into medical school. So, just having the grades isn't enough. There is a quite complex selection process, and I think the interview process, and a number of us have been involved in both schools, does require—or your performance is likely to be better if you've practised or rehearsed with folk who understand the system.

[467] **Dai Lloyd**: On that point, Rhun.

[468] **Rhun ap Iorwerth**: Should the grades be enough for a Welsh-domiciled student who wants to study in Wales to actually get an interview? I understand that the selection process is much more complex than that, but if you actually live in Wales, you should get to the interview stage if you have the right grades, no matter how badly you'd filled in your application form. [*Laughter.*]

[469] **Professor Donnelly**: It's an interesting question. I think, because of your caveat at the end, I would argue in terms of any standardised selection process that, really, for a level of fairness, then, I guess all of the medical schools across the UK would say what they will try and do is be fair, but what

they are looking for are certain criteria that they would argue provide evidence for the individual being able to progress through what is one of the most difficult undergrad programmes—very intense, particularly once you hit the clinical arena. It's a particular skill set. So, in fact, as I'm thinking through it, the clinician in me would argue, 'Actually, the grades themselves aren't just—'

[470] **Rhun ap Iorwerth:** I appreciate that, but should there be an effort to prod that young person a bit further to see, 'Actually, we need to make sure that you are not suitable to come to medical school'?

[471] **Professor Donnelly:** Definitely, and I do think that's where you go further down the pipeline, and for us to be able to identify those individuals and support them, if in fact we think they've got the skills and aptitude, because aptitude is a key element to all of this, and those kinds of social skills. Medicine—I'm generalising—is a kind of social interaction, generally. So, yes, I think there are nuances around this, but we'd agree the principle that we need to set mechanisms in place where we increase the opportunity for those Welsh domiciles.

[472] **Julie Morgan:** I'm interested to hear you say that, as far as you know, there is no sort of coaching or training to deal with interviews—in Wales, did you say?

[473] **Professor Donnelly:** I'm not aware of any schools that do that.

[474] **Julie Morgan:** You're not aware of any.

[475] **Professor Donnelly:** So, that's completely anecdotal from my perspective. So, it is just that. But I guess, behind that is: is that something we should be doing? If we've got high-calibre individuals in Wales who can attain at that academic level, and who possibly have the skills, should we not then provide what is provided elsewhere in the UK, which would be that kind of coaching to get through—

[476] **Julie Morgan:** And is that in state schools in England?

[477] **Professor Donnelly:** I think it's across the piste, actually. I think certain—. Obviously, private schools will target it, but—

[478] **Julie Morgan:** They've always done that sort of thing.

[479] **Professor Donnelly:** Yes, sure. I think, in certain schools in England I am aware of, where, in fact, they would have that approach because they have, if you like, a history of feeding into medicine. There's a tradition of it. I think that's what we need to get over perhaps.

[480] **Dai Lloyd:** Rhun, on this point.

[481] **Rhun ap Iorwerth:** Who should do that? You mentioned that you're not aware of the medical schools in Wales doing it, but should it be the deanery doing that?

[482] **Professor Donnelly:** Well, in terms of intake to medical school, I think NHS Wales should be doing that, with the universities and with ourselves. I think this is a Wales responsibility. I think we have to, again, set the conditions whereby any schoolchild sees it as an option and if they don't make the grades for medicine, they then think, 'Well, actually, nursing, health or science in health', because we need to push science as well. So, it's broader, I think, than just the medicine.

[483] **Rhun ap Iorwerth:** On that note, would you support a significant investment in a roadshow-type thing that goes around Wales selling the NHS? It could actually be selling good health as it does so. I know the Food Standards Agency had this—had the lorry. It travelled Wales, and why not? But actually, this is something that is very current and needs to be—

[484] **Professor Donnelly:** Definitely. I think that sounds like a really good idea in terms of one strand. I mentioned earlier about a kind of summer school as well. I do think that we could be very innovative around this and expose schoolchildren to a whole range of scientific experiences that just trigger that thought: 'Oh, right; health might be for me.' It might be physiotherapy, and that's great because we need physiotherapists. It actually doesn't matter. It's about seeing health as an option in terms of a career option.

[485] **Dai Lloyd:** Yes. Good. Julie, back to you.

[486] **Julie Morgan:** Yes. Thank you. We've heard about the possible need for some trainees to move to England for sub-speciality training. What effect does that have on recruitment?

