Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

08/02/2017

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd. Lle y mae cyfranwyr wedi darparu cywiriadau i'w tystiolaeth, nodir y rheini yn y trawsgrifiad.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included. Where contributors have supplied corrections to their evidence, these are noted in the transcript.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Rhun ap Iorwerth Bywgraffiad|Biography	Plaid Cymru The Party of Wales
Dawn Bowden Bywgraffiad|Biography	Llafur Labour
Jayne Bryant Bywgraffiad|Biography	Llafur Labour
Angela Burns Bywgraffiad|Biography	Ceidwadwyr Cymreig Welsh Conservatives
Caroline Jones Bywgraffiad|Biography	UKIP Cymru UKIP Wales
Dai Lloyd Bywgraffiad|Biography	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Julie Morgan Bywgraffiad|Biography	Llafur Labour

Eraill yn bresennol
Others in attendance

Dr Sara Bodey	Partner Meddyg Teulu, Practis Bradley, Bwcle, Sir y Fflint (GP Survival) GP Partner Bradley's Practice, Buckley, Flintshire (GP Survival)
Dr Linda Dykes	Meddyg Ymgynghorol mewn Meddygaeth Achosion Brys, Ysbyty Gwynedd a Meddyg Teulu â Diddordeb Arbennig mewn Geriatreg yn y Gymuned, Bwrdd Iechyd Prifysgol Betsi Cadwaladr (Gorllewin) Consultant in Emergency Medicine, Ysbyty Gwynedd and General Practitioner with Special Interest in Community Geriatrics, BCUHB (West)
Lowri Jackson	Uwch gynghorwr polisi a materion cyhoeddus Coleg Brenhinol y Meddygon ar gyfer Cymru Royal College of Physicians senior policy and public

	affairs adviser for Wales
Dr Charlotte Jones	Cadeirydd Pwyllgor Meddygon Teulu (Cymru) y BMA Chair of the BMA's General Practitioners Committee (Wales)
Dr Gareth Llewelyn	Is-lywydd Coleg Brenhinol y Meddygon ar gyfer Cymru Royal College of Physicians Vice President for Wales
Dr Rebecca Payne	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Dr Heidi Phillips	Partner Meddyg Teulu, Canolfan Feddygol Fforestfach, Abertawe a Chyfarwyddwr Derbyniadau ar gyfer y rhaglen feddygaeth i raddedigion yn Abertawe (GP Survival) GP Partner Fforestfach Medical Centre, Swansea and Director of Admissions for Swansea Graduate Entry Medicine programme (GP Survival)
Dr Trevor Pickersgill	Cadeirydd Pwyllgor Meddygon Ymgynghorol Cymru y BMA Chair of the BMA's Welsh Consultants Committee
Dr Isolde Shore-Nye	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Yr Athro/Professor Dean Williams	Ysgol Gwyddorau Meddygol Bangor Bangor Medical School

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	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.

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

[1] **Dai Lloyd**: Bore da i chi gyd a chroeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. A gaf i estyn croeso i'n tystion—a mwy amdanyn nhw nawr yn y man—a hefyd estyn croeso i'm cyd-Aelodau ar y pwyllgor yma, gan gofnodi bod Dawn Bowden yn ymddiheuro? Mi fydd hi yn hwyr y bore yma, ond mi fydd hi'n cyrraedd nes ymlaen. A gaf i bellach egluro i bawb yma a hefyd yn yr oriel gyhoeddus bod y cyfarfod yma yn naturiol yn ddwyieithog, a gellir defnyddio 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 electronig arall sy'n gallu ymyrryd ag offer darlledu, a hefyd i gadw'r ffonau symudol yn ddigon pell oddi wrth y meicroffonau achos mae rheini'n amharu? Nid oes eisiau cyffwrdd y meicroffonau: maen nhw'n dod ymlaen ac i ffwrdd yn awtomatig. Nid ydym yn disgwyl tân y bore yma, felly os bydd yna larwm tân, dylid dilyn cyfarwyddiadau'r tywyswyr, os clywch chi ryw sŵn uchel yn clochdar yn y cefndir.

Dai Lloyd: Good morning, everyone, and welcome to the latest meeting of the Health, Social Care and Sport Committee here at the Assembly. Can I please welcome our witnesses—and more about them in a moment—and I also welcome my fellow Members on this committee, and also note that Dawn Bowden has sent her apologies—she's going to be a little late this morning, but she will be arriving later on. Can I please explain to everyone here and also in the public gallery that this meeting of course is bilingual? 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 turn off their mobile phones and any other electronic equipment that may interfere with the broadcasting equipment, and please keep your phones as far as possible from the microphones, please, because they also cause interference occasionally? You don't need to touch the microphones: they come on automatically. We are not expecting a fire this morning, so if you do hear the fire alarm, please follow the directions of the ushers, if you do hear a loud bell in the background.

09:31

Ymchwiliad i Recriwtio Meddygol: Sesiwn Dystiolaeth 3—Cymdeithas Feddygol Prydain (BMA) Cymru Wales a Choleg Brenhinol y Meddygon
Inquiry into Medical Recruitment: Evidence Session 3—BMA Cymru Wales and Royal College of Physicians

[2] **Dai Lloyd**: Felly, gyda chymaint â hynny o ragymadrodd, symudwn ni ymlaen i eitem 2, a'r ymchwiliad i recriwtio meddygol. Hon ydy'n sesiwn dystiolaeth Rhif 3, ac o'n blaenau ni y bore yma mae Cymdeithas Feddygol Cymru—BMA Cymru—a Choleg Brenhinol y Meddygon. Felly, rwy'n falch iawn i groesawu Dr Charlotte Jones, cadeirydd pwyllgor meddygon teulu Cymru y BMA, Dr Trevor Pickersgill, cadeirydd pwyllgor meddygon ymgynghorol Cymru y BMA, Dr Gareth Llewelyn, is-lywydd Coleg Brenhinol y Meddygon ar gyfer Cymru, a hefyd Lowri Jackson, uwch-gynghorydd polisi a materion cyhoeddus yng Nghymru o ochr Coleg Brenhinol y Meddygon. Yn ôl ein harfer, rydym wedi derbyn eich papurau bendigedig chi ac wedi craffu yn ofalus arnyn nhw, ac felly maen nhw eisoes yn rhan o'r ymchwiliad yma, ac mae yna nifer o gwestiynau wedi'u paratoi yn seiliedig ar beth rydych chi eisoes wedi'i gyflwyno i ni. Felly, gyda chymaint â hynny o ragymadrodd, awn ni'n syth i mewn i gwestiynau, ac mae'r cwestiwn cyntaf gan Jane Bryant.

Dai Lloyd: So, with that much of an introduction, we'll move on to item 2, and the inquiry into medical recruitment. This is evidence session No. 3, and before us today we have the British Medical Association Cymru and the Royal College of Physicians. Therefore, I'm very pleased to welcome Dr Charlotte Jones, chair of the BMA's general practitioners committee, Dr Trevor Pickersgill, chair of the BMA's Welsh consultants committee, Dr Gareth Llewelyn, vice-president of the RCP for Wales, and Lowri Jackson, senior policy and public affairs adviser for Wales from the Royal College of Physicians. As is usual, we have received your excellent papers and have looked very carefully at them, and so they are already part of this inquiry. Many questions have been prepared based on what you've already told us in your submissions. So, with that introduction, we'll move on to the questions, and the first question is from Jane Bryant.

[3] **Jane Bryant**: Diolch. Good morning. Your papers that we've had share

a good amount of common ground, I think, on the evidence that you've given, but where do you feel that the key current and future pressure points are in terms of medical workforce?

[4] **Dr Pickersgill**: I'd like to say that the issue is really about under-doctoring of the NHS in Wales, but across the UK as well, compared to similar countries in Europe and indeed elsewhere in the States and the Commonwealth—Australia, New Zealand et cetera. We have 50 to 100 per cent fewer doctors per head of population than they have in those countries. And with pressures on finances in the NHS, as there will be, I suspect, for many years to come, that's going to be a struggle to staff, there's no doubt about it.

[5] **Dr Jones**: Could I just add to Dr Pickersgill that I completely concur with what he said, but I would expand that into the wider primary healthcare team as well, including our practice nurse colleagues, our district nursing and community nursing colleagues and other allied healthcare professionals. So, those who are supporting the doctors of the NHS, they too are facing significant workforce problems. It's across the whole piece of the NHS in Wales, and across the UK, actually.

[6] **Dr Llewelyn**: I think that the college also appreciates that it's a whole workforce problem, from pharmacists, opticians, everybody who works or who has contact with patients—this is not just about doctors, but it's one key issue.

[7] **Ms Jackson**: It's also worth adding that it's not just that we can't fund the doctors—actually 40 per cent of consultant physician posts that we advertised in Wales last year couldn't be filled, and that was, in the majority of cases, because there literally were no applicants. So, it's worth remembering that, actually, where the money is available, we can't actually get anybody to apply for those jobs in the first place. It's not just a Welsh problem: that is a UK problem. The only part of the UK that doesn't have a recruitment problem, really, is London, so we have to ask: are we training the right number of doctors to start with, and where are they going at the end of their training?

[8] **Dai Lloyd**: Ocê. Rhun—yr ail gwestiwn.

Dai Lloyd: Okay. Rhun—the second question.

[9] **Rhun ap Iorwerth**: Bore da

Rhun ap Iorwerth: A very good

iawn i chi gyd. Er mwyn inni allu cynllunio ar gyfer denu rhagor i astudio meddygaeth yng Nghymru, hyfforddi yng Nghymru ac i weithio yng Nghymru, mae'n rhaid deall beth ydy'r ffactorau sy'n gwneud i rywun fod eisiau dod yma—ac, yr un mor bwysig, y ffactorau sy'n gwneud iddyn nhw beidio â bod eisiau dod i Gymru. A ydy'r wybodaeth gywir yn cael ei chasglu? Beth fyddech chi'n licio ei weld yn cael ei wneud yn wahanol er mwyn gwneud yn siŵr bod y darlun llawn yna gyda ni o beth ydy'r ffactorau sy'n dylanwadu ar benderfyniadau pobl?

morning to you all. In order for us to plan to attract more people to study medicine in Wales, to train in Wales and to work in Wales, we need to understand what the factors are that attract people here—and, just as importantly, the factors that would mean that they perhaps wouldn't want to come to Wales. Is the correct information being gathered? What would you like to see done differently in order to ensure that we do have that complete picture of what those factors are that influence on individuals' decisions?

[10] **Dr Llewelyn**: Diolch yn fawr. Rwy'n meddwl mai data ydy un o'r prif broblemau sydd gyda ni. Nid ydym ni'n gwybod yr atebion i rai o'r pethau rwyt ti wedi'u gofyn, a heb hynny, mae'n anodd cynllunio. Y sefyllfa, wrth edrych ar draws y gwasanaeth iechyd i gyd, yw bod gyda ni broblemau efo pam nad ydy plant ysgol eisiau mynd mewn i'r gwasanaethau iechyd, felly mae gyda ni waith i'w wneud fan yna i hyrwyddo plant i feddwl am ofal iechyd fel maes gyrfa. Rydym ni eisiau edrych ar bwy rydym ni'n denu mewn i'r ysgol feddygol—a ydym ni'n denu pobl o'r cefndir iawn, rhai sydd efallai'n mynd i aros yng Nghymru? Pa fath o brofiad maen nhw'n cael wrth fynd o gwmpas Cymru? A ydym ni'n rhoi profiadau da iddyn nhw pan maen nhw'n mynd, dywedwch, o Gaerdydd i fyny i ogledd Cymru? Wedyn, mae gyda ni'r meddygon

Dr Llewelyn: Thank you very much. I think data are one of the main problems we have. We don't know the answers to some of the questions you've asked, and without that, it's very difficult to plan. The situation, looking across the health service in its entirely, is that we have problems with why schoolchildren don't want to join the health service, so we have work to do there to promote children to think of healthcare as a career path. We should also look at who we attract to the medical school—are we attracting people from the correct background, people who maybe will want to stay in Wales? What sort of experience do they have in going around Wales? Are we giving them good experiences when they go, let's say, from Cardiff up to north Wales? Also, we have junior doctors—are they getting the experiences? Are we looking after them properly? Are we

iau—a ydyn nhw'n cael y profiadau? A ydym ni'n edych ar eu hôl nhw'n iawn? A ydym ni'n hybu pobl i ddod fewn? Ac unwaith maen nhw i mewn, a ydym ni'n edrych ar eu hôl nhw pan maen nhw i mewn? Mae'r rheini'n gwestiynau mawr.

promoting people to come in? And once they're in, are we looking after them once they've arrived? Those are big questions.

[11] **Dr Jones**: I think that's all quite correct there, what Dr Llewelyn says. I don't think we're capturing the information properly around our workforce numbers. And it's not just about total headcount, it's actually about the clinical commitment that they're able to give to the NHS—and that's across the whole workforce. I don't think that we are linking in enough with our colleagues, who are perhaps capturing this in different ways across the UK and wider, and looking at where that works and where it doesn't work and actually improving it for Wales.

[12] I think there have been some improvements in the last year with the campaign. Certainly within general practice we are hearing that there's a rise in applicants. There was certainly a lot of interest in posts across the healthcare spectrum and I think what we need to do is to make sure that any expressions of interest are followed through, not just those who apply but those who don't apply and why that is, and whether there are factors that we can address for the future.

[13] We are promoting Living Well, Living Longer in Wales—I think that's fantastic; it's a wonderful place to live and work—but I don't think we're promoting highly enough the quality of the training experiences. I think we have to be cognisant that there are still some myths out there—that you have to speak Welsh to work in Wales. Whilst we want to promote and protect the Welsh language and improve the knowledge of the culture of Wales, that can be done whilst one in working in Wales, but we need to remove that myth that you have to physically speak Welsh, but allow opportunities for developing that where they can.

[14] We need to remove the myth that you will be placed anywhere in Wales, because that can be a barrier for some people if they've got no idea where they're going to work in Wales. We know that there is choice within the system, but we need to promote that. I think we do need to be cognisant of many people coming out of university these days with significant debts—why it's cheaper to live in Wales and you get a much better work-life balance—

and also looking at opportunities for their partners and their children, because people are coming out of postgraduate schools with partners and children, and even from undergraduate schools. We need to make sure that there are opportunities for their spouses, good childcare, good schools, and that we're promoting what's available out there.

[15] I don't think we follow people through in training enough in terms of where they end up working. I think we need to widen access. I know that you have an expert coming in in the next session to talk about how they're working on widening access. I think we need more places. I think we need to make it more attractive for schoolchildren to choose to do medicine these days—specifically on medicine—because if they're looking at medicine as a career across the piece and thinking, 'Actually, if I'm a bright child, why would I choose medicine?', we need to say, 'Choose medicine in Wales because of the opportunities it brings to you and your family.' I think we need to link into those medical schools that have Welsh students going to them and make sure that they're aware of the attractiveness to come back to where they've got family links or links with a geographical area.

[16] But, as I say, there has been some improvement with the initiatives that have been brought, particularly for general practice, the incentives around paying for exam fees has been very, very welcomed by the profession. But more needs to be done and we need more momentum—not forgetting about those healthcare professionals we have working now and keeping them within our workforce and making sure that they are able to do the job they're trained to do and that they're enjoying their job, because that is how we will foster excitement within the up-and-coming generation to take on long-term careers in healthcare in Wales.

[17] **Dr Pickersgill**: Far be it from two neurologists sat here, because we're both in the same profession, speciality, to blow our own trumpet, but in neurology training across the UK, Wales has been top, I think, in four out of the last five years or three out of the last four, and that kind of reputation gets people wanting to come and work and train in Wales. General practice is very good as well, in the top quartile consistently across the whole of the UK. People don't know that. If you're looking at that specialty, you will, of course, look into the background, but we don't make enough of that, I don't think, as a country, as a Government, that, actually, training here is really good. And then there's the lifestyle and the cost of living and all the other things that are rather more obvious to those of us who are here, but maybe not to those of us who are not here.

[18] One of the points I think it's worth stressing—certainly, I saw it in the written evidence time and time again—was that the number of Welsh applicants to Welsh medical schools is going down and we really need to know why and reverse that, because, when you come to medical school here, you tend to stick, like you do wherever you go. And when the Welsh schoolchildren go to Newcastle or London or Scotland, they'll probably stay there. Some will come back, but mostly they'll stay there.