[487] **Professor Donnelly:** Helen, I don't know if you want to pick that up around—

[488] **Dr Baker:** Yes.

[489] **Professor Donnelly:** We do have a number of training schemes that straddle, particularly in north Wales, with Betsi Cadwaladr University Local Health Board and into Mersey Care NHS Foundation Trust. I guess the theme there for us is, over the last number of years, what we've been trying to do is to make those training programmes sustainable and self-sustainable in the north. So, I guess there are risks around this, and we have talked about this recently, in that if we have trainees who want to work in the north, for example, and then we rotate them into Mersey, it's back to that, 'If they're aged 25, there is a risk inherent in that.' So, we are mitigating the risk of them not getting all of their training in north Wales by abutting into England, but actually, they may be attracted into the Mersey area, into England. So, I think there's a kind of risk. I'm not sure whether we have any data on that per se at this stage.

[490] **Dr Baker:** The programmes where we've done this and we've introduced a Mersey-Manchester component are very new. They're programmes that we've established in the last sort of few years. So, at the moment we don't have any evidence around the trainees completing their training and then deciding where to take up their consultant posts. But, as Peter's indicated, we are aware that, by mitigating the risks associated with the trainees not having to rotate between the north and the south, which was what was previously the case and why we've established those links with the north-west and Mersey, by doing so we've potentially created a different risk, which is them having access and having a peer set that they regularly interact with that is_then in the north-west and Mersey, and they may take up consultant posts if they're advertised at a better point in time in the trainees' experience.

[491] **Dr Matthews:** Sorry, could I just add? In addition to the risk—perhaps you'd agree Helen—there's also the potential benefit that people who are rotating in from Liverpool might want to stay in Dyffryn Clwyd or Wrexham or Bangor, when they're coming across and doing their sessions in the smaller district general hospitals as well. I think there probably is a little bit of balance there.

[492] **Julie Morgan:** Thank you.

[493] **Dai Lloyd:** Okay. Rhun.

[494] **Rhun ap Iorwerth:** We had some witnesses this morning—in that particular session it was emergency session and oncology—

[495] **Dai Lloyd:** And radiology.

[496] **Rhun ap Iorwerth:** And radiology. And they were of the firm opinion that we have the capacity to significantly increase training places in Wales. Do you agree with that, first of all? And if you do, why are we not increasing the number of training places?

[497] **Professor Donnelly:** Perhaps if I start off, and I might hand over to Helen half way through. I think the specialties you've identified have been recognised by the all-Wales medical workforce group as—. Based on the supply-and-demand data that we've pulled together, there is a requirement for an increase in the numbers in that workforce pipeline. And, in fact, through the interim process that we agreed with Welsh Government last year, there is an agreement and 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, which would, I think, meet the workforce demand. So that you're aware, through that interim process, there has been an agreement to increase other specialities, including geriatrics, which clearly maps to the shape of training and the demographic that we have, and general pathology, which, again, the workforce data showed that, and we had agreed then for this cycle to look at those other specialties that you mentioned. So I don't know if you want to add anything to that, Helen.

[498] **Dr Baker:** I think, in addition to that, we need to be mindful that, if we create additional posts at a speciality level, at the moment we don't have enough foundation trainees or medical students coming through the pipeline to be able to do, and fulfil, those posts. At the moment, the number of core entry-level posts that we advertise already exceeds the number of foundation trainees completing foundation by about 60 or 70 trainees. So, at the moment, if we want to fill our posts, we are relying on the need to import trainees from England or elsewhere. If we increase this without increasing our pipeline through medical schools and through foundation, then actually

all we will be doing is battling against England and other countries in order to get trainees. And by doing that, we need to make sure that we've got a very strong product that we want to sell in order to attract those trainees across.

[499] **Rhun ap Iorwerth**: Okay. Maybe if we focus on that for a short while: speaking with Cardiff University medical school, I think, there is an ambition to grow significantly the number of medicine undergraduates that we have in Wales, hopefully through the development of links in north-west Wales, and the development of medical training there. What is your calculation on the prospect, in terms of numbers, of increasing the number of medical graduates in Wales annually, if we start from next year, the year after?

[500] **Professor Donnelly:** 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. As Helen mentions there, and just to drill down to some of the numbers again, the combined output from Swansea graduate entry and Cardiff University runs at about 370 per year. The number of F1 posts, which is their next stop into foundation, is 339, so we already have a gap of 30.

14:00

[501] Whenever we get to F2, we hold onto—we retain—about 60 per cent; and we've always retained 60 per cent. Even pre Swansea medical school, we retained. So, it fluctuates, but we're around 60 per cent.

[502] If you just see this as a simple mathematical equation—I know it isn't—but if you increase the input and you keep those percentage retentions the same, we're going to keep more. I think that's put too simply, but that's the basis upon which we would very much welcome that. We think it's about: if we were to increase, where's the trick here? How can we be clever about that increase? I know there have been conversations around if there was an increase of x—and I know a number of 200 has been floating, which is fine—let's be innovative around that because, clearly, if we look at all of the workforce data that we have, and NHS Wales's intention of moving to a more integrated approach to the delivery of healthcare, just as a general principle, that will mean, in some shape or form, more community-based clinicians. Again, that's oversimplifying it—but more community-based clinicians. I do think that the trick is for us to run a parallel curriculum with either Cardiff or Swansea, or both, combined with north Wales, around a kind of community

curriculum; i.e. where the learning is in the community but also in secondary care and also—wherever. So, actually, they'd be more flexible around those medical student placements. For that to be north and west—

[503] **Rhun ap Iorwerth:** And the west as well, yes.

[504] **Professor Donnelly:** Because the evidence is: if you have exposure anywhere—actually, this is across all professions—but within medicine, if you have any exposure, even if it's negative, you're more likely to consider it. If you have exposure and it's positive, you're even significantly more likely to consider it. So, I think that increase in numbers we would welcome. There still would be a question or a call—it's a policy position, I guess—in terms of increasing the F1 and F2 places; otherwise the equation doesn't work.

[505] **Rhun ap Iorwerth:** Yes, they need somewhere to go.

[506] **Professor Donnelly:** Yes. And again, thinking of specialty, depending on the scope of the increase as it works through the pipeline, we'd need to look at the number of core—the entry level—depending on the total increase.

[507] **Rhun ap Iorwerth:** Okay. There's scope there as well, through community medicine, to develop a specialism in rural medicine in Wales. Would that be a direction you'd like us to—]?

[508] **Professor Donnelly:** Again, I think it's a very pertinent question. With our stakeholders over the last few years—the health boards, colleges, the GMC and the Welsh Government—we have been talking about a kind of rural health curriculum. So, recent conversations that the deanery has had with a number of key stakeholders, including the medical director in Hywel Dda and the GMC more recently, is that there is an option for us, for Wales, I think, to get on the front foot with this. There isn't a rural health curriculum out there in the UK. What the GMC have introduced recently is what they call credentials. So, it's a process whereby a certain skill set can be credentialed by the GMC, and therefore I have a badge attached to me—but not just a badge; I have a set of skills. So, we have a view that there is an opportunity in Wales for us to look at a rural health credential and work on that, over the next six to nine months, and for that to then steer the rest of the UK. I think that would particularly help, because I think that would act as a vehicle for clinicians to land. This is more than medicine, because I do see it as a rural health curriculum. You could visualise the curriculum itself.

[509] **Rhun ap Iorwerth:** And combining that—a real specialism—with anchoring students as Bangor medical students, or Haverfordwest or wherever you might be, would be a way to give us a better chance to retain our medically trained professionals in those rural areas.

[510] **Professor Donnelly:** Yes, definitely. Again, I think we have to be clever around that because the curriculum requirements will be at the same level as every other curriculum. I think it's not without our gift to lead on that and actually implement it. It's an idea at this stage, but I think we're starting to firm it up by having those real conversations; i.e. let's get a curriculum team together. That's the conversation I've had recently. Let's stop talking about it; let's get a curriculum team together and start to draft it. Then, as we go through this, just check with the GMC in terms of: is this viable, is this feasible et cetera. So, I think it's a huge opportunity for us to move on that.

[511] **Rhun ap Iorwerth:** We've come a long way round; we've come back to where we were before. So, you're in a position where we have 200 more graduates per year, say. Where does that leave you in terms of the need to set firm and ambitious targets for increasing training places and your ability to fulfil those targets?

[512] **Professor Donnelly:** It's a challenge. If there was—. Obviously, we would have the time period to do this because of just working through med school. If we were to match the numbers—so we just have that as a concept. If we match the numbers, we would be looking then, in this case, in this example scenario, at 200 additional F1 and then 200 additional F2. We do have capacity issues and I think we would have to look cleverly at that.