[19] **Rhun ap Iorwerth**: Beth rydw i yn ei weld yn ddiddorol iawn, ac rydw i'n ddiolchgar i chi am eich atebion—beth rydw i'n meddwl sy'n ddiddorol ydy ein bod ni'n clywed hyn dro ar ôl tro. Mae'r ffactorau rydych chi wedi'u crybwyll y bore yma yn rhai sydd yn cael eu codi yn gyson, ac eto mae'n ymddangos nad ydy'r *issues* yna'n cael eu taclo. Beth, felly, sydd angen ei wneud er mwyn gallu defnyddio'r pryderon yna—y ffactorau yna rydych chi wedi'u henwi—fel sail ar gyfer yr ymgyrch i ymateb i'r heriau? Ai mwy o *urgency* gan Lywodraeth ydy o? Ai ffurfioli'r ymateb i'r *issues* yna? Beth?

Rhun ap Iorwerth: What I find very interesting, and I'm grateful to you for your answers—what I find interesting is that we hear this time and again. The factors that you've described this morning are ones that are raised regularly, and yet it appears that those issues are not being addressed. So, what needs to be done, therefore, in order to be able to use those concerns and those factors that you've described as a foundation for a campaign to respond to those challenges? Is it greater urgency from the Government? Is it to formalise the response to those issues? What is it?

[20] **Ms Jackson**: One of the things that we've been talking about for a few years now is a more joined-up approach to recruitment—that, actually, a lot of the messages are different between health boards. Apart from the occasional one-off campaign, we don't have a very structured approach to recruitment. Something that, I think, has come up in every bit of written evidence that I've seen is that lack of a strategic vision for what the NHS looks like in 20 years. If you consider that it takes 15 years to train a doctor, it's very difficult to start training doctors now for the NHS in 20 years' time, without knowing exactly what the vision for that NHS is.

[21] We've been calling for a national workforce plan for some time now, because, as far as we're concerned—and I think that was the point that you've just raised—the data collection, the data sharing between health boards, we're not aware that that's happening in any kind of structured way

and it is incredibly difficult, given that for many of our specialties in Wales, we have very small numbers. Ideally, we'd be looking at this on an all-Wales basis and saying, 'Well, actually, does one health board need five specialists and the health board next door only has one?' Are those health boards sharing that specialist load? Are they commissioning that work between each health board? We don't know—we honestly simply don't know. The statistics that I can give you from our workforce paper, they are all gathered by the RCP itself. So, those are our data. There are very little publicly available data from NHS Wales or health boards. Even when you FOI things, it's quite difficult to get really robust statistics.

[22] **Rhun ap Iorwerth**: So, you are having to FOI in order to find out the statistics that you need.

[23] **Ms Jackson**: We have FOI'd, but we also conduct—we have a medical workforce unit that looks at the numbers across our membership, across the UK, and we run our own census, we run various medical workforce surveys, and a lot of the data that we are able to then use to try and influence change, they are our own data that we've gathered from our own members.

[24] **Rhun ap Iorwerth**: What are your thoughts on you having to FOI to find out data that you need to build up a picture of how to take your profession forward?

[25] **Ms Jackson**: In an ideal world, it would be publicly available and also, importantly, easily understandable. I imagine that it would be pointed towards StatsWales or various NHS repositories, but, if anybody's ever tried to look through those Excel tables, they're not fun.

[26] **Dr Jones**: Can I just make a point that the workforce group for primary care has made some significant improvements and the plan is there? There's not enough momentum at the moment, but I believe that having the Minister leading that has meant that things have happened perhaps sooner than they otherwise would have. Because I have spent many years of my life, and hours of my time that I will never get back, in workforce meetings, going round and round the same difficult position all the time on the workforce for the future. What we know is that we seem to focus on head count, not actual clinical commitment—I think that's across the piece.

09:45

[27] We know that we're going to need more doctors, so we need to be planning for that. We know that the current number of doctors we've got is inadequate—focusing primarily on doctors at the moment—so we need to expand that. And, as I said, we need more momentum. We need to be linking into the workforce statistics that are available, and using the resources of people like Health Education England in England, but we need to be having some robust workforce measurements coming from health boards, and I would concur with Lowri that, actually, it's very, very, very difficult to get that information. It's also very difficult to get information on vacancies that are available outside of primary care within secondary care, because you just cannot find out. We know that there are consultant vacancies. The health boards tell us that they have difficulty finding the right calibre of applicants. They're having difficulties finding the right calibre, but, equally, they say there's no point advertising. But if I was training in England, thinking, 'Well, I've got family in Aberystwyth, I'll have a look to see what jobs there are', if they're not there to see, how on earth am I ever going to come? There's a lot of that that goes on. I think we have to be transparent. Yes, there are job vacancies. Yes, there are challenges for health boards. But, actually, let's be honest about it, and let's find a way forward. But you need to have momentum behind that. It's pointless us just talking about the problem; we need to actually find the solutions, and, hopefully, we're going to bring some of those to you today.

[28] **Dai Lloyd**: Angela, some of this is partially answered, but carry on.

[29] **Angela Burns**: Thank you, and thank you for your paper. A lot of my questions have been answered, but I just wanted to raise your eyes a little bit to national pay structures and national recruitment structures. Last week, we heard some interesting evidence from junior doctors, and, particularly in emergency medicine and paediatrics, were talking about how they would further their careers. You've cornered the market in neurology here, which is excellent, but, of course, other specialisms are not in that position. So, we were listening to a junior doctor, for example, saying that she really wants to become a neonatologist and move on, but she's going to have to leave Wales in order to pursue that career, more than likely—I mean, heavily more than likely.

[30] So, I just wanted to get your views on the tensions that you think exist between having a Wales national structure, a UK national structure, and the banding issues and the impact that that might have on speciality recruitment and training.

[31] **Dr Pickersgill**: The issue about the training rotations is a very good one, and of course it depends what speciality, or sub-speciality, you're interested in. There is an increasing tendency for surgeons, physicians, to not just concentrate on a broad speciality, so gastroenterology for instance, but a very small part of that speciality, so inflammatory bowel disease, for the sake of argument, or neurology MS, like I do, or stroke medicine, or headache or whatever. And, sometimes, if you really want to be the top dog in a region in Wales, in Cardiff or whatever, and an expert in a small area like that, you have to go elsewhere for training, whether it's post-graduate, or even as a consultant getting experience elsewhere, going on sabbaticals, et cetera. And that kind of thing does need encouraging, but you need to ensure that the doctors who are making the commitment to try and learn and be the expert in an area like that are encouraged to (a) do that, but (b) return to, and bring their expertise back to, Wales.

[32] The issue more generally about recruitment—you know, emergency medicine, A&E, for want of a better expression, they have about a 25 per cent, I think, vacancy rate in their middle-grade doctors, the registrars, broadly. Paediatrics, child health, it's 10 to 15 per cent, and, in other specialities, it's higher. I heard yesterday from a surgeon in Gwent that, for core surgical training this year, the number of applicants has reduced by 30 per cent over about three years to Wales, and that's worse than it is England, although it is a picture across the UK; applications are generally going down.

[33] The issue about cross-border rotations is a good one, and I'm glad you raised it, because we have not just the issue about the unattractiveness, for some people—but not everybody, of course—of having to, in some specialities, rotate from north to south Wales across a four or five-year training programme, which is a big upheaval, actually, but the reluctance, I think, of adjacent deaneries, so, for south Wales, the Wales Deanery and the Severn Deanery, and, in north Wales, the Mersey Deanery, joining up and making fantastic possibilities in terms of training rotations. So, a year in Bristol for south Wales trainees, or Oxford—it's not that far—or Liverpool or Manchester if you're training in north Wales, depending on the specialty. There are fantastic sub-specialty training opportunities in all these cities in Wales and in England, but we've got to make sure we're not completely insular about that, because, like the neonatologist you've just talked about, they may not be able to get the right experience just in Wales to make them attractive in the general job market, whether they want to stay in Wales or not.

[34] And then you raised, I think, the issue of contracts. The new junior doctors contract in England is, of course, not particularly welcomed by the junior doctors in Wales and, as a general point, that's not something that the BMA or, indeed, junior doctors would look forward to having. But the stance of the Government of not wanting to impose—never wanting to impose—contracts on any group of staff in the NHS in Wales is certainly very welcome, and that's something we keep telling everybody lots. There is an issue about the basic salary scales, and, in particular, for those small number of specialties where there's little or no on-call—so, pathology, I know you've had some evidence on. Those guys could lose £45,000 over a training rotation, which, when you've got big student debts and are trying to buy a house and raise a family, isn't to be sneezed at, let's be honest.

[35] **Angela Burns**: And, as you go through your career, is there a growing pay differential between England and Wales in terms of salary that you might earn?

[36] **Dr Pickersgill**: Charlotte will answer for general practice, I know, but, in terms of specialist practice consultants, under the current English and Welsh consultant contracts, there are differences at different stages, but, over a whole career, there's not a lot in it. But the English consultant contract is currently being negotiated. It may well be imposed by Jeremy Hunt—who knows—and we don't know what those numbers will look like. But initial soundings are that there will be a much more attractive salary scale for new consultants in England.

[37] **Dr Jones**: With respect to GPs, there is a differential; it's about £10,000 to £15,000. That is reducing, but not reducing quickly enough to actually—. If somebody's on the border, say, in Newport, they may choose to work in Bristol. If they're interested in north Wales, they may choose to work in Liverpool or Chester, and we have seen that in action. What I would say, though, is that the main differential is largely due to the expenses that GPs—. The money that comes into the contract isn't for GP earnings; it's for the provision of the entire contract there, and the biggest expense there, as I'm sure you already know, is staffing. And a lot of those changes have been imposed from Westminster in terms of the expenses for staffing, which impacts greatly, actually, on general practice, the income you can take back from that. But there is a differential—we have to be honest about it. We can promote the other benefits of living and working and training in Wales, but we have to be honest about it and we are making strong representations to

address that through increasing resources into the contract and addressing some of the expenses elements separately. But practices do need additional resource and support urgently in order to keep general practice going.

[38] **Dai Lloyd**: Rhun, cwestiwn byr.

Dai Lloyd: Rhun, a brief question.

[39] **Rhun ap Iorwerth**: Is there a case for the introduction of golden hellos at certain parts of a doctor's career in order to bring somebody in, in exchange for a five-year commitment, or whatever it is, to the NHS in Wales?

[40] **Dr Jones**: Certainly, within general practice, there is the availability of incentives in those difficult-to-recruit areas, and I understand that that has had a positive impact on recruitment, which will start in the next year. Also, paying towards exam fees, which are inordinately expensive for general practice trainees; that has been welcomed as well. I actually had a golden hello way back yonder when I started. It was a payment of £5,000 to incentivise me to stay in general practice. There was no attachment to it, from what I recall, in terms of duration of stay within the area. I was going to stay anyhow, so I think what we need to do is to actually target those payments to areas where they're having difficulties recruiting—or, actually, are we looking at it the wrong way round? Should we be looking at the model of how we provide general practice, and should we be looking at the pressures that are making people choose maybe not to go into practice in Wales or within a partnership, and actually looking at how we could invest and use those moneys better? I think there's an argument for both, but we've got to make sure any moneys that are used are used effectively, given the constraints we all face in Wales.

[41] **Rhun ap Iorwerth**: And in secondary?

[42] **Dr Llewelyn**: A hefyd ar draws y gwasanaeth iechyd i gyd. Os oes yna arian yn mynd i gael ei roi, mae'n rhaid i ni feddwl am yr holl system, rydw i'n meddwl.

Dr Llewelyn: And I think across the entire health service. If money is being given for this, then we have to think about the whole system.

[43] **Rhun ap Iorwerth**: Yn enwedig pan fyddwn ni'n sôn am y costau enfawr o gyflogi *locums* ac ati, mi fyddai gwneud taliad i ddenu rhywun llawn amser i ysbytai yn gallu bod yn

Rhun ap Iorwerth: Particularly when we consider the huge costs of employing locums and so on, making a payment to attract someone on a full-time basis to hospitals would be

rhywbeth deniadol. very attractive.

[44] **Dr Llewelyn**: Ydy. **Dr Llewelyn**: Yes.

[45] **Ms Jackson**: It may be worth also remembering that, actually, after a certain point, the money is less important to trainees than the work-life balance. So actually, when we talk to trainees, they're earning very good money for people of their age already, but they just don't have any time to spend it. So, our work with trainees tells us that actually the want mentorship and leadership opportunities, they want more clinical leadership and research and quality improvement projects. They want to free up some of that time from providing that service to actually developing themselves and their careers. So, while golden hellos may be part of what might attract them in the first place, keeping them here actually is a lot more nuanced, and actually improving that work-life balance, and part of that then is making sure that there are enough trainees so that they're not constantly covering trainee rota gaps.

[46] **Dr Jones**: Can I just say something about the use of locums, if you'd indulge me? I think that, whilst we understand why locums have to be utilised within the whole of the healthcare system, I think somebody somewhere should be asking the question: why are we using a locum? What's preventing that person from taking up a substantive post?

[47] That does bring me back to the advertising of vacancies. I have a very good friend of mine who was a locum consultant in NHS Wales in emergency departments and earning a very good salary, and wanted to take a substantive post, but there were none being formally advertised, and although he had informal conversations with health board staff, and I think things are now moving, there was a whole year when nothing was changing and he wasn't being made aware of when they were going to advertise any vacancy to actually apply for one. That's something we've got to change—we've really got to change.

[48] **Dai Lloyd**: Okay. Angela, briefly, then Julie.

[49] **Angela Burns**: To Charlotte and Lowri, really: Crown indemnity for GPs. Would that keep them and attract them?

[50] **Dr Jones**: Well, for general practice, Crown indemnity doesn't actually exist.

[51] **Angela Burns**: No, I know, but—

[52] **Dr Jones**: So, the Welsh risk pool, would that help? The Welsh risk pool is funded by the NHS in Wales, by the health boards, so would they take on covering GPs at no cost? That's not something that's ever been offered. The Welsh risk pool itself does not actually cover every aspect of indemnity, so it looks after the organisation rather than the individual. It only covers clinical instances, so the other aspects of a complaint or a claim, such as around disciplinary proceedings, GMC proceedings, criminal proceedings, anything like that, or professional issues, it does not cover. So, therefore, it would give you some cover but not all cover. As we all know, when a complaint is made against the profession, it often covers an array of areas and, actually, if you have Welsh risk pool cover and additional cover, it may actually cause the GP or the doctor to fall in the middle there and be a little bit vulnerable to not having all aspects covered.

[53] **Angela Burns**: I have to say that you are the first GP I've spoken to who's not a fan of trying to get them to pick up the indemnity.

[54] **Dr Jones**: Oh, it's not that I'm not a fan of picking up the indemnity. What I'm saying is that it's a very, very, very complex area. I've been intimately involved in the negotiations in England and I've done numerous papers for Wales. I've been involved in the implementation of Welsh risk pool for out-of-hours care. It's not that I'm against it. It's an extremely complex area and what we have to do is make sure that what is in place for GPs and any doctor is the right cover and that it covers them for all aspects of a potential claim. So, it's not that I'm saying 'no'. I'm saying it's one of a range of options. It's actually in a paper that I've given to Welsh Government. I wrote the 'Focus on…' document for the BMA as well in England, and you will see in that that it's something that we can't just say, 'Right, we're going to do x' without thinking it through, because, say you bring in Welsh risk pool tomorrow—great, they can go and get top-up insurance. There's a run-in and run-off period for claims, because they come in up to six years later, and, as I say, we need to make sure that the individual is having the right cover as is the organisation and NHS Wales.

[55] So, it's extremely interesting. It's probably worth a whole committee hearing on its own, and I'm sure I could bore you all to tears for a long time. I'm very happy to pick that up separately if you'd like to, but it's not quite as simple as just having Welsh risk pool. Actually, a lot of people think it is, and

when you get into the detail of it, it really isn't. We are, though, committed to addressing that going forward, and it will be part of our GP negotiations for 2017-18, and I do actually have a date in the diary to take that forward. I have to say that Welsh Government are committed to working on this, because they know it's a huge problem for GPs and the wider teams they're having to use, because, of course, we are liable for those healthcare professionals that work delegated from us.