[513] But, having said that, if in fact that is a community strand, I think there's possibly more emphasis on us attaching those F1 and F2s within primary care, and I don't mean GP, but within the primary care setting. That's not without its challenges, I guess, as well, in terms of capacity, because each of those, particularly the F1s—. If foundation remains in the current form that it is—. F1s are pre-registration, so they are limited in terms of what they can do clinically on a day-to-day basis. When they're post-registration, into F2, they have slightly more autonomy. So, actually, community placements—the trainees get more out of community placements if they're post-registration because they are able to get hands on, for want of a better term.

[514] So, I would say it's doable. Now, this is six or seven years in the

future. We don't know what the foundation might look like. We also don't know if the point of registration for medics in the UK will change—currently it's the end of F1. It's under discussion about moving the point of registration to the point of qualification from medical school and possibly the introduction of a medical licensing assessment across the UK. They're going to consultation around that fairly soon and they're having workshops in Wales actually around that. So, I think the opportunity would be, if those 200 are community focused, for us to look at where we would place them, with capacity issues. I don't know if Phil has—

[515] **Dr Matthews:** There's certainly a willingness and capacity in terms of manpower in general practice to do a lot more teaching, both at undergraduate and foundation level. We already have a very committed trainer base, especially for training for general practice. Some of my colleagues might say the infrastructure in terms of premises might need some attention, but there's the ability, there's the willingness, and a number of people who want to do this out there to feed into the rural strands that Peter's been talking about. Also, there's more GP exposure in both foundation and at undergraduate level, which we know—if I can just blow that side of the trumpet—at the moment feeds into the ability to grow your own GPs and for people to work in more remote situations.

[516] **Dr Baker:** In addition, we also don't know what the landscape will look like fully for specialty training. With the 'Shape of Training' review that took place a number of years ago, medicine programmes are likely to change over the next few years, as we're embarking on the pilot for that and also plans for a pilot for surgical training. So, all of that could look very different in the next four to five years and so that would also impact upon the capacity.

[517] **Dai Lloyd:** Okay. Dawn, some of your issues have already been answered.

[518] **Dawn Bowden:** They have been, to an extent. Can I just pick up—? In relation to GPs, can I just pick up—? In your evidence, you talk about whether we ought to consider the case for setting targets for GPs, which has been done in the other nations. Can you perhaps just expand a little bit more on that?

[519] **Dr Matthews:** Yes, I think that paragraph in the evidence shows that the ratio, for instance, in Scotland, of the number of places to population is far higher than it is in Wales. Obviously, they had a different starting point in

that they've got more medical schools and all that sort of thing. But I think we do need to show some ambition in terms of recruiting to general practice. One of the restrains, if you like, is that we've had this target for over 10 years now—136 places a year. Because of that constraint, each area, each of the 12 schemes in Wales, out of necessity, has a quota, because you need to have, because of the programme structure, a certain number of hospital jobs and you need to have a certain number of trainers in that area. But I think, if Welsh Government wished to increase the number of posts, that we could, perhaps, try and fill flexibly in places like Wrexham, where you might get a field effect where you might get some more people being trained in Wrexham, for instance, and then perhaps drifting out into other areas because their training had been in north Powys or other parts of the Betsi Cadwaladr trust. I think the same probably applies to Gwent; we could certainly get a lot more people going to Gwent, and once we've got them in Wales, people put down roots there, their partners put down roots, and I think the—. Certainly, we need to focus on places like west Wales, which are the hardest hit by the recruitment crisis, along with north Wales. But if we can get more trainee practitioners and then practitioners into Wales, surely more of them will stay because they've put down roots and their partners have got jobs, and that sort of thing.

[520] **Dawn Bowden**: What sort of numbers do you think—? Because, I mean, you were talking about Scotland, which has increased to 400, hasn't it? They've got kind of double the population of Wales. What sort of numbers do you think we ought to be looking at?

[521] **Dr Matthews**: Well, they've got 400 for a 5 million population, and we've got 136 for a 3 million population. So, by that, we should be talking somewhere around the order of 200.

[522] **Dr Matthews**: An oft-quoted figure you've probably heard from elsewhere, from the GPC, is 180 to 190. Certainly, that would put us on a par with England, where the ratio—. Scotland have been a bit more ambitious and they are having trouble getting to that 400 figure, but they're over 300 now.