[56] **Angela Burns**: Is your paper in the public domain?

[57] **Dr Jones**: I'm more than happy to share it with anybody. It's not private at all.

[58] **Angela Burns**: Would that be all right, Chair?

[59] **Dai Lloyd**: Yes.

[60] **Dr Jones**: Yes, of course.

[61] **Angela Burns**: Thank you.

[62] **Dai Lloyd**: Julie, you've been very patient, and some of your prepared questions have been asked.

10:00

[63] **Julie Morgan**: Yes, thank you. There were a few things I wanted to pick up on on the way, but they've sort of passed now. It was just, really, following on what, I think, Lowri was saying about GPs practising. I had a meeting with a GP in my constituency last week, with small children, and, basically, she was saying that she was really considering giving up because the burden was too great managing the work-life balance, and was feeling that it almost wasn't worth doing. The number of patients hadn't increased, but the complexity of the patients had increased, and she said it was difficult to get a new partner to come in when somebody had retired. I just wondered if that was something that you saw all over Wales and whether that is a typical sort of situation.

[64] **Dr Llewelyn**: I think that—not particularly for GPs; I can't speak for GPs—generally, the main issue is the workload. In all the things that we've looked at, that's the key thing and, as Lowri was saying, getting that life-

work balance right. I think that we need to be a bit more savvy about how we do that better. Charlotte will talk about the general practice—.

[65] **Dr Jones**: Goodness me. I could go on another day on this. I'm surprised she says that she's not seeing more numbers. That's certainly not something I've heard anywhere else—.

[66] **Julie Morgan**: It's the complexity she said—.

[67] **Dr Jones**: The complexity is going up, the workload demand is going up significantly, as are the other challenges facing general practice and, actually, the whole of the healthcare system. What we need to do is to make sure that we address all the various pressures, so that's the workload pressure that we're facing, the recruitment problems that we're facing and, of course, the resource issues. There's a perfect tsunami here just waiting to happen. We've been warning about it for many years. There have been some moves to address some of those pressures. So, on the complexity of the care, we've got more healthcare professionals coming in to work through clusters. We need more of that because it's not making enough of a difference day to day. We need the resources to allow GPs to more strategically plan and deliver care, and have the time to review how things are working at their own individual practice level and across the wider geographical area through the clusters. But we also need the resources as well.

[68] So, it's not just about recruiting GPs; it's about the practice nurses to support, it's about having clinical pharmacists to support and physios, so that, actually, GPs can do the job they've been trained to do, which is what they want to do, rather than having to do the complex care as well as, say, a form for picking the rubbish up from the back door, or personal independent payment forms and reports, for which, actually, the GP report has absolutely no benefit to the individual claimant and is putting a huge problem within the system of additional administrative bureaucracy that we do not need. We are trying to work on those issues. They are, again, very difficult ones to unpick and to get the right system in place. But we are very aware of the challenges that individual GPs and individual practices are having, and we are committed to working on that and, again, working to solutions collaboratively with Welsh Government to address those.

[69] I would like to just bring in slightly though here—and this will probably be of big interest to the committee—that if we had a shared

agreement going forward in terms of a strategic vision—and we have an agreed plan for primary care specifically, going forward—the implementation of that at a health board level can be difficult. Actually, at times, it feels that it is obstructed at the health board level, and I ask you as a committee: what levers do you have to make sure that health boards are taking forward the strategic vision for the NHS in Wales? I think that's something that does need to be looked at, because the reports that I'm getting back and my sense is that it's not always followed through in, perhaps, a timely fashion or in the way you would want it to. I would specifically raise that the release and use of cluster monies to transform general practice, I don't think, have enabled the transformation that was envisioned at a national level and, certainly, general practices are not feeling the benefits of that.

[70] **Julie Morgan**: So, when you say it's obstructed by the health boards, you mean deliberately, sort of not—

[71] **Dr Jones**: I'm not saying deliberately. All the health boards are in a difficult financial situation and they're trying to balance their books. Sometimes it can be difficult to see the wood for the trees because there is such pressure on services. But I do believe that, if there is a shared vision, then that has to be delivered, and I'm asking what levers you actually do have to make sure that that is delivered in a timely fashion to the healthcare professionals working on the ground. It's not a problem peculiar to Wales; I understand that similar is happening in other parts of the UK as well. But I would ask you to make Wales different and actually make sure that the transformation does happen when an agreement is reached and the resources are given.

[72] **Julie Morgan**: I would have thought that was something we could include in our report.

[73] **Dr Llewelyn**: I think the issue, perhaps, has been that we've all been looking at our own little bits—so, hospital care, primary care—and that we've not actually, really worked together in a more constructive way than perhaps we could have. I think the report that we produced points towards that—that we have to change the way that we work. So, general practice may mean that we need to be moving physicians with special interests to be doing more clinics in the community so that they can support general practice a bit better. So, there are quite a few things that we can do, because the patient cohort has changed dramatically, hasn't it, over the last 20 years? We've now got patients with multiple comorbidities and the population is much older,

and, so, much of the care is being moved to a community setting, and that's what we want. It's about how the hospital bit of it can support that in a slightly different way to what it's doing, rather than just accepting patients in all the time and trying to look after them.

[74] **Dr Jones**: And I think it's fair to say that, on a daily basis, the pressures that are faced across the piece—we actually need to build in strategic time for the clinicians who are delivering services to have that time to actually look at: are we providing services in the best way possible?

[75] **Dr Llewelyn**: There are models—there are diabetologists who do diabetes clinics in the community, looking after those more complex cases. We've got an example in Cardiff and Vale. So, there are good practice examples, and we just need to spread that about a little bit.

[76] **Ms Jackson**: That is the old story, though—there are good practice pockets all over Wales. Whether those are then being joined up, that's another question. For example, on that theme of the need for a strategic approach while also, I suppose, firefighting, we've got a great project in north Wales where we've collaborated with a team at Ysbyty Gwynedd on delivering telehealth. So, specifically patients needing palliative care, and a couple of others with chronic diseases, can now stay at home in their village in rural Gwynedd and teleconference in to a consultant at Ysbyty Gwynedd. It's saving a lot of them up to two hours driving each way and it's saving their families from taking a day off work to take them to those appointments. We've got 80 per cent patient satisfaction with this new approach. Everybody's happy with it. But can the project team get a meeting with the executive board to talk about how they could expand that? Those meetings get bumped on a constant basis because they're firefighting. We appreciate that health boards are busy at the moment trying to stop ambulances from lining up outside the door, but, actually, what we're not doing in a strategic way is looking at those pockets of good practice and giving those time to flourish, grow and to really expand to make sure that they're treating more and more patients. Because, every single patient you can treat in a GP clinic through a telehealth conference in rural Gwynedd, that's one less patient coming in to Ysbyty Gwynedd and sitting in a clinic for four hours while everything overruns.

[77] **Dai Lloyd**: Caroline Jones, y cwestiwn nesaf.

Dai Lloyd: The next question is from Caroline Jones.

[78] **Caroline Jones**: Diolch. Is it fair to say, though, that change takes a long time to implement? You know, patients have to get used to the changing environment of primary care, and it's going to take time to filter through. What are your views on that?

[79] **Dr Llewelyn**: Yes. So, the whole thing is changing—that is, everything is moving. The patient cohort is changing, and we've got to put in some more robust preventative planning with diabetes, obesity, making sure that the population is healthier. And the workforce is changing. In my era, you wouldn't take a gap year; it wouldn't happen. So, doctors now are looking more at their whole career pathway, working until they're in their late 60s, and they're having breaks. They're having a year or two of a break, usually at the end of foundation 2 year—at the end of core training 2 year, they will have a break, and we need to see what they are doing—many go abroad. Can we get them back—making sure that we've made connections there? So, workforce planning is complex, and it's something that you have to be on top of all the time, because everything is shifting. It's sort of shifting sands, really, and we've just got to be on top of the game with it.

[80] **Caroline Jones**: I was thinking more in the line of educating people, perhaps, to go to the pharmacy as opposed to the doctor. I was looking at the type of change in that respect, which will take time to implement, and once the public are educated in these preventative types of ways, then the GPs and primary care will eventually see the benefits. That's the term that I was looking for.

[81] **Dr Llewelyn**: Yes. So, there's a cultural change isn't there, and maybe we need to be a bit more vociferous, really, in the way that we tell people that pharmacists—.

[82] **Caroline Jones**: Communication.

[83] **Dr Llewelyn**: Yes, communication too.

[84] **Dr Jones**: I think, really, speaking on the self-care agenda, there needs to be a robust plan for actually taking that forward. I set up an out-of-hours organisation back in 2004—a very successful one—building on the old co-operative model where we'd all cross-cover everyone's patients, and actually I've seen, since that time, such a change in patient attitude towards medicine. It's more of a convenience and a want, rather than a need and appropriateness, and we need to change that. I think the clusters are an

exciting opportunity in order to educate the local population as well, and in terms of engaging with our clusters—our pharmacists, our optometrists, our social care, our voluntary sector—you know, in terms of actually being aware of all these organisations, and how we can all help each other maybe through social prescriptions as well, and through changing people's attitudes.

[85] But I do think the self-care agenda needs a robust plan for that. I've never seen one anywhere for taking that message forward, because it is something that needs to be taken forward, given how the media play into some of these things and actually make situations worse. I'm thinking around measles and meningitis—you know, parents reading these will see their child's got a temperature and they may have a bit of a rash, and because they haven't got mum, dad, the wider community, friends or neighbours, who they would have otherwise used, maybe years ago, for a second opinion, they will naturally default to the service, whether they need to or not. I understand that, but we need to start reversing that and get a proper robust self-care agenda. Not making it an obstructive approach to healthcare, but actually saying, 'This is how we can provide it', which is appropriate and good for the future.

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

[87] **Ms Jackson**: I think it's also worth remembering that, while there are huge pressures on general practice and primary care, at the other end, what our doctors are finding—those who are working on the general take—is that, actually, very few of those patients turning up at A&E or at the acute medical unit don't need to be admitted, but they actually only need to be admitted for two or three days, because they need to be treated for an acute episode, but then, ideally, discharged within two or three days. What we're finding, actually, is that in some hospitals—and it's one of those examples of 'statistics can prove anything'—the better they get at ambulatory care, i.e. people arriving, turn them around and send them home, the average length of stay is going up in those hospitals. So, the better we get at ambulatory care—and we are in some hospitals getting very, very good at that—there's a knock-on effect, because the people who are being admitted are staying for 30 days or longer because of the lack of social care options available to them. And, actually, when you speak to our hospital doctors, they are telling us that the two biggest things by far that are causing them problems are the inability to recruit, but also the lack of social care options and the inability to discharge patients once they're—. So, we talk a lot about people turning up at A&E inappropriately. Actually, most people who come to A&E are there

because a health professional of some sort has told them to go, but they don't need to then stay in hospital for longer than a few days. But they are then taking up a bed, because once you're in the system it's difficult to leave the system.

[88] **Dr Jones**: We find the social care challenges in primary care very difficult, because sometimes there is no other option other than to send them into hospital. There are some very, very good examples of ambulatory care units working with our colleagues in secondary care and primary care, and that's working very, very well; it's exciting. Again, I don't think we promote how these exciting portfolio-type ways of working are out there, again, to attract people in, saying, 'You're not going to be doing just this avenue of work; there're all these opportunities out there.' We don't spend enough time promoting what's good about what we're doing in Wales.

[89] **Ms Jackson**: The traditional model of training has always been that you do five years undergrad, you do your four years general, you do your five years specialty, and you do this quick run-through, and you become a consultant by your mid-thirties. Actually, increasingly, with the generation coming up now, they don't necessarily want that. As Gareth said, they want maybe a gap year, maybe they want to do an MD, maybe they want to take a bit of time out for research, and maybe they want to take some time out to locum in different specialties while they decide what they want to do forever. So, there's much more openness to portfolio careers, and I don't think the NHS in Wales has caught up with that. Really, we should be offering clinical fellowships—you know, two days in the community, two days in a hospital clinic, maybe a day doing research. We should be building more of that. We're operating on a scale that means we could, in theory, come up with some really innovative job descriptions and not just be advertising the same old job descriptions with the hope that maybe this time we'll find a candidate.

[90] **Dr Jones**: And, thinking about neonatologists, having bursaries to allow them to go and get additional skills somewhere else, or to take up a fellowship learning about the latest techniques in New Zealand or Australia, but then bringing that back to Wales and actually bringing that learning and teaching into Wales, which will then attract other people thinking, 'I want to be a neonatologist; Oh, Dr Pickersgill did this training and this fellowship out there, I'd like to go and work under him to learn about that.' Again, I think there are different ways of, maybe, attracting people in.

10:15

[91] **Angela Burns**: May I just make one very brief comment? You're absolutely right, but unlike a great many other professions, the medical profession is quite unusual in that you are at a much older stage in your life when you are doing what can be seen as more training, more learning, all these sabbaticals, et cetera, and then you've got the problem of the partner and the family. And if you've got young children or a partner who has got a good job somewhere, you don't want your family split up like that, whereas if you work for BAE or if you work for pretty much any private sector company or most public sector companies, you're not having to move around quite so much, and that's the issue, and that's what we need to crack.

[92] **Dr Jones**: I was in a joint medical family, and my partner chose about three different specialties to train in before he decided to stay in the one he was in. And he did move around, because he had to go and find the opportunities to train as he wanted to do. But I would say that the actual advice given by medical colleagues in terms of what to do, how to do it and where these fellowships and extra training opportunities were was great, and actually, when you look at them, there's no reason why one couldn't follow and temporarily leave a practice to go and have a sabbatical and follow your partner. But I think we need to make these, maybe, case studies and make them examples so that people do understand that, once they come to Wales, they don't necessarily have to just stay here to develop their skills; they can get them from elsewhere and bring them back here. But yes, I think most of us who go into medicine actually view it as a vocation, and always want to take that academic challenge. It's not a case that we do our A-levels, pop into medicine and then we stop; we always want to carry on our learning. I think that's what is different, probably, about healthcare professionals: you want to continue lifelong learning.

[93] **Dai Lloyd**: Jayne, you're going to wrap up this session, although your question has been partially answered, I would suggest. But feel free to drift wherever you want to go.

[94] **Jayne Bryant**: Yes, it has been partially answered, but Dr Llewelyn, you've mentioned that everything is changing, and it was really interesting to hear the ideas about innovation in staff development; I think that's something that we'll all take on board. But the WIHSC report of 2012, I think, called for new service models, such as increased centralisation at some hospitals. Do you think that would be sufficient to ensure enough doctors are

available to staff current and future hospitals?

[95] **Dr Pickersgill**: I think there is an issue about centralisation, which is—it's been the elephant in the room for donkey's years. As has been said many times by you and, indeed, us today, what are we going to be staffing in 10 years' time? Medical recruitment, NHS recruitment and workforce planning is baking a cake that takes 10 years in the oven, but you don't know what the temperature is, you don't know how big it needs to be at the end, or even what flavour, but you've got to decide on the ingredients now. It's very tricky. And if there is going to be a wider provision of more community-based 'hospital services', and keeping people in the community who are ill with multiple co-morbidities, rather than the current default: admit to hospital, that's going to need a very different workforce to the primary care and secondary care workforce we've got now.

[96] Then you've got to consider the—you mentioned WHSSC, the specialist services commissioning body—well, the very specialist services can't be provided in every district general hospital in Wales, or anywhere else for that matter. Neurosurgery has been a classic example, which I know a fair amount about, in terms of being involved with it, and Gareth's neuroscience and neurology delivery plan from a year or two ago is a good example of how the health boards are not deliberately obstructing, but kind of getting in the way of stuff that should be happening. So, there was a defined need and central funding for two, I think it was, extra neurologists—one in west Wales, one in Cwm Taf—but it took over a year for all those individual health boards along the M4 corridor to actually decide how much of the central pot of money each of them was going to get and how much of the pie they were insisting on having themselves. They weren't working together, they were battling for money, and that's a concrete example. But on the specialist services in terms of training, doctors who want to train in a specialty will want to go to a place where there is an active research department with a good output in terms of conferences, where there are academics and where there are sometimes, never mind British, but world-leading experts in their areas. And staffing such rotas for specialist services—whether it's cardiology or cardiac or brain surgery—out of hours means it can't be done in every hospital.