[523] **Dawn Bowden**: Yes, okay. And just one quick question then, if I may, Chair. I just wanted to move towards how the deanery works with LHBs, in particular in ensuring that service needs are met. How do you work that relationship to work that through?

[524] **Professor Donnelly**: Across the UK, this is possibly one of the most complex issues in terms of marrying the curriculum requirement for that trainee that year and the service pressure.

[525] This isn't a dichotomy; I think this is along a continuum. Where we get that right—. Actually, emergency medicine is quite interesting. So, on the GMC trainee survey, emergency medicine comes—. The trainees in Wales are saying that they're quite dissatisfied with the workload; i.e. they're saying they're busy. But then, at the other side, we've got the highest score for satisfaction in EM training in the UK. So, there's a kind of formula there, isn't there? What we've expressed a number of times is that possibly the best training is where the trainee is busy—not too busy where they get stressed and their performance drops—but busy doing what the LHBs and the population need. So, not too busy, but it maps to the curriculum requirement that year, because each year will be different. If I'm an emergency medicine ST4, I will have specific requirements. The next year I will have different requirements. So, the trick is marrying that and making sure that even though our EM departments are extremely busy, as you'll be aware, and extremely pressured, that the trainees feel supported, because we have the supervisors there and we have high-calibre trainers who are supporting them. So, that's an example of where we're getting it right.

[526] I guess I would go back to our quality management framework and how we work with health boards, because frequently, if a quality of training issue is flagged—and it can be flagged through a whole range of sources: the trainees themselves, through their annual review of progression; through the GMC survey; through our educational contract—a theme is that the trainee's not getting to their curriculum requirements because of service pressure, and that's something we just work on constantly with the health boards in terms of suggesting rota changes and just suggesting a whole range of things and innovations about how we can free them up and whether we can use other staff to free them up and then have an agreement. So, I think it is an ongoing challenge for us. I think in general in Wales we get that right. So again, the high-level figure from the GMC trainee survey, which is a UK survey—for the last four years we have been the best in the UK in terms of overall satisfaction, and for each of the five years for which the data is there, our score has gone up incrementally.

14:15

[527] Now, if you look statistically, I think the four countries are fairly close

together, but in terms of overall satisfaction, we have the best score, which is a positive. It is a constant balance, really. The trainees are professionals, and if an emergency arises, they will deal with the emergency elsewhere perhaps that doesn't map to the curriculum. If that happens too regularly, they may get to their annual review of progression, which is a kind of panel appraisal, and then we say to them, 'You're not progressing', but it's a systems issue because of that pressure. So, it's constantly working with the health boards to say, 'Look, if we get this right—the quality of learning—we improve the retention recruitment, the rotas are more sustainable, your medical locum bill goes down, and we're in a positive spiral', but it's that kind of medium to long-term approach.

[528] I would have to say that, in general, the health boards are very amenable to this conversation. We have to say that very upfront. I think all of the medical directors and particularly who we interface with—and they're related to associate medical directors for education—do take this very seriously and work very closely with us.

[529] **Dawn Bowden**: Okay, fine. Thank you very much.

[530] **Dai Lloyd**: And Julie to wrap up the last couple of questions.

[531] **Julie Morgan**: I was interested in what you said to Dawn about Scotland putting up its targets for GPs. Do you have any knowledge of Scottish retention of doctors who have trained in Scotland?

[532] **Professor Donnelly**: Sorry, Phil—that's for you.

[533] **Dr Matthews**: There is some evidence with their rural practice programme, where they've made great strides in trying to place and support people not just in training but afterwards in rural areas. Their retention rates are pretty good, really. I think the last document I read—they were retaining in the order of 60 per cent of people who were being trained in the highlands and islands in fairly remote—not always in the highlands and islands, but fairly remote parts of Scotland. So, there is some good evidence that it works. The World Health Organization has produced a document on what's evidential in terms of getting recruitment and retention into remote areas, and they stress the need for support and placement in remote areas from an early stage in medical training, both at undergraduate level, foundation and afterwards, and not just in medicine but for all healthcare workers. We need to expose people to community placements, rural tracks—all those sorts of

things.

[534] **Julie Morgan**: So, that is something we could possibly follow in Wales.

[535] **Dr Matthews**: As Peter said, there have been some ongoing discussions, and we very much support that.

[536] **Julie Morgan**: Yes, but we could learn from what's been done in Scotland.

[537] **Professor Donnelly**: Definitely. I think Scotland is an example. In fact, there are very rural areas in north England that kind of—. Because 'rural'—we can have a long debate about the definition of that—is, in essence, about access, I think, to a whole range of things. So, I think there are lessons to be learned, and we do have huge opportunities within the kind of rural health that we—I mean Wales—are possibly not using, but I think some of the conditions will need to change for us to be able to do that.

[538] **Julie Morgan**: Right, thank you. We've been discussing the structure and the content of the training as we've been going along. Is there any sort of one thing that you think should be changed in order to improve recruitment and retention?

[539] **Professor Donnelly**: Again, that's a very valid question and I guess I would reflect on the conversation we just had earlier with the health board. One of the key elements—not without its risks—or one of the key places we need to get to is where we have a process in place whereby we have a certain level of agility and flexibility to move trainees around to maximise their learning opportunity. So, the kind of pattern at the minute—and I'm overgeneralising—is they will be placed in hospital X for six months. Because of their employment model, they will be employed by that health board, and because of the funding model, which is a very traditional 50/50 per cent—so, the health board provides 50 per cent; we provide, as a deanery, 50 per cent—all of that builds in flexibility. So, if we say to the trainee, 'Look, we've got a really good opportunity to go to'—random hospital—'the Royal Glamorgan Hospital because they have got a paediatrician with a particular interest in X. That would add to your curriculum. We're going to send you there for a month'—the process that we currently have doesn't allow that flexibility and agility. And I think that is a barrier to us as a deanery being able to innovate in terms of allocation of trainees in a flexible manner. We are very cognisant of, if we move a trainee from hospital X to hospital Y in

another health board, the rota won't be manned there. So, I think it is about us looking innovatively at that funding model to build flexibility and agility. So, if there was that—or to at least revise that—. We have done that in terms of employment. The shared services through Velindre are the single employer for GP trainees. I think that standardised process and mitigated risk have been seen by the trainees as extremely positive, because every time they rotate, they're not waiting for another contract to be issued and they don't have to go through induction again and they don't have to go through various processes.

[540] So, I think having that agility and flexibility around the employment/funding model would allow us to be more innovative with training, and it maps to the community. If we place trainees in the community, they are going to be less likely to be available for the rota in the hospital setting and then we come into the model again and we get into a circle.

[541] **Julie Morgan:** Thank you.

[542] **Dai Lloyd:** Just a follow on on that agility—obviously, we've had a couple of lively discussions with various junior doctors over the last couple of weeks. In terms of that agility, there was mention of allowing or having the capacity to allow F2s to, say, do locums in general practice. Now, obviously, they are fully qualified and registered, but they cannot, for a whole variety of reasons, not least indemnity and contractual obligations. Would your ability to be agile be looking at that sort of stuff?

[543] The other issue that was perplexing our juniors was the performers list—you know, different performers lists—and sometimes, when you've been abroad, trying to get back into Wales and gaining access to that GP performers list can be an issue. I don't know if you want to develop your agility argument.

[544] **Dr Matthews:** Just taking them in reverse order, if I may, the performers list issue is high on the BMA's agenda, obviously, because of the cross-border issues. I think there's a general view that, if there were a way of being on a performers list in England and qualifying for Wales and vice versa, that would be useful. I know there are lots of legal issues around that and there'd need to be agreement between Governments for all sorts of things. Can you just restate the other part of your question again?

[545] **Dai Lloyd:** Just allowing F2s to be able to do locums in general practice. I know there are issues about that as well.

[546] **Dr Matthews:** Yes, obviously, there are matters in statute that would prevent it at the moment. I think one of the views put forward in the transcript I read from one of your previous contributors was advocating an F3 year, which, again, would need statutory changes. We're not able to do that at the moment. 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. I think, personally, that we need to improve community exposure at all levels of medical education, as I've said before.

[547] If I might make another point? Going back to what Rhun said earlier, if there were some parameter at an early stage of entry to medical school that could favour home-grown applicants, again, there's good evidence that, if you grow your own medical students, the value of increasing the number overall is synergised, for want of a better way of putting it. So, I think we'd support that as well.

[548] **Dai Lloyd:** Great. Thanks very much.

[549] Unrhyw gwestiynau? Rhun. Any questions? Rhun.

[550] **Rhun ap Iorwerth:** One last question, on the suggestions from some that there should be a withdrawal from national selection processes for training, at least in some areas, and that it is a system designed for the NHS in England, basically—the health education. What do you think?