[97] **Dr Llewelyn**: I think the centralisation has to happen, but I think that we've also got a very rural population and, also, one of the things that we've been trying to promote is that, perhaps, Wales has a unique opportunity to develop rural medicine as a speciality. We don't have any problems staffing the bigger hospitals; it's the smaller hospitals where the problems are. Rural

medicine is not a speciality, and we'd like to see that happen. We've got a unique opportunity to, perhaps, develop that in Wales.

[98] **Ms Jackson**: I think it's also worth remembering 'Shape of Training', which was a four-nation-sponsored review of postgraduate medical education, published in 2013. There are parts of it that are UK-wide, there are parts of it that are led by the GMC, and there are parts of it that could be carried out on an individual nation basis. We haven't seen a great deal of progress on it for some parts of those recommendations, but where, for example, the colleges have been told to go away and do things, we've done those. So, in the RCP, certainly, we've revised the curriculum for general medicine, we've moved from a two-year general curriculum to a three-year, and that will be implemented in the Wales Deanery from next August—so, August 2018. So there are things happening. There are moves towards a workforce, a medical workforce, with a more broad-based skillset in general medicine, recognising that, actually, as that base of patients with chronic, complex multi-co-morbidities grows, we actually need physicians who are able to handle a broad range of different general medical problems.

[99] Something, for example—. To go back to Trevor's point—well, to go back both to Trevor's point and an earlier point that was made around vision, the previous Welsh Government committed in February 2015 to a 10-year medical workforce plan. It's two years later and we haven't seen anything. We've been following its progress with interest and it keeps getting bounced around. Our understanding at the moment is that it's sitting with NHS Wales workforce education and development services. They, we are told, are waiting for the outcome of the parliamentary review. Actually, that's a process that we'd argue needs to be reinvigorated, because if you're constantly waiting for the next report to come out before you take any action, you'll be waiting a long time. So, as Trevor said, having that goal, knowing what your service and your workforce looks like in 15 or 20 years—. The Shape of Training review did try to do that, to some extent, because it tried to say, 'Well, actually, what is the direction of change and who are the doctors we need to start training?' and so some of that work is happening at a curriculum and at a deanery level, but it's still not necessarily happening at a national, strategic level.

[100] **Dai Lloyd**: Rhun.

[101] **Rhun ap Iorwerth**: Fe wna i symud ymlaen o hwn, os—

Rhun ap Iorwerth: I will move on from this, if—

[102] **Dai Lloyd**: Ie, *go on.*

Dai Lloyd: Yes, go on.

[103] **Rhun ap Iorwerth**: Yn sydyn, o ran cynyddu'r nifer o israddedigion sy'n dod i astudio yng Nghymru, dechrau'r broses ydy hynny, wrth gwrs, ond rydym ni'n gwybod bod yna llai o gyfran o'n myfyrwyr meddygol ni yng Nghymru yn dod o Gymru o'i gymharu efo Lloegr a'r Alban. Pa mor bwysig ydy cynyddu'r gyfran yna sy'n astudio yng Nghymru a chynyddu niferoedd absoliwt, yn cynnwys ehangu addysg feddygol i lefydd y tu allan i Gaerdydd ac Abertawe?

Rhun ap Iorwerth: Just quickly, then, in relation to increasing the number of undergraduates coming to study in Wales, that's, of course, only the beginning of the process. We know that fewer, as a proportion, of our medical students in Wales come from Wales, compared to England and Scotland. How important is it to increase that proportion that study in Wales and the absolute numbers, including expanding medical education outside Cardiff and Swansea?

[104] **Dr Llewelyn**: Wel, rydym ni eisiau mwy o lefydd, ac mae'r prosiect o efallai cael ysgol feddygol ym Mangor—rydym ni'n cefnogi hynny. Byddai'n rhaid inni edrych ar ba fath o ysgol feddygol y mae hynny'n mynd i fod: a ydy o'n mynd i fod yr un un model ag sydd gennym ni ar y funud, neu a ydym ni'n mynd i drio creu rhywbeth gwahanol? A yw'n mynd i fod yn ysgol ôl-raddedig, fel Abertawe? Achos efallai bod yna fwy o gyfle, wedyn, i bobl sydd yn dod o Gymru i ddod yn ôl—wedi gwneud graddau y tu allan i Gymru, wedyn dod yn ôl i Gymru i wneud meddygaeth. Felly, mae'r prosiect yna'n un diddorol, ac mae angen inni edrych arno, ac efallai bod hynny'n rhywbeth y bydd *Health Education Wales* yn ei wneud—a ydyn nhw'n mynd i edrych ar hwn fel rhan o'i portffolio nhw? Nid wyf yn gwybod.

Dr Llewelyn: Well, we want more places available for students and the project to have a medical school in Bangor is one that we support. We would have to look at what kind of medical school that should be: will it be the same model as we currently have, or are we going to create something different? Is it going to be a postgraduate school, such as the one in Swansea, because perhaps there are further opportunities, then, for people who are from Wales to return—having studied for their degrees outside Wales, they can then return to study medicine. So that project is certainly an interesting one that we need to look at, and perhaps that is something that Health Education Wales will look at as part of their portfolio. I'm not sure if they'll do that.

[105] **Dai Lloyd**: Fe wnawn ni'n siŵr eu bod nhw. Reit, rwy'n credu ein bod ni wedi dod i ddiwedd y cwestiynau, felly diwedd y sesiwn. A allaf ddiolch yn fawr i chi'ch pedwar am eich presenoldeb, a hefyd am ateb y cwestiynau i gyd mewn ffordd mor raenus ac aeddfed, a hefyd y papurau y gwnaethoch chi baratoi cyn y cyfarfod? Maen nhw i gyd yn fendigedig a byddan nhw'n bwydo i mewn i'r ymchwiliad. Yn ogystal â diolch ichi unwaith eto, gallaf bellach gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r sesiwn yma er mwyn ichi allu ei wirio fe. Ni allwch chi newid eich meddwl am ddim byd, ond o leiaf medrwch chi wneud yn siŵr bod pethau'n ffeithiol gywir. Felly, gyda hynny, diolch yn fawr ichi gyd. Cawn ni egwyl am 10 munud, rŵan, i'm cyd-Aelodau, cyn inni ddechrau'r sesiwn nesaf. Diolch yn fawr iawn ichi.

Dai Lloyd: We'll have to make sure that they do. Okay, I think we're at the end of the questions, then, and therefore the end of the session. Thank you very much to the four of you for coming and for answering our questions in such a competent and mature manner, and also for the papers that you prepared for us before the meeting. They are excellent and they will feed into the inquiry. And as well as thanking you, can I also tell you that you will receive a transcript of this session so that you can check it for accuracy? You can't change your mind about anything, of course, but can you please check that things are factually correct? Thank you very much. We will take a short break now for 10 minutes, for my fellow Members, before we begin the next session. Thank you very much.

Gohiriwyd y cyfarfod rhwng 10:25 a 10:37.
The meeting adjourned between 10:25 and 10:37.

Ymchwiliad i Recriwtio Meddygol—Sesiwn Dystiolaeth 4—Coleg Brenhinol yr Ymarferwyr Cyffredinol a GP Survival
Inquiry into Medical Recruitment—Evidence Session 4—Royal College of General Practitioners and GP Survival

[106] **Dai Lloyd**: Croeso i'r sesiwn ddiweddaraf yma yn y Cynulliad o gyfarfod y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon. Dyma'r bedwaredd sesiwn dystiolaeth, a hon o dan eitem 3: ymchwiliad i recriwtio

Dai Lloyd: Welcome to this most recent session at the Assembly of the Health, Social Care and Sport Committee. This is the fourth evidence session, under item 3: inquiry into medical recruitment. And

meddygol. O'n blaenau ni mae tystion o Goleg Brenhinol yr Ymarferwyr Cyffredinol a hefyd o GP Survival—goroesi meddygaeth deuluol, y buaswn i'n meddwl. Reit, fe wnawn ni gyfarch yn swyddogol Dr Rebecca Payne o Goleg Brenhinol yr Ymarferwyr Cyffredinol; Dr Isolde Shore-Nye, hefyd o Goleg Brenhinol yr Ymarferwyr Cyffredinol; Dr Linda Dykes, meddyg ymgynghorol mewn meddygaeth achosion brys yn Ysbyty Gwynedd a meddyg teulu â diddordeb arbennig mewn geriatreg yn y gymuned, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr; Dr Sara Bodey, partner meddyg teulu, Practis Bradley, Bwcle, sir y Fflint; a hefyd Dr Heidi Phillips, partner meddyg teulu yn Fforestfach—adeilad rwy'n ei adnabod yn dda iawn, yn Abertawe.

before us we have witnesses from the Royal College of General Practitioners and from GP Survival. I welcome Dr Rebecca Payne, from the Royal College of General Practitioners; Dr Isolde Shore-Nye, also from the Royal College of General Practitioners; Dr Linda Dykes, consultant in emergency medicine, Ysbyty Gwynedd, and also a GP with special interest in geriatrics in the community with Betsi Cadwaladr University Local Health Board; Dr Sara Bodey, GP partner at Bradley's Practice in Buckley, Flintshire; and also Dr Heidi Phillips, GP partner in Fforestfach—a building I know very well indeed, in Swansea.

[107] Rydym ni wedi derbyn eich tystiolaeth ysgrifenedig bendigedig chi. A oes rhywun eisiau dweud rhyw ychydig eiriau fel cyflwyniad? Oni bai am hynny, fe awn ni'n syth i mewn i gwestiynau. A oes rhywun eisiau dweud rhywbeth fel cyflwyniad, neu a ydych chi'n hapus jest i dderbyn cwestiynau?

We have had your written evidence, which was excellent, thank you very much. Would anyone like to make any opening remarks, by way of introduction? Otherwise, we will go straight into questions. Would anyone would like to kick off with some opening remarks, or are you happy just to receive questions?

[108] **Dr Dykes**: I've got one, if that's okay.

[109] **Dai Lloyd**: Yes.

[110] **Dr Dykes**: I'm delighted to be able to share with you some of the key lessons from the successful recruitment scheme for clinical fellows in Bangor's emergency department. From my written evidence, you already know that it's possible to recruit doctors to Wales—it is possible, even in the face of the UK-wide recruitment difficulties in emergency medicine—but, we

do have to work hard for each and every recruit. We are selling posts, and it's a buyer's market. We have to be realistic about that. Too many medical posts are, quite frankly, dreadful, and it doesn't matter how fancy your full-page colour advert in the *British Medical Journal* is, you can't polish a turd. If I do nothing else today, I hope to convince you of the need to build posts around doctors and not the other way around.

[111] Doctors have lives outside of medicine and anyone recruiting must understand the psychology, the motivations, the life stages and other push-and-pull factors of their potential recruits and ensure posts meet those needs, or you won't get anybody for them. We designed our clinical fellow posts around the wish list of the junior doctor we were targeting as our first recruit. It's also vital to grasp that the values and priorities of generation Y, those born after 1985, are different to those of us who are generation X, and to the baby boomers. Generation Y are almost all of our junior doctors now, most of our younger GPs, and they're just emerging into the system as consultants.

[112] Finally, and I'm very mindful this is a contentious issue, we have to be honest and acknowledge that the perceptions held by those outside of Wales of some elements of life inside Wales, such as our education and language policies, exacerbate the normal reluctance of any family to consider relocating and disrupting children's schooling. This can adversely affect the recruitment of doctors in their mid-to-late 30s until the mid-50s or so, and that's in addition to the fact that many families will not move anywhere when the kids are in school. Setting these challenges aside, however, the Bangor ED clinical fellow scheme demonstrates the power of creative, flexible, doctor-centric posts to bring doctors to Wales year after year, and then they come back as consultants, and then they bring their own students, and it all goes from there.

[113] That concludes what I had prepared to say to you and now I'm all set for your questions. Thank you.

[114] **Dai Lloyd**: Dyna ni. Sara.

Dai Lloyd: Thank you very much. Sara.

[115] **Dr Bodey**: Since I did my written submission there's been a document produced looking at foundation doctors and their career decisions. I don't know if you've seen this document. It just reinforces the increasing trend for doctors at this stage to not go on to speciality training. I've actually brought

one of these doctors with me, and he's sitting in the gallery upstairs. He's somebody that I first met as a medical student in practice with me. He's currently an F2 doctor in Liverpool, and like about 50 per cent of F2 doctors, he's not going to go on to speciality training. He wants to have some time out to think about what he wants to do. He's going to locum. He can't do that in a GP practice. He can't get that GP experience at that stage, because of the current regulations. He can do anything else. If he could do it in GP, then he would do, and if that was available in Wales, he'd come and work in GP in Wales, in a supervised capacity. It's what they're asking for. It fits in with what Linda's saying about responding to what doctors actually want to do as opposed to what we design. That's what I would like to get across today.

[116] **Dai Lloyd**: Grêt. Diolch yn fawr. Heidi, wyt ti'n hapus, neu wyt ti eisiau dweud rhywbeth?

Dai Lloyd: Heidi, are you happy, or would you like to say something?

[117] **Dr Phillips**: Yes, I'm Heidi, I've been a GP for 15 years. I'm also admissions director for Swansea graduate-entry medical school and I'm doing a Master's in research in the recruitment and retention of GPs in Wales. So, I think I'm uniquely situated to understand the retention and the recruitment issues. From the work that I've done, it's showing that medical students need exposure to general practice. Seventy-one weeks in the curriculum are spent in secondary care and 11 weeks in primary care. The majority of the taught course—and I'm talking over 90 per cent of the theoretical course—is taught by secondary care doctors. All the evidence and the literature show that if you want to influence people to choose a career path, you need to give them good role models and you need to give them exposure to those role models. That's what we need to be focusing on. We have a pipeline from school to medical school to workforce, and we have a leaky pipeline. We need to look at all the stages along that pipeline.

[118] **Dai Lloyd**: Diolch yn fawr. Rebecca.

[119] **Dr Payne**: I haven't prepared anything to say, and what I'd like to say is that, actually, when it comes to Sara and Linda, these guys have made recruitment a success, so I'm very keen that they have maximum opportunity to share what they have practically done that has addressed many of the recruitment challenges we face.

[120] **Dai Lloyd**: Well, the avenues of questioning will tease out further

details. Isolde, do you want to—?

[121] **Dr Shore-Nye**: I don't particularly have anything additional to add other than to say that I am a GP working within the area and I'm a cluster lead as well, so obviously recruitment and retention are high on my list of priorities as well as the college.

[122] **Dai Lloyd**: Excellent.

[123] Diolch yn fawr. Reit, awn ni i mewn i gwestiynau ffurfiol, ac mae yna ryw 50 munud gyda ni, i ddechrau efo Julie Morgan.	Thank you. We'll go into formal questions, then, please, and we have about 50 minutes for this session. Can I start with Julie Morgan?

[124] **Julie Morgan**: Thank you. Just to pick up what one of you said about it not being possible to get a locum at a GP practice, I wonder if you could expand on that. It's not possible to do that. It's not built in in any way.

10:45

[125] **Dr Bodey**: It's not possible if you aren't on the GP specialist register or in a recognised training post. So, there are various doctors who would want to gain experience in general practice who don't meet those criteria; and because of the performers lists regulations, they're not allowed to work in GP. You can't do even a supervised post if you're not either on a recognised training scheme or on the GP specialty register. So, there's a really small pool of people that we can then call on to be doctors in a GP setting. There are lots of doctors who would want to have that opportunity. I've been told by somebody who has recently left the General Medical Council that the performers lists legislation is within the gift of the Welsh Government to change to make it possible. It needs to be in a supervised and regulated way, to avoid abuse of such roles, but I think it could easily be made possible. And certainly, I think the evidence that I submitted gave you an idea of the number of doctors who would be interested in that sort of role.

[126] **Dr Payne**: Can I add some detail around that? Currently, the training scheme is that a doctor will come out of medical school, do their foundation years and then they may embark on some time out, which is what Sara is describing—where people are spending time locuming in psychiatry or any other specialty. That's not available to general practice at that level, as a very junior doctor. In order to be a GP locum, you have to have gone through the

full training scheme and then locum. So, we're talking about something very different to what's currently in the system and something that doesn't exist at present.

[127] **Julie Morgan**: Right, but you think—

[128] **Dr Dykes**: Can I give a little context that may help? So, we have a situation in general practice at the moment whereby we make good use of advanced nurse practitioners, paramedic practitioners and non-medical clinicians, which is fantastic, but we have the somewhat incongruent situation where we've got those, and we're quite happy for those to work mostly autonomously with a little bit of paper-based supervision quite often, and yet we won't allow a doctor who has been at medical school for five years and has at least two years of postgraduate training to work in a supervised environment in a practice. It's a little incongruent and slightly insulting.

[129] **Julie Morgan**: Thank you. Right; to move on, there's been a lot of publicity and concern about the pressures in primary care, particularly recently. Do you think people do see general practice as an attractive career option?

[130] **Dr Phillips**: No.

[131] **Julie Morgan**: No. Right.

[132] **Dr Phillips**: I think there are two sides to that. You've got the recruitment and the retention side. I've done a survey of the Swansea medical students. One of my students actually did a survey. They don't see it as an attractive option because they see what we see, which is a 10-minute revolving door, starting at 8.30 a.m. through to 6.30 p.m., with no protected time for education, no protected time for the expansion of other interests, and no protected time even for administration. It's relentless. When you look at the other side of it, you see the GPs—our role models—who, from the evidence I submitted, are burnt out, exhausted, demotivated and demoralised. I'll show you this. I don't know if you can see it. What you can probably see is a page of green. That's the second screen of two screens of an on-call morning. A morning—8.30 to 11.30 a.m.. There are 59 extras. So, all the appointments have already gone for the morning and, on the second page, there are 59 extras and 11 house-call requests. That's for one doctor. If we're talking about 10 minutes per patient, and 59 patients demanding to

be seen that day who can’t wait until tomorrow, do the sums. We haven’t got that time to see them. So, as well as that, we are trying to enthuse and motivate these students to come through when we’re facing this. So, it’s a multifactorial problem.

[133] **Julie Morgan**: So, has anybody else got any comments on that?

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

[135] **Dr Dykes**: There’s an added thing onto there, which is, because the NHS across the UK now has been under pressure for seven, eight years, really, and then the wheels really fell off in those parts of the UK maybe four, five years ago, our students and our young doctors have never seen it working properly. They have no idea what it is like when the wheels were on the bus, and it’s all going lovely. So, their entire perception is clouded by this, and we have the same in emergency medicine—our guys look at us and go, ‘I’d love to do it, but I’m not doing what you’re doing until I’m 68.’ So, it’s very difficult.

[136] **Dr Payne**: There’s also an impact on the retention as well. I’ve been a GP now for 10 years, and the job I do now is completely different to the job I did 10 years ago, and very different to the job when I started my first placement in general practice as a doctor in 2002. The level of complexity that we’re dealing with, in terms of many, many more older patients with really complex medical problems, but also in terms of the steps that we’ve taken to diversify the people within the practice—actually that makes it a lot harder, too. So, if the nurse practitioner is seeing the more simple cases, that means everybody who comes to sees me is complicated. In the past, I might have seen people with sore throats, people who wanted a pill check, and that would give me the catch-up slots so I could spend a bit longer with people with mental health problems or more complex medical needs. Once you take all of the easy stuff out, unless there is then that expansion in the time available to deal with the complex things, work becomes an awful lot harder.

[137] **Julie Morgan**: So, all the patients you’re seeing are ones who couldn’t

be diverted to somebody else.

[138] **Dr Payne**: Yes, they are.

[139] **Julie Morgan**: They need to be seen.

[140] **Dr Payne**: Yes, and it also depends on the practice. So, some of the smaller practices won't have that larger workforce around them, but they have the huge problems with volume because you're not diverting anybody off. But in some of the out-of-hours settings I commonly work in, and other, bigger practices, if you've taken off the simple cases, you're left with very complex decision making to do. It's not just the volume of patients, it's the complexity of the decisions and the need for a new decision with a patient every 10 minutes that can be very, very difficult. At the end of the day, you've just got nothing left.

[141] **Dr Bodey**: There's a real danger of cognitive fatigue kicking in, and errors creeping in because we're exhausted from making decisions.

[142] **Dr Dykes**: There is evidence on that. If you Google 'Israeli parole board data', then you will find a graph of an Israeli parole board—thousands of thousands of cases every year—and in the morning, when they're fresh and bright, they will let lots of people out of prison, and then by lunchtime when they're knackered—and you're making high-impact decisions: you know, if you let somebody out and they go and kill somebody, then the parole board's in trouble—they won't let them out. You see it—it's amazing. It's like, over the morning your ability to make decisions goes like that, and you feed and water people, and it goes right back up again, and falls down. The problem is that we're probably running a great deal of our medical workforce in all our settings, in the acute settings particularly, on decision fatigue, they can't do it, and then you revert to the most risk averse way of doing it, and then you end up with even more strains on the system. So, your judgment ability goes, and then you end up admitting people because you just can't muster the mental energy to decide if it's safe, or to work out an alternative—talking to colleagues who are in the same sort of position. But Israeli parole board data—Google it, it's fantastic.

[143] **Dai Lloyd**: Okay. Julie.

[144] **Julie Morgan**: I was just going to say, obviously there are not enough doctors or GPs to do the job, but can you suggest what would be your

biggest priority in terms of improving the situation?

[145] **Dr Phillips**: The elephant in the room is to improve the work-life of current GPs, because we can talk about recruitment, and we can pay £20,000 to get somebody to come in and work, but once they actually are in the job and they realise what the job entails, they can't stay in the job. They can't do what it is we're doing for years and years. That's why, apparently, the average age of a female GP leaving general practice is 45. So, we've got to do something about it.

[146] **Julie Morgan**: How can you do it without more doctors if the number of patients all need to be seen?

[147] **Dr Dykes**: I think it's may be where the Bangor clinical fellow experience helps. So, obviously, we were facing, as you'll know from the written evidence, going into 2011 with only one substantive doctor, and he was trying to leave, on our middle-rate tier. I worked out how I could do it, and I knew I'd be able to recruit to it, and I said to my managers, 'I want to set up this new breed of doctor, and oh, by the way, we've got to let them out to play'—it's with Welsh ambulance, they're contributing to the health community—and he says, 'But we're so short of doctors, how can you let them out to play? You'll end up with only 0.8 doctors rather than one', and I'm going, 'Because if not, we'll have 0.0 doctors—it's not that difficult.' So, you're recruiting to that, and then they have a sustainable, fun time and then their mates go, 'Hang on a minute, I can go there too.' And that's the exact situation we've had. So, you have to improve the lot of what you've got to make the job attractive, and, sure, you will have a temporary dip in capacity, but you have to take that if you're not going to, just, you know, ram more people in, and we have a lag phase before we can suddenly conjure up more people. But you can improve the lot of those whom you've got going through at the moment and then that will actually help solve the long-term problem. But getting over this blip is very difficult.

[148] **Dai Lloyd**: Rebecca. Sorry, Sara.

[149] **Dr Bodey**: There are doctors there at this more junior level and at other levels who could be a resource, but, at the moment, we're not making it possible for them to contribute.

[150] **Dai Lloyd**: Okay. Rebecca.

[151] **Dr Payne**: There are a few more practical steps that could be taken straight away, and I'm aware that there is ongoing work in a number of these areas, but it's not come to fruition yet. So, the first of these is indemnity, and, at the risk of sounding a little bit geeky, this is absolutely imperative to sorting out the problem. So, doctors have to pay for insurance to practice. My insurance costs me £120 a day. Now, I need that insurance if I'm going to go and do a locum for Isolde, but if I do a locum for a health board practice or work in the out-of-hours setting, I don't have to pay that additional £120 a day. Now, what that means is if I'm offered work in a non-conventional setting, for example out of hours, or if I'm offered work—I do some teaching of communication skills at the university—there's a real incentive for me to not go and help Isolde, because not only is the insurance extremely expensive, it's also very inflexible. So, if I've worked the maximum number of sessions I can work that month, there's nothing I can do to help Isolde, because I'm just not insured, and I can't just say, 'Well, insure me for one more session.' You're looking at then increasing your premiums, going forwards.

[152] So, that's having a real adverse effect, firstly on the ability of GPs already in the system to up their hours, because the indemnity stops that. It's reducing our ability to flex up to help with winter pressures or help colleagues in crisis, and, actually, it's estimated that you would have extra GP capacity within the system if that was addressed. Because if somebody's insured for, say, two or three days a week and the average time that Welsh GPs are working in general practice is 60 per cent, that's their insurance—that's it. But if you had a solution to this, they would be able to flex up. But once you increase your sessions, you're then committed to that for at least a month, so people won't want to do that if they just want to increase on a day. They'll just say, 'Oh, I won't work that day.' So, finding a solution for this would really help immediately release extra qualified GP time into the workforce in a flexible manner, able to provide assistance when it's most needed.

[153] The other thing to look at is how we do stuff within practices, and, as GPs, we know that we need to do many things differently, and a lot of surgeries are quite a long way down this road of transformation, looking at how things like the letters coming into the practice are handled and looking at which staff members see the patients. We're doing all of that already, but some of the practices, particularly those that have really got their backs to the wall—when you're under huge pressures, that's when it's hardest to take the step back and look at what further you can do to transform. We need

more active support from health boards, and, to be fair, they're already trying to do this, but we need them to look at what can be given to practices to help them analyse their workflow, analyse their patterns, explore other options out there.

[154] Not all the answers will lie within NHS Wales. So, our colleagues over the border are providing support for practices to look at the letter system. They're looking at services—there's one offered by an organisation—Care UK—I'm not selling them; they're just one of the organisations out there. Shropdocs is too. I believe there is a small outfit in Cardiff Bay that do this as well. So, they're supporting struggling practices to send some of their telephone consultations out, so they're handled by people elsewhere, and these innovative solutions—. Individual practices are often struggling to find out about them or to resource them, but the health boards have got that clout and that buying power to look at these.

[155] There are also things on the IT side that make it incredibly clunky and difficult, things like accessing discharge summaries—I'm sure you've heard this before—that can be a real challenge, or looking at what's happened to a patient in hospital. Sometimes, the systems are really clunky, and asking NWIS to really prioritise work relating to general practice would mean, if the systems were less clunky, we could actually be more effective in the time we have.

11:00

[156] So, there are some simple solutions—well, I say 'simple'. They're solutions that could be enacted right now with enough sense of urgency on the agenda to really prioritise this. And also, we need to see a shift of staff from the secondary care system into general practice. The problem is everybody's stressed, everybody's under pressure. There aren't enough nurses; with pharmacists, we've had a massive influx of pharmacists coming in to general practice, but we're now running out of people to pull over. Every couple of years, it seems there's a different workforce that's going to save general practice—it's the occupational therapists, it's the physiotherapists, it's the pharmacists, it's the nurses, it's the paramedics. We really value all of these staff, but actually, as GPs, we provide a unique contribution, too, and that needs to be recognised.

[157] **Dai Lloyd**: Okay. Angela, you've got a brief question, then Jayne.

[158] **Angela Burns**: Yes. Can I go back to clinical excellence, because this is what I don't understand? I totally get your point that 10 minutes isn't enough to see a person, it's not enough to build a relationship, to get to grips with, maybe, comorbidities, et cetera, et cetera. So, there are massive changes going on throughout the NHS, and I'm going to use paediatrics as an example. So, now we have a situation where paediatricians are being moved around the country, because what the royal college is saying is that, in order to be trained in paediatrics, in order to be a good paediatrician, in order to have further training, you must train at a place that does a certain number of paediatric births et cetera—obviously it's paediatric births, nobody else gets born; I don't think you get born old, although I feel like it at times. [*Laughter*.]

[159] **Dai Lloyd**: Some people are, but I digress. [*Laughter.*]

[160] **Angela Burns**: So, you absolutely have to be in that kind of environment. So, who says that you can only have 10 minutes with the patient? Why isn't the royal college saying, 'Actually, clinical excellence, clinical standards, which thou shalt not break'—[*Interruption*.] I understand that, but somebody, somewhere must have said it's okay to do 10 minutes. So, why aren't the royal college saying, 'Actually, in a GP practice, you've got to have 15 minutes', or 'You've got to have 20 minutes'? Is it the health board that's saying it, or is it the Government? I understand the pressure of work, but that doesn't apply anywhere else, because if I just said, 'Actually the pressure of work means you've got to have full-scale paediatrics down at Withybush', then the royal colleges beef up their muscles and say, 'No way, you've got to go to Carmarthen.' So, in that sense, they're all big and strong and say, 'This is what you've got to do', and the Government meekly says, 'No, you're absolutely right, and we'll reconfigure everything to follow that model'. So how come that's not working here?

[161] **Dr Payne**: From a royal college perspective, we've debated some of those issues in the past, including should there be a cap on the number of patients a GP can see each day. The problem with that is the way that the contracts are configured. So, as a GP partner, Isolde has responsibility for the primary care needs of those patients on her patch. So, if we start saying as a royal college to Isolde, 'You have to spend 15 minutes with every patient', what happens when it gets to 6 o'clock and she's still got 30 patients who need 15 minutes left? And that's a very practical difficulty we've run into. Now, that is because of the independent contractor status, but we know that independent contractor status brings huge, huge strengths. It means people

take responsibility for their patients, it means that practices have been able to innovate and transform without the whole layers of health board bureaucracy around things like recruitment, around change, and all those areas. So, the difficulty is, although we recognise the quality and the improvements in quality that will come from 15 minutes, actually to mandate that would be to destroy general practice, because you cannot do it with current workloads in the current setting, but it's not—

[162] **Angela Burns**: But if you follow that argument through, Rebecca, and we talk about the drop-off and the fatigue et cetera, then you surely run an enormous risk of actually a GP not picking up, or misprescribing—

[163] **Dr Dykes**: That's why the indemnity is so expensive.

[164] **Angela Burns**: Yes, because they are completely knackered and they can't do the job. So, at some point, there has to be, surely, a balancing of the seesaw between the pressures of the job and the actual reality and clinical safety of both you, as a practitioner, and your patient. Is there not a case that, by trying to even that up slightly, you then put the onus back on society, the system, to actually say, 'Oh my gosh, we've really got to do something about getting more GPs in? Let's look at—'. Because whilst the status quo remains, and you guys say, 'Do you know what, it's all right, I'm going to end up having 51 extra patients and 11 house calls every day, and I will just soldier on because there's no alternative', then the system won't change. In order to effect system change in almost anything in the world, you've got to have that revolution at the bottom, and somebody, somewhere has got to draw that line in the sand and say, 'This can't go on, because—'. And I would have thought that clinical excellence and clinical standards and clinical safety would have been one of the lines in the sand that could have been drawn.

[165] **Caroline Jones**: But then how do you prioritise between patients—who is urgent and who is not; who is to be seen and who you are going to leave that day?

[166] **Angela Burns**: No, I agree, but it works in other areas, so I can't understand why we can't do something about making it work in general practice.

[167] **Dr Phillips**: One of my GP respondents, I can quote him as saying, 'General practice is the cesspit of the health service', and those are pretty

strong words. But, essentially, what we're seeing are the patients who can't see anybody else—so, if they want to see a dentist, they can't get to see a dentist, they go and see their GP. If they've got problems with their housing, they go and see their GP. If they've got problems with neighbours—the GP. So, a small percentage of what I do is what I trained to do and what I learnt in medical school. A huge amount of what I do is sorting out the social ills of my patients. And where do I draw the line? Do I, as this busy doctor at the end of the day say, 'Right, there's this number extra—who am I going to choose? Who am I going to value over somebody else?' And we can't, not least because, if I leave it and one person doesn't get seen, they go to A&E and then we get hit in the press, or I get a complaint, which I had a couple of weeks ago because I couldn't see a lady because I had to go and see a patient at home with urinary sepsis. So, the patient who turned up demanding to be seen, I asked if she could please come back two hours later so I could go and see this ill patient, and I got a complaint. That's the reality. We are expected to see everybody.

[168] **Angela Burns**: But don't you think that's why you need the fire cover? Surely, that's why you need the air cover from somebody to say, 'Actually, clinical excellence says that, when you're looking at the complex cases'—because you've hived off the easier ones, the sore throats, to your allied healthcare professional—'if you are looking at the complex cases, you've got to have extra time—you've got to have the 15 minutes, you've got to have the 20 minutes'. What I'm really trying to understand is: who's come up with the 10-minute rule?

[169] **Dr Dykes**: It was an improvement from five minutes. [*Laughter*.] I remember when I first qualified, and that was when GP jobs were in the BMJ as well, and it was a big thing: 'We've gone to 10-minute appointments, woo-hoo'. I think it's a very fair question that general practice needs to get a grip on.

[170] **Dr Bodey**: I think we've sucked up an awful lot of pressure personally over the last few years that has hidden this until it's got to crisis point. It is the way the contract is designed. There isn't an option for us to say 'no', as it stands. I know practices have been threatened with breach of contract if they've tried to, but it's a valid question and it's one that the profession needs to think about.

[171] **Dr Payne**: I'm happy to take it back to RCGP council to ask them to revisit the issue. The difficulty is, within the current contract, that would put

the practice in breach of contract and the health boards would have quite a lot to say about it. And I wonder if it's an area where it might be useful to get a health board perspective on how they would respond, because it is that concern that, by putting in these hedges and these safeguards, we would destroy general practice as it is. And you say, 'Well, you could move to a salaried model', but, actually, if you were to look at the volume of work Heidi did that day and look at putting a salaried GP in there who can only work a certain number of hours a week—so, European working time directive, you need to have certain breaks—in many salaried settings where I've worked for a health board they haven't been encouraged to take that overall responsibility for the patients that an independent contractor does. Actually, we would be worse off rather than better off as a society.

[172] **Angela Burns**: I do totally understand, but it just strikes me that what we have here is a vicious circle. In order to break any vicious circle, you've got to make a cut in the system somewhere to attract more GPs, and to make the work-life balance and make people want to do this job, then you've got to start changing something. And it strikes me that the thing to change is the working practice so that you can get more people who want to come and do it.

[173] **Dr Phillips**: Just to come back to you on that, if you changed my working practice and gave me 15-minute appointments right up to 6:30, 7 o'clock, 8 o'clock, wherever you want to set it, and that's where I finish, who's going to see that extra demand?

[174] **Angela Burns**: Well, hopefully, there are more GPs that we can then start—. You know, it's 'chicken and egg', isn't it, but you've got to try and do both at the same time.

[175] **Caroline Jones**: But that would impact straightaway. Patients would be suffering, and so would our doctors' reputations.

[176] **Dai Lloyd**: Isolde.

[177] **Dr Shore-Nye**: Can I just come back on the point about who makes the 10-minute rule? I think one of the advantages of the independent contractor status is that flex in the system, that ability to model how you manage your patients depending on your community and how your citizens utilise your service. If we had those extra doctors or those extra healthcare professionals available—. We audited our average length of consultation, and it was longer

than 10 minutes. So, actually, patients are getting a longer than 10-minute appointment, and we have the arbitrary 10-minute consultation because we have days like Heidi has, where you are over and above your capacity. I think what you're also getting at is mentioning about how we manage that ever-increasing demand, and that demand may be perceived by healthcare professionals as inappropriate, but, by those service users, it's not deemed as inappropriate. We're all citizens ourselves, as well as healthcare professionals, and we all live within our communities, and we can all understand why people are using these services. So, it is beyond just having the extra doctors. We can flex our systems, we can manage our services, we can look, as the college, into workload, and how we act when we get to the limit of our competencies, or burnout or overload, but, actually, it also has to come from how we also manage that demand, whether real or unreal.

[178] **Dai Lloyd**: Okay. Moving on, Jayne.

[179] **Jayne Bryant**: Diolch. I think Linda mentioned earlier about the targeted recruitment campaign in Ysbyty Gwynedd. Perhaps you could expand again on that really and just say what lessons could be learned perhaps for primary care, to attract more people into primary care.

[180] **Dr Dykes**: The starting point of our recruitment campaign was getting the job right, because I think there is a great—. We fell for this hook, line and sinker for several years, with bigger and bigger, shinier adverts, before we actually realised that the reason why we couldn't recruit was because our jobs were appalling. So, the first thing is you've got to make the job right, which, in the general practice context, brings us back to problems we've been discussing. What we've discovered in emergency medicine is that, obviously, it's a highly pressurised environment. You'll all be fully aware of the difficulties we face as a speciality in EM at the moment, and, actually, the time away from the hot zone, whilst still doing paid, useful work for the NHS, is why we can still keep doctors willing. Rebecca's got a great quote, which is that, sometimes, you feel like you're a recruiting sergeant for the Somme, knowing what's going to happen. And it's kind of true, if you haven't actually got the package of the job that means it's not just utter death, misery and mud and destruction.

[181] So, the starting point has got to be getting the jobs right. After that, you start to model everything through, and then, by the time you actually get to the recruitment campaigning and the adverts, that's the last bit. If you're doing it right, then word will get out via the other means we now have. We've

made—well, I've made—extensive use of social media. My entire 2017-18 house of clinical fellows—I'm over-subscribed again—has been done without a penny spent on advertising. It's just been through NHS jobs and lots and lots of social media. It's spent a lot of me—it's many, many hours of my time, but I've got doctors coming in. But it has to start with getting the jobs right, and the jobs have got to be moulded around the people you want to come to get them, or they just won't come. We're seeing this left, right and centre.

[182] **Dr Payne**: Can I just pick up on Linda's point as well, because I don't think she ever says enough, actually, about the personal impact that she's had into that, in terms of contacting people, following them up, setting up WhatsApp groups for the new doctors coming into her department, and offering a really personalised experience? A few years ago, I talked to a Canadian recruitment organisation, and they wanted to know what I wanted from life, what my husband wanted from life, what his job was, what sort of school did I want my kids to go to, was I was looking to be near the sea, and all this really, really personalised hand holding—'Let's find the right, not just job for you, but life for you.' And, as a college, we really welcome the fact that we've got the single point of access now for shared services. I've been trying to find some guinea pigs to phone up and see how it's going. But, actually, until you get the personal approach that Linda's been providing, you're not going to be able to help people envisage their new life in Wales. And all the things like help finding schools, help finding accommodation—Linda's been phoning me up when she's got nowhere for people to say, going, 'Can they stay in your house in Anglesey?' That's the level of individualised support that has brought the doctors over. And, actually, it's not a case of just copying what she's done without getting that really personalised level of investment in.

[183] When I was a medical student, when I did a general practice placement, I was living away from Cardiff, and the GPs—a different GP took me home for dinner every single night, and I became a GP.

[184] **Dai Lloyd**: So shallow. [*Laughter*.]

[185] **Dr Payne**: And it's those really personal approaches actually that make a difference.

[186] **Dr Dykes**: It fits into that Generation Y stuff. I mentioned it earlier in my little preamble. We know that our younger colleagues, we know that they

are different in their views and their values. We know that they typically very much appreciate and need mentoring. They find that very, very difficult to do independently. So, some of the things that I do are, if I'm at a conference, I'm aware how we recruit and how I pick up potential recruits, and even people I will have a talk to and do some career counselling with them, even if they're not coming to me, they're going to say, 'Hey, there's that really nice consultant in Bangor and she's got some really good posts; go and have a chat to her.' It's just networking. You go through with them and you talk to them and they just need support and just some guided decision making on things.

11:15

[187] The other thing is it's just networking. It just struck us before we came into this room, when we were waiting in the waiting room. Look at this: women network. That's actually really, really interesting. So, you've got people who—you know, those of us who actually do it. I've fixed recruitment in my department—it is constant and ongoing hard work, but I have fixed it and, unless we actually now balls up, we're home and dry. It's hard work continuing, but it's all networking.

[188] **Dai Lloyd**: Okay. Rhun on this point.

[189] **Rhun ap Iorwerth**: I know about the great work that Linda does in primary care as well as in ED in Ysbyty Gwynedd, but that in itself isn't sustainable. We can't have a Linda Dykes everywhere—somebody who's willing to go above and beyond. We can't have somebody who's willing to actually cover those 59 other calls by staying there until midnight.

[190] **Dr Dykes**: Which is why I've got no doctors.

[191] **Rhun ap Iorwerth**: So, how do you formalise and who should be responsible for formalising, making systemic, if you like, what Linda, and others like her, are doing? Who should be doing that?

[192] **Dr Payne**: I think that responsibility rests primarily with Welsh Government to instruct the health boards in: 'We have a model, this works: copy it.' Actually, a lot of what Linda has achieved is by breaking the rules and doing stuff subverting the normal mechanisms, having an unofficial website—I hope you don't mind me saying this, Linda.

[193] **Dr Dykes**: No, that's fine. I don't keep rules. I'm a disruptive innovator. It's called 'being naughty'.

[194] **Dr Payne**: So, how do you get something that works, that breaks the rules, into a system that is absolutely rule-bound? Having worked for health boards, it is so difficult to bring about change. So, I would suggest that we actually have a cultural problem within the Welsh NHS, where, so often, the default answer is 'no', and, unless you're prepared to ignore it, like Linda, it's very, very difficult to get stuff done. So, without that cultural shift, without a real focus, a national level of learning from that case study, and commitment to industrialising that approach, I don't feel very optimistic.

[195] **Dr Bodey**: It needs to be the right people in the right place as well. It needs to be flexible locally to respond to the specific needs of each area.

[196] **Rhun ap Iorwerth**: But the job spec for that person driving that change has got to be right. In the same way as Linda wants to get the job spec right for the doctor, we need to get the job spec right for the person or the department or the organisation that actually drives the change.

[197] **Dr Dykes**: See, I think it should be clinician driven.

[198] **Dr Bodey**: It needs to be clinician-driven, yes.

[199] **Dr Dykes**: I think it needs to be clinician-driven. Hiving it off to HR, who, by their very nature, because they have to do it—I'm not dissing HR; there has to be attention to detail, making sure, you know, the dots and t's. That's just not the same skillset that gets the people in. It has to be clinician-driven. Clinicians have got to take ownership of it. We thought, before the penny dropped that the jobs were shit and it was our responsibility, that it was HR's job to find us doctors—human resources; they're resources that come. That's not how it works. So, within every patch or team, you've got to have clinicians who will actually take ownership of the problem, like I have. Now I can teach all the clinicians how to do it, but some get it and some don't. If they don't, then it's just natural selection—they're just going to have to wither, and then we're going to have to find and mentor—. I've taught my juniors how to do it and they're now coming through as consultants.

[200] **Rhun ap Iorwerth**: What happens if consultants, clinicians, are instructed that part of their job spec is to lead their recruitment within their

departments?

[201] **Dr Dykes**: I think that if you instruct anyone to do it, it won't happen. They've got to be inspired to do it. But they have to have some time and space. I've done it mostly in my own time with my own money and this is a problem. So, if you can find a way that, actually, the Welsh NHS encourages, within some job plan—it'd be quite nice not to be doing it all in my own time—then you would probably find more people enthusiastic to do it. The normal response I get when I tell my colleagues throughout the UK what I've been doing is, 'Well that sounds marvellous, but I'm not prepared to put the work in'.

[202] **Dr Payne**: And also the consultants we've got need to be doing jobs that they believe in, and they feel positive, they feel supported, they feel like the system works, that they can do a good job. Because the authenticity with which Linda speaks, having redesigned the jobs to be jobs that people want to do: things like—haven't you got a coffee machine in the department? You know, just access to a cup of tea. There are places where you can work in Wales for health boards where you can't get a cup of tea all shift. Until those basics are right, it doesn't matter who markets it or how enthusiastically they do it, you have to have the authenticity from believing that it is a good job that you are recruiting people to.

[203] **Dai Lloyd**: Ocê. Mae'r amser yn llamu ymlaen rŵan. Rwy'n credu ein bod ni wedi cyfro'r rhan fwyaf o'r materion, ond mae yna'n dal i fod rhai cwestiynau i ddod. Jayne, a oeddet ti eisiau gofyn dy ail gwestiwn?

Dai Lloyd: Okay. Time is running on. I think we've covered most of the issues, but there are still a few questions remaining. Jayne, did you want to ask your second question?

[204] **Jayne Bryant**: Yes, thank you, Chair, just briefly. Do you think the differences throughout the UK—the sort of things in England with the junior doctor contracts—are having an impact here on our ability to recruit and train?

[205] **Dr Dykes**: Yes. There was some work out just yesterday—I haven't read the full paper; I had a quick look at it. It came up on Twitter yesterday. It's in one of the *British Medical Journal* journals. I'm not sure which it is; it's obviously not the main BMJ. I think it is an interview survey of junior doctors in England. It actually looks like the contract dispute there has driven this 30

per cent increase in general practice applications, because the enforced new contract there is more favourable to community-based working, but they're now fleeing from the same acute sector jobs, which is actually going to bring emergency medicine and other acute jobs down onto their knees even further. And of course, where have the emergency physicians fled to? Well, they're in Bangor. [*Laughter.*]

[206] **Dai Lloyd**: So, it's your fault.

[207] **Dr Dykes**: Yes, it's my fault. I just go poaching.

[208] **Dr Payne**: Could I answer that question, too? So, one of the challenges we have in Wales is the fact that, I believe, last year, 70 new GPs qualified. We need 200 new GPs a year to qualify. And, so, we have been reliant on qualified GPs crossing the border. So, actually, when there are woes in terms of recruitment in England, that will affect us. Now, there are opportunities for us to capitalise on the discontent of colleagues there because of the new contract, but there are also concerns I think you may have heard about from the BMA AiT rep last week, that it may result in a significant increase in pay for junior doctors compared to in Wales. So, it's hard at the moment to know how those two are going to balance out and what the impact on recruitment will be.

[209] In terms of recruiting GPs who have already qualified, all those factors about jobs for spouses, about schools for children, and concerns from the reporting about the Welsh education system, these are absolutely key barriers that are stopping people coming to join us. And in terms of ways to address that, actually, having that whole family package, talking to people at an earlier stage in their recruitment, 'What does your partner do?, and these are the opportunities, say, in academia and, say, in education'—. I think, Linda, you've got an example of a colleague who left because of his primary school teacher wife.

[210] **Dr Dykes**: Yes, I've got a couple, actually, of really fantastic clinical fellows. For some reason, lots of them are married to primary school teachers, and they're coming from England. Obviously, this is a problem, because they don't speak Welsh, and you cannot work as a primary school teacher in Gwynedd or Anglesey if you don't speak Welsh, and then further over. So, of course, they won't settle. They don't want a long commute; one of the reasons they're moving is for quality of life reasons, and so, you know, it's going to take a significant time to train a primary school teacher to be as

good in a second language as you need to be to be able to teach children. I mean, it's just so key. So, he was like, 'I'd love to stay longer, but I just can't'. His wife couldn't find any employment, even for bank work. She was commuting back to Watford. So, he did his eight months with us. He would like to have extended to 18 months, but he just couldn't.

[211] We've also discovered with our consultant recruitment—so a different cohort from our clinical fellows—that we cannot recruit anyone with school-age kids for love nor money. We've managed to recruit those whose children are preschool, no problem—absolutely no problem. The kids go to school, they become bilingual, even at nursery, within two or three months. It's absolutely phenomenal; it's not a problem. But we've had others who will go, 'I can't move. I'm not willing to move the kids, and I'm worried about the schooling issue'. We've recruited one other consultant with children, and then she waited until the youngest was in sixth form. She actually wanted to come to us for five years, but she would not move until the kids had finished their main schooling. So, you either do something about that, or you just say, 'That's not the target group'. You know, we need to be going for the lifestyle changers; we need to be going for the gay couples who are less likely to have children—of course, many do, but less likely. And we need to be going for those who are, you know, divorced or something and they actually now want a fresh start. Or you recruit them before. You get them straight out of training and you do all the sort of long-term nurturing stuff that I've done with my medical students, because that's where the roots lay, actually, you know, 12 years ago. But, you know, there are things you can do in a shorter timescale, too. You've just got to cater for the market. As I said earlier, it is a buyers' market, and we are selling.

[212] **Dr Payne**: Also, on a similar note, younger doctors who haven't yet met somebody, a lot of them are really scared about, 'If I move to a rural area, will I meet anybody?' There was a—

[213] **Dr Dykes**: [*Inaudible.*] dating service at RAF Valley.

[214] **Dr Payne**: There was a GP from Herefordshire who managed to recruit through a dating agency called Muddy Wellies, which, apparently, specialises in rural dating, and that's how they found the next doctor.

[215] **Dai Lloyd**: Sara.

[216] **Dr Bodey**: I just wanted to say a few things about the situation in

England. I think we do have an opportunity just at the moment to try and increase recruitment to GP training in Wales. What happened locally—. I'm a GP trainer on the Wrexham scheme and, last year, having historically been under-filled for years and years, we were full and we were turning people away. In Wrexham, every single GP practice is on the edge and at a high risk of having to hand back contracts. Yet, we were turning away GP trainees who wanted to come and train in that area. We've only got eight places on the Wrexham scheme. Wales is the only country in the UK that hasn't increased the number of GP training spaces in recent years. I think it's a real opportune moment at the moment to try and increase the number of spaces available for GP trainees, while we have a short-term, potential increase in interest from across the border.

[217] **Dai Lloyd**: Okay. Heidi, as well, on this point.

[218] **Dr Phillips**: Every year, I have 1,000 applications for 70 places. People want to be doctors. I've put a proposal in for a primary care academy in Swansea, but it doesn't need to be just Swansea. Basically, 90 per cent of doctor-patient interactions occur in primary care. We have this huge wealth of people who want to be doctors. If we can recruit from Wales, from areas all around Wales, into medical schools—our studies and studies abroad show that they're more likely to remain in Wales—then we can actually keep doctors working in Wales. If we teach medicine through a primary-care lens, rather than the secondary-care focus, we will actually be exposing these students throughout their journey to primary care and seeing patients at the point of coming into the service. Then, they're more likely to stay in primary care.

[219] The other thing about the primary care academy idea is that, if you sort the job out—so, you've got GPs working alongside community nurses, PAs, social services—so, at the point of contact, the patient gets directed to the right person, then you're freeing up your GPs to do the work that they trained for. They re-motivate and re-enthuse and the students they're bringing up behind them are seeing that model.

[220] **Jayne Bryant**: I was just going to come back—I agree entirely with what you're saying, Heidi—to you Rebecca, when you were talking about expecting OTs or physios to save GPs. On Monday, I was at a GP practice in my constituency that has taken on a prescribing physio. They said that they see a third of people with musculoskeletal problems and that's taken a real pressure off the GP. I was just thinking, that's such an important point—to

think that we can support our GPs in that.

[221] The other point I was going to make was, Heidi, when you were talking about turning people away—no, sorry, Sara was talking about turning people away, because you've got so many people applying for these jobs or wanting to be part of it. Is there any way of directing them to other places where there might be spaces or are there just no spaces?

[222] **Dr Bodey**: The system does do that, but we lose some of them to England. Where I work, doctors are often geographically set in that border territory. So, they will potentially have significant others who work in industry at Ellesmere Port or something like that, so they want to apply in that area. If they don't get their first-choice scheme within Wales, they're not going to want to go to Haverfordwest or somewhere like that because of their family ties. So, they might go to Chester, they might go to Mersey, and we lose them from the Welsh general practice at that point. I had a fabulous foundation 2 doctor last year who applied to Wrexham and didn't get in because we had this complete turnaround, which I suspect was the effect of what was going on in England at the time.

[223] **Dai Lloyd**: Okay. Rebecca.

[224] **Dr Payne**: One thing we haven't touched on is the impact of the performers list on recruitment. There are four performers lists across the UK. You have to be on the one for Wales to work. So, we have the situation where, if you are a locum on the border, and you've trained, say, in Chester, the amount of paperwork and bureaucracy has been a real deterrent. Although steps have been taken to try and address this, actually that legacy of the bureaucracy has been a real issue. I believe there's now something in place where people should be able to work for three months, but it's unclear if that is working as well as it could.

11:30

[225] The other real problem, particularly affecting north Wales, has been people who are returning from places like New Zealand who cannot get back into Welsh general practice. Although there is a returners scheme, people have found it extremely difficult to access it. Linda has got a doctor working with her in the care of the elderly team who wanted to come back to general practice but was unable to do that.

[226] **Jayne Bryant**: Why is that a particular problem in north Wales?

[227] **Dr Payne**: Because people want to come to north Wales because it is lovely.

[228] **Jayne Bryant**: Come to Newport.

[229] **Dr Payne**: Linda could tell you more about—

[230] **Dr Dykes**: Yes. It is the wife of one of my clinical fellows, actually: UK-trained, a UK GP, MRCGP, had been working in Holland in a very similar health system in terms of epidemiology and clinical practice for 11 years. She came back for a year, and because she was only coming back for a year, frankly, nobody could be bothered. You know what? They are really enjoying it, and I really think they might have stayed. But, as it is, she will be going back to her practice at the end of the time. We found a job for her as a specialty doctor in care of the elderly in the community, and she is doing an absolutely grand job. England is going to nail us on this if we are not careful. In my report, I put a link in on the PDF to the England—I can't remember what the document is called; Rebecca will help me out here. The have got a specific new supporting returners scheme, and we are not going to get any returners at all if England gets it organised. We are just going to lose, and we've got to sort it.

[231] **Dai Lloyd**: Okay. Last two questions: brief questions and brief answers, really. Dawn and then Caroline.

[232] **Dawn Bowden**: Okay. Thank you, Chair, and apologies for being late. I have missed all your evidence, but I have read your papers so, hopefully, I am up to speed. Just a general question around training, really, for GPs. I noticed that, in your submission, Sara, you talk about the difficulty that you can't get in to do locum work as a GP unless you have had various other types of training first. The RCGP are talking about the need to have mutual recognition of training, appraisal processes and validation. Can you say whether you think the shape of medical training gives sufficient opportunities in relation to GP and community medicine, as opposed to hospital specialisms?

[233] **Dr Bodey**: Not at all. As Heidi was saying earlier, I think the focus is still very much secondary care, all the way through medical school and through foundation. One of the things that we don't do well in Wales is have

doctors at foundation level having exposure to general practice. Certainly, in the north-west deanery in England, it is now compulsory. Historically, in Manchester, that has always been the case. They have historically had a high recruitment into GP specialty training, which is probably linked to that exposure at postgraduate level. We don't do that well in Wales. There is an issue with concern about destaffing medical rotas if they were to increase those jobs. My solution would be to increase the number of GP specialty trainees who contribute 18 months of hospital care as part of their training, which would then free up more junior doctors to have the opportunity to do F2 posts in general practice. There's a real wish from doctors to do it, but it's not done very well. My proposal for having the stand-alone posts made possible within general practice would potentially help to increase that opportunity as well. Again, there's a real interest from junior doctors to have that opportunity to try general practice before they commit to training in it.

[234] **Dr Phillips**: Another point would be to allow dual accreditation. I trained as an anaesthetist, and I had to give up anaesthetics to become a GP. I now only work two days a week in general practice. There is no reason I couldn't have done both and been a part-time anaesthetist and a part-time GP.

[235] **Dawn Bowden**: Yes, that was the supplementary that I was going to ask, actually—whether there is a barrier to doing that.

[236] **Dr Dykes**: A GP needs to dual [*Inaudible.*]. I have ended up dual training, and I am dual qualified, but that was under previous training rules, and I wouldn't be able to do it now. Desperate need—. It would also help the haemorrhage of trainees out of emergency medicine because, actually, they tend to go to general practice, funnily enough. That's perceived as the easier option. It's a skill set that actually matches incredibly similarly, and that also leaves you equipped to work in the community, which I am doing now on secondment. There are no pre-registration opportunities for doctors within community hospitals or home settings currently in Wales, nor in most of the country. So, there are huge opportunities, yes.

[237] **Dr Phillips**: But why are you forcing people to choose? That's basically what it comes down to. Why can't they do both?

[238] **Dai Lloyd**: Caroline can wrap up, and Isolde can answer it.

[239] **Caroline Jones**: Do you think the current structure and content of

doctor training is appropriate, or do you think changes could be made to help with recruitment and retention?

[240] **Dr Shore-Nye**: I will answer that because I can answer that. Actually, I was going to come in on the point about foundation, in that the royal college is very supportive of having essentially as many doctors as possible to do general practice within the foundation phase. At the moment, it's certainly our philosophy that every doctor should experience general practice as part of their training and, as such, that would enable people to make a career choice that would most likely, and hopefully, increase the number of people doing general practice. So, at the moment, in Wales, no, I don't think the trainee junior doctors—

[241] **Dai Lloyd**: Rebecca, the absolute last word.

[242] **Dr Payne**: Okay. The other really important issue is parity of esteem. It is still the case that we have junior doctors on the wards who will not tell the consultants they want to be GPs because they will be denied opportunities to do different complex tests on people and they would be denied learning opportunities. And actually, if I could pick one thing I'd like you to do today, I'd like you to legislate so that people in hospitals cannot disrespect general practice, because the effect that has on vulnerable medical students and junior doctors, who have this drip, drip, drip throughout the training of, 'Oh, only stupid people become GPs', 'Oh, you can do more than that'; it really, really stops people going into general practice. So, yes, we need parity of esteem.

[243] **Dr Dykes**: I'm going to break in: it is quite astonishing the difference in how you get handled by specialty junior doctors in hospital when you're phoning as a GP, rather than calling as an emergency department consultant. That's disgusting.

[244] **Dai Lloyd**: Right, we're out of time—over time. We were all getting carried away with the unbridled enthusiasm of it all.

[245] **Dr Dykes**: There is a lot we can do.

[246] **Dai Lloyd**: Yes.

[247] Felly, diolch yn fawr iawn ichi gyd—gwerthfawr iawn. Fe gawn ni	So, thank you all very much; it was very valuable. We'll take a break now

doriad nawr am bum munud. Diolch yn fawr iawn ichi.

for five minutes. Thank you.

Gohiriwyd y cyfarfod rhwng 11:36 a 11:43.
The meeting adjourned between 11:36 and 11:43.

Ymchwiliad i Recriwtio Meddygol—Sesiwn Dystiolaeth 5—yr Athro Dean Williams
Inquiry into Medical Recruitment—Evidence Session 5—Professor Dean Williams

[248] **Dai Lloyd**: Croeso yn ôl i fy nghyd-Aelodau i'r sesiwn ddiweddaraf o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. Mae Angela yn cyflwyno ymddiheuriadau—mae hi wedi gorfod gadael, ac felly bydd rhaid inni ymlwybro ymlaen heb Angela yn ein plith, ond rwy'n siŵr y byddwn ni'n gallu ymdopi.

Dai Lloyd: Welcome back to my fellow Members to the latest session of the Health, Social Care and Sport Committee here that the Assembly. Angela has given her apologies—she's had to leave, and so we will have two carry on without her during this session, but I'm sure that we'll be able to manage.

[249] Fe wnawn ni symud ymlaen at eitem 4 ar yr agenda y bore yma, ac rydym ni'n parhau â'r ymchwiliad i recriwtio meddygol: sesiwn dystiolaeth 5 nawr ac o'n blaenau y mae'r Athro Dean Williams. Croeso i chi, yr Athro Dean Williams o Ysgol Gwyddorau Meddygol Bangor. Rydym ni wedi derbyn tystiolaeth ysgrifenedig ymlaen llaw, ac felly, gyda'ch caniatâd, fe awn ni'n syth i mewn i gwestiynau ar yr holl agenda yma. Felly, croeso i chi at y bwrdd, ac mae'r cwestiwn cyntaf o dan ofal Dawn Bowden.

Let's move on to item 4 on the agenda this morning, and we continue with our enquiry into medical recruitment: it's evidence session 5 now and before us we have Professor Dean Williams. Welcome to you, Professor Dean Williams, from the Bangor School of Medical Sciences. We have had written evidence from you in advance, so we can go straight into questions, if that's okay with you. So, welcome to the table, and the first question is from Dawn Bowden.

[250] **Dawn Bowden**: Thank you, Chair. Good morning, Professor Williams. Can I just start with a general question, really, asking you about the profile of

students coming to your school? Are they primarily Welsh? Do you have a lot of English? And, basically, where do they go once they've finished? That's probably the biggest question.

[251] **Professor Williams**: Yes. Expectation management. It depends. We have a few different cohorts of students now. The school has grown over the last four or five years.

11:45

[252] We started with a BMedSci programme, initially, and we were just taking virtually any student to get the programme up and running. It was very important to get it up and running at that time, I felt. I'd say that the demographics of the students are pretty much similar to the rest of Wales, in many ways. We have a few Welsh from north Wales, a few from south Wales, a few from England and some from abroad. I think the change for us, more recently, has been the physician associate programme, which we started with Swansea. We got recent money for that from Welsh Government, and we've got five Welsh speakers in that, out of 12, and nine, I think, are from Wales out of the 12, so I'm very pleased with that number. I'm trying very hard to get more Welsh people on the courses, because of the obvious need.

[253] In terms of where they're going, I think the biomedical courses that we have running offer good employment opportunities in the labs throughout the UK. It's an accredited course. On the BMedSci, some of them are still hankering to do medicine even though they failed to get in first time around, and some of them are going to courses in the UK, but very few. To date, only one in Cardiff, and that was through negotiation. Of the rest that are doing medicine, some are in Europe, one is in the States and one is in Ireland. The rest, then, continue to do research programmes, or go into other types of work. The key thing is for us to manage expectations, because a lot of them think they can come into the programme and hopefully do medicine, not realising, sometimes, that it is a very competitive world, and that's one of the key things, so that we don't get disappointed students reflected in poor student surveys.

[254] **Dawn Bowden**: So, do they come with an idea that they want to stay here, or are they just coming with the idea of wanting to study medicine, or wanting to study whatever the specialty is, and they make their decisions, then, as they go along—is that it?

[255] **Professor Williams**: Yes, I think the local students—certainly from north Wales—a lot of them have chosen to go to Bangor, and my impression is that a lot of them want to stay in north Wales, given the opportunities. The ones who come from England, I think, are not particularly wanting to stay in Wales. They're just looking for a good programme they can enter, and I think Bangor's been there a long time, so it's still on the map as a place that they can go to study. So, hopefully they select us based on the profile, and the quality, and the surroundings for study. I feel that, providing we can keep on recruiting local people, hopefully they will stay, and we can offer those opportunities if they arise, but at the moment, several of them disappear and we never see them again. The important thing for us is that we've learnt over the last few years to give quality programmes, and the feedback we're getting from students who leave us is that once they're gone, they realise how good it was. They've told us that as well, which is nice to know, but they should really tell us just before they leave rather than afterwards. [*Laughter*.]

[256] **Dawn Bowden**: Okay. Thank you.

[257] **Dai Lloyd**: Julie Morgan.

[258] **Julie Morgan**: Diolch. So, do you raise much awareness in the local communities about what you're doing, or with the schools?

[259] **Professor Williams**: Well, yes. I'm also undergraduate organiser for Cardiff medical school for the clinical placements up in north Wales—for the ones in north-west Wales. We've had a programme for quite some time where my manager, Kim, goes to the local schools—several of the comprehensive schools—and now, increasingly, younger groups as well, to push the medical agenda for students who maybe think they're not good enough, or maybe aren't thinking about medicine. So, we promote that as part of helping Cardiff, trying to get more Welsh students into Cardiff, but I've piggybacked onto that—I don't mind saying. The Bangor side, as well as having our own impact on people, we also piggyback on that, so they're aware of what's happening in Bangor as well, if they're unsure about medicine or want to do other courses. The school's only been there for a few years, and I think, because of that, we're new and sometimes the careers teachers in the schools are not familiar with it, so it's ongoing work, but the profile is definitely improving.

[260] **Julie Morgan**: Right. Thank you.

[261] **Dai Lloyd**: Jayne.

[262] **Jayne Bryant**: That's great to hear, that that's happening. I'm very pleased to hear that. How does this school work with the local health boards and other medical schools in Wales to achieve clinical placements for students?

[263] **Professor Williams**: Some of the courses are more clinically orientated than others. I pride myself on introducing clinical exposure as much as possible. The students really enjoy that clinical exposure, it's a key part of what of we do, and because I'm a consultant vascular surgeon in Bangor, I really take them under my wing so that they come up for clinical placements. My favourite type of teaching is when they have some classroom teaching in the hospital, and then I take them to the ward to see my patients who have the conditions that I've just taught them on in the classroom. I do that for Cardiff students as well. I've done that for several years, and promoted that for a long time. So, I use the board in that respect, with my dual roles, to make the most of that opportunity that I have, but I get a lot of honorary clinicians coming from not just Bangor but from Glan Clwyd and from Wrexham in particular. They come over and teach for us. These are clinicians who, in their fields, are very knowledgeable and they bring the clinical edge to the teaching—mindful again about not pushing it too hard, because some of these guys are not going to be doing medicine eventually, but they might do things allied to medicine. But I do use staff across the patch, being mindful of being inclusive for all of north Wales and not just Bangor.

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

[265] **Dawn Bowden**: I just took a mouthful of biscuit, I do apologise. Can you tell us a bit more about how the school works with the NHS and higher education in England?

[266] **Professor Williams**: With England?

[267] **Dawn Bowden**: Do you have particular or special arrangements with any—?

[268] **Professor Williams**: No, not at all, not with England. I mentioned about the board connections already. With England, I must say I'm not mindful of what's happening in England. It might take students away, rather than working with them, I would say. That sounds a bit harsh, maybe, but that's

the truth.

[269] **Dai Lloyd**: Well, very wise. [*Laughter.*]

[270] **Professor Williams**: We obviously have connections with—. I mean, we're a long way from Cardiff, and in some ways—

[271] **Dawn Bowden**: Indeed, so it's the north-west of England—

[272] **Professor Williams**: Yes, but at the moment I see them as competition rather than any friendly discussions, and we all watch what each other's doing anyway, naturally so. For my courses, I don't need them and I'm very happy with the provision I have in north Wales. We have stunning teaching feedback for north Wales, and clinical placements have been excellent for years now. Cardiff are very reliant on this and very proud to be part of that as well, outside the school of medical sciences, but as part of the clinical placements for Cardiff students.

[273] **Dawn Bowden**: Okay, so you haven't felt the need to go there and make any kind of relationships with them.

[274] **Professor Williams**: No, not so far.

[275] **Dawn Bowden**: That's fine. Okay. Thank you.

[276] **Dai Lloyd**: Caroline Jones.

[277] **Caroline Jones**: Diolch, Chair. With regard to medical recruitment, what contribution can you see the school making now and in the future? Do you feel the training needs to change in any way?

[278] **Professor Williams**: Obviously, I don't train; I'm not training medical students to be doctors. We are delivering medical sciences and we have biomedical scientists being trained on accredited courses with us. Obviously, it would be nice to think that at some point we will—. It would be nice to have a medical school in Bangor for north Wales and for the rest of the UK, providing quality education. I would hope that would be—. That would be an important part, I think, of the workforce issue that we have. Recruitment and retention is a major problem for us in the north. I know it's a problem in many places, but by golly, we've got it bad in the north. I would hope the reason I'm so keen to pursue this—and it's a lot of work—is because I see

the worth in it, and I hope others will do too. In terms of the impact of the school, that would be—I mean, I'm afraid that's down to the politicians for the most part, I think.

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

[280] **Dai Lloyd**: Rhun, speaking of politicians and stuff.

[281] **Rhun ap Iorwerth**: I, as you know, am a big supporter of the establishment of a medical school in Bangor. We've discussed it before. I see it as a medium-term goal. What I see as the short-term goal—the immediate goal, actually, probably—is to establish medical training within Bangor, perhaps a new community model of medical training in partnership with Cardiff. Do you see that as something that we not only could but should be looking to introduce, almost immediately, in order to build up the infrastructure of medical training in the north-west of Wales?

[282] **Professor Williams**: A lot of things in there, Rhun. In terms of infrastructure, we already have it. We've been training for many years now for all clinical placements and done very well with that. We know there was an announcement from Jeremy Hunt, wasn't there, about increasing medical student training, and my concern is that if we keep on delaying things, we'll miss the boat yet again. I think we missed a great opportunity a few years ago when they created the north Wales clinical school, when Swansea then created a whole medical school. We missed out terribly and that's been of no use to us whatsoever in terms of recruitment. The school of medical sciences is improving recruitment a bit; people are coming to see me because they know it exists. It's nowhere near the impact that a medical school would have, but it's showing itself to be somehow—. I think the news is beginning to get out there that we have something brewing. I'm wary that, if we hold on to things as they are, and hope that Cardiff will help us somehow, we're going nowhere in the longer term. As I see it—. You know, I look after Cardiff medical students and we enjoy taking them, and we've got a very enthusiastic group of teachers in north Wales, and some Swansea ones and from Manchester and Liverpool now, but I think that—. We would still have the same teachers for medical students in Bangor. There wouldn't be much of a change. The clinical placements would be the same. But I'm wary of how much workforce we'll have left at this rate, and there'll be no point in training, because we'll have nothing to put them into.

[283] **Rhun ap Iorwerth**: How important would you see the development of

rural medicine as a specialism as part of the project of developing medical education in Bangor?

[284] **Professor Williams**: I think it's very important. The centralisation agenda that's ongoing is very damaging to rural provision, because we don't have the numbers. I think we should be wary of the quality we deliver and not the quantity, because otherwise we are going down the Swanee very quickly, and I am very worried about that.

[285] On the rural provision, Cardiff has made noises recently about providing more students for us for rural provision, but it's not the big numbers. It's not going to be a game changer for us. I think we'll be in the same trouble, or even worse, in a few years as a result of this. I think there needs to be a bigger emphasis on what we're doing up there. I genuinely feel that these small, little bits of change are not going to be game changers. We know this from around the world, where health provision has been in real trouble. The governments involved have made major changes, either in the type of provision from the established medical schools or having new medical schools. They definitely have provision focused on where the needs are—either they're rural, or, where there are population differences, where they have to focus on getting doctors of a particular minority back into those areas. There's good evidence from America and Australia on this, and I think the rural provision is a key thing, but I really feel that politicians need to recognise that, as you do. I think a medical school based on rural provision would be an excellent thing, a little bit like what they do in Scotland, where some of the students are told at the start, 'You'll be going into rural provision straight away'. So, either we need a game changer like that, or we need to start thinking about a rural school for rural north Wales.

[286] **Rhun ap Iorwerth**: If we are able to, in the next year or two, as soon as that, start anchoring medical students in Bangor—be that third years, perhaps, starting in Bangor doing the latter part of their medical training, or moving to get first years coming there, or whatever it might be—how soon would you expect us to see an impact on recruitment within the NHS? Because surely that is what we are training doctors for—to help work in the Welsh NHS.

[287] **Professor Williams**: I think there are two aspects to the impact. The first one is the fact that you have a medical school. SMS has had some impact on this, but as soon as you have a medical school, it has an immediate impact, because senior clinicians, and indeed middle grades and junior

grades—if you've got a medical school, it makes it more attractive. There's a silver lining on the placements. It gives it a certain credence that you're going somewhere that has a medical school. That's an instant hit. I've had people come and see me in the last few weeks—a new pathologist up in the north who's come to see me because he came partly to Bangor from the north-west of England because he heard there was a school of medical sciences that is making progress. So, it has an immediate impact.

[288] The second impact then is, of course, the students coming through. So, if the students are trained, particularly from day one, in north Wales, it's very likely that they'll forge roots and stay there, even if they're not from there initially. Although I'm very keen on making the most of the local student population we have from Anglesey, Gwynedd and north Wales in general. But once they start there, they'll tend to stay there. So, we'll have a house officer—. So, the golden handcuffs won't be such an issue, I don't think, because they'll already be settled there. And why not settle there? If we've got the jobs and the training, it's a nice part of the world—my wife tells me. So, I think we've got a very good product to sell, and I think it would go a long way to solving the issues, with the juniors coming through as well as the established consultants coming along, really, I think, in big numbers when they realise there's something good going on.

[289] **Rhun ap Iorwerth**: And it's taking that first step, because if you look at Keele University, which now has a medical school, it started off as an offshoot of Manchester and they built it up incrementally over not too long a timescale. You're confident that that can be done if we take some initial steps.

[290] **Professor Williams**: Yes, because we already have—. I mean, I've talked to a lot of people about this, but because we already have the clinical placements, and we have a Master's programme and a Bachelor of Science programme, that actually is a curriculum in its entirety for medicine.

12:00

[291] **Rhun ap Iorwerth**: You tell me when you want me to stop—

[292] **Dai Lloyd**: Well I've got a question on the Bangor medical school myself, but—. Having been intimately involved 15 years ago with the development of the Swansea postgraduate medical school myself, obviously a couple of things come into play: what comes first, what comes after—

chicken, egg; egg, chicken. Teaching hospital, medical school; medical school, teaching hospital. Now, obviously in Swansea we had Morriston and Singleton very well established as teaching hospitals. How do you see the importance of developing Ysbyty Gwynedd to fulfil an enhanced role like that? Because obviously to fulfil—. And I want to see a medical school in Bangor, all right? I would encourage dialogue with Swansea, certainly. And along the lines of what you said about Keele, well, we've seen that in Swansea University. Swansea University has had its second campus now, and it's going up the ratings and that all started from having a medical school—that's what kick-started it. It was very much backwater, with all due deference to my home university, but it's having the medical school that kick started everything, and now it's got a £450 million second bay campus on the back of all of that. But it also did have well-established teaching hospitals before we all started that, which was a strength, obviously. So, I was just wondering what your thoughts are about that, because we want to see this happening, lots of us do. But there's some groundwork to be done, obviously.

[293] **Professor Williams**: Yes, of course, but I think we're fortunate in that—coming back to Rhun a little bit—we've been taking Cardiff students and Swansea students now for quite some time, and the feedback is very, very good. The Cardiff guys come up and they have nothing much to say to us. They have a traffic light type of system where you go from reds and then to whites—I know there's no white in traffic lights—and you go amber, then green, and we show greens across the patch. They just look at us and say 'Wow.' This is for students who were kicking and screaming initially to come out to north Wales, because it's a long way away from their base in Cardiff, and we end up with stunning feedback. I think this is a reflection of the enthusiasm north Wales has, and the ability to teach. I know that these scores are not the be-all and end-all, but what we have is a group of people who are not paid particularly extra—the board gets the money; we get SIFT money, of course—but these are enthusiasts. We get these students, and we're very keen to see them. We hope some come back, of course. Some do, but not many. We had six last year, and we had over 100 in north Wales all together. But I think the quality is already there—absolutely. I think nobody would challenge that. I think we have stunning results for somewhere so far away. They could go to London much quicker than they come to us, and a lot of them really resist coming to north Wales, for understandable reasons—it's so far away. So, I think I can justifiably say we have some excellent teaching, so that groundwork is all done. The only thing we don't have are the superspecialties like cardiothoracics and neurosurgery. But of course, that

makes up a very small part of the curriculum. That can be done in Cardiff—that would be fine—or even Liverpool or Manchester if need be.

[294] **Dai Lloyd**: Okay.

[295] **Rhun ap Iorwerth**: That leads me to on to something else I wanted to ask you about. Either working together alongside medical training in Bangor, or saying, 'Scrap that, that doesn't happen,' what is the role of Liverpool and Manchester universities in terms of training people for the Welsh NHS? What's the potential there? Even by getting them to introduce elements of rural medicine, Welsh language provision, whatever it might be through those institutions, that were for many years, of course, seen as the north Wales medical schools.

[296] **Professor Williams**: Yes, well, my wife went to Manchester medical school because it was a lot closer than Cardiff, and my wife's very Welsh speaking and very Welsh cultured. But we get placements from Liverpool and Manchester. Less so in Bangor, because there are distances involved, but certainly in Wrexham and around Glan Clwyd, and particularly in general practice, there are quite a few students from Liverpool and Manchester. From my experience, in the west it's limited. But, absolutely, there is no reason why—if they were going to expand—we wouldn't welcome them, in terms of placements, and it might help us with recruitment. But, personally, I've always had a hankering that there should be a Welsh solution to this, rather than going to England. I know it's closer than Cardiff, but I've always liked—politics aside—that somehow there could be a Welsh solution to this, rather than going to England to look for our solutions.

[297] **Rhun ap Iorwerth**: And you make that case very strongly. Is there an argument that, actually, Liverpool and Manchester universities are using up fairly hard-to-find placements in some areas that you would want in a medical training facility in Bangor?

[298] **Professor Williams**: Well, I've talked about this before, I think, with one representative from the Government. Of course, one of the major issues here—if we were to develop a medical school in Bangor, we would need placements. Now, we could be very careful. Some of the reasons why we have very good feedback is because I limit the number of placements to a number of students. We don't oversaturate the placements with too many students, because that results in poor experience. If we were to develop something in Bangor, that means that there would be fewer placements for somebody else

and that could well be Cardiff. Now, Cardiff, with its expansion, and with Swansea's expansion—it means they really do need the north Wales placements. If you are going to have things in Bangor, it means that—actually, there isn't the capacity to take many more, I feel. We might be able to, but, based on what I understand about placements, this could be a bottleneck, and we've got to get, at the end of the day, the best conditions we can get from a training programme for our health. So, you can stuff them in, but I think that might be, possibly, detrimental. One of my concerns with the whole process is that Cardiff medical school does well within the rankings, but I'm worried about would there be any pressure—that they'll know that they would lose placements if Bangor was to develop its own school.

[299] **Rhun ap Iorwerth**: But that suggests that, maybe, a formal partnership between Bangor and Cardiff would be a way forward that actually—

[300] **Professor Williams**: Absolutely. I've been trying to do that for—. But to get from the start—. I mean, if it was a combined—. I've been to Swansea in the past, I've talked to them about this, but they were concerned a little bit about their own future at that time. But, absolutely, if there was an all-Wales solution to this, I'd be all ears.

[301] **Dai Lloyd**: Obviously, when you do get a medical school, then at least some of the local consultants, if not most of them, have some sort of teaching commitments and they become tutors/professors, and that's an encouragement—

[302] **Professor Williams**: That's right. That's the silver lining—we all like to recruit—

[303] **Dai Lloyd**: High-quality medical staff in that area.

[304] **Professor Williams**: Yes, absolutely. Quality as well as quantity.

[305] **Dai Lloyd**: Yes, absolutely. Can I just ask, before we finish, about your physicians associate course? Let's talk about now a bit and what you do—just expand on that. How common is that sort of course? Obviously, it's the sort of stuff that's starting to happen.

[306] **Professor Williams**: That's mushrooming. That is a big area. Barefoot doctors, of course, came from—it was China or India, because they couldn't

get doctors to go to rural areas. Doctors trained and went off to the big cities. I recognise that theme even today. So, they decided on having barefoot doctors, who had minimal training, not as much as a medic, but enough to make them useful in the community to look after the ailments of the population. In the States, they've been going on for quite some time—many years now. I think there are some 50,000 or 60,000 physicians' assistants or associates, whatever you want to call them, really to bolster the workforce, because they're still short of doctors, and in particular areas.

[307] In the UK, I think, if I remember correctly, they think it's going to be 1,000 PAs coming out in the next two, three years to help with the real shortfall in medical provision. So, they are seen as part of the medical workforce, as being part of the medical teams, but also in general practice. They are trained for two years under a medical model—pretty intensive. They are all graduates in life sciences or appropriate subjects. I've just been doing an exam paper this morning while I've been waiting, just to get up to speed. We've got 12 in Bangor. It's a pilot—the Welsh Government gave us money for 12 in Bangor and there were 15 allocated to Swansea. I think there are around 27 universities across the UK now where they're all having PA programmes starting, and there's more interest from Wales as well, as we speak. But I haven't had any confirmation, any further moneys from Welsh Government, because it was a pilot. I'm hoping for some good news, hopefully soon.

[308] **Dai Lloyd**: Just in terms of the record, how are PAs thought to slot into the medical workforce? Because, in terms of—are we talking paramedics? What are their indemnity and clinical responsibilities? If they're attached to a GP practice, it's still the GP who carries the can, or—

[309] **Professor Williams**: Yes. They are not generally seen as independent practitioners. So, one of the issues has been, I think, there was some worry about advanced nurse practitioners and stepping on toes a bit between the roles. They are independent in terms of their practice, but, ultimately, there'll be a senior keeping an eye on them. But, if you like, the amount of supervision they require depends on their seniority. So, for me, I'd really like one on my firm, but I can't be greedy, because I train them—I can't train them and take them. But to have one on my team whom I could leave, just like a house officer, because, ultimately, the junior doctors are under my care as well, but there ought to be indemnity as done for any health professional—. There's still a discussion about the governance. They don't actually have the GMC or anything yet at this time, but I think it's coming.

Scotland were a bit hesitant, but I think they've taken them on board now as well. And because they are generically trained, they can fit into any specialty. So, as news is spreading, because people are saying, 'Oh, we could do with one of those', because they can be trained generically and then focus on a particular area. So, that's a big advantage, I