[551] **Professor Donnelly:** I think, up to this point, we would feel that we have a level of influence over those recruitment processes that place us in a position where we can't, for want of a better word, protect the interests of Wales. The advantages I think at this stage outweigh any disadvantages. The risk, if we did separate, is that we would have a different selection process, and especially training, which means trainees would not be able to flow across. So, the national process, even though I understand some of the arguments against, and possibly some of them are anecdotal, because we have national recruitment, means that trainees, if they're above the bar through that recruitment, are eligible to get a job anywhere and can move across through inter-deanery transfers et cetera. I think it's that

standardised approach—you know, if I flick back 10 years, the selection process wasn't robust, it wasn't standardised, it wasn't as far as it should have been. We now have very clear and, I think, an increasingly competency-based selection process under recruitment, which is what it should be in terms of assessing skills. So, it isn't just an interview as such. You know, it's multi-stations assessing clinical aspects. So, for surgery, for example, clinical skills are assessed.

[552] So, I think at this stage our view is that being in a UK national selection—the advantages outweigh any disadvantages. I think we're constantly keeping that under review in terms of if that position changes, in terms of our level of influence, I think particularly with Health Education England.

[553] **Rhun ap Iorwerth**: One of the examples that we heard recently was from dermatologists who saw excellent training places in Wales being taken up by, perhaps, students who had qualified and had more experience in dermatology in teaching hospitals in London that made them better choices for those training schemes in Wales than students taught in Wales. But, actually, they had no intention of staying in Wales. They come here, get the training, and then go back. Is that an issue?

[554] **Professor Donnelly**: I'm sure that happens, and will happen in such a complex system. I guess I would go back to: their stated intention may be to go back to wherever, but again, if we can ensure that they get a positive experience—a more positive experience—here than the place they've just come from, then we're going to increase the likelihood, whatever the specialty, of them saying, 'Actually, the work-life balance, the service experience, the perception of the quality training and the quality of training is better here.' So, I think there will always be that flow, and I guess that medical recruitment is very complex in terms of that flow across. I would also say that those trainees coming into Wales is a very positive thing, coming from elsewhere.

[555] **Rhun ap Iorwerth**: Of course, yes.

[556] **Professor Donnelly**: So, yes, we would accept that 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 retention. What are we currently doing and what else do we need to be doing?

[557] **Dr Baker:** I would also add to that: 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 to go alone and hold a Welsh recruitment process, we'd increase that perception to trainees.

[558] **Dai Lloyd:** Okay. Phil.

[559] **Dr Matthews:** Just one final point: one common misconception is that people don't end up where they want to be, particularly in the larger specialties. We hear that anecdote from time to time. The fact of the matter is that what happens is people, basically, get their first or second preference, not just by country but within 50 miles of where they want to be. We've got good evidence to that effect as well.

[560] **Dai Lloyd:** Great.

[561] Diolch yn fawr iawn i chi. Dyna ddiwedd y cwestiynu, ac felly diwedd y sesiwn. A allaf i longyfarch ein tystion ar safon y wybodaeth, a diolch iddyn nhw'n fawr am eu presenoldeb? Diolch yn fawr iawn i chi.

Thank you very much. That brings us to the end of the questions, and therefore the end of the session. May I congratulate our witnesses on the quality of their evidence and thank them very much for their presence? Thank you very much.

14:29

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd
Motion under Standing Order 17.42 to Resolve to Exclude the Public

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac o'r cyfarfod ar 1 Mawrth 2017 yn unol â Rheol Sefydlog 17.42.

Motion:

that the committee resolves to exclude the public from the remainder of the meeting and for the meeting of 1 March 2017 in

accordance with Standing Order 17.42.

Cynigiwyd y cynnig.
Motion moved.

[562] **Dai Lloyd**: Symudwn ymlaen nawr fel pwyllgor i eitem 6, a'r cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod heddiw, ac o'r cyfarfod ar 1 Mawrth hefyd. A yw pawb yn cytuno? Pawb yn cytuno. Diolch yn fawr.

Dai Lloyd: The committee will now move on to item 6, and the motion under Standing Order 17.42 to resolve to exclude the public from the remainder of today's meeting, and from the meeting on 1 March. Is everyone content? I see that everyone agrees. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 14:29.
The public part of the meeting ended at 14:29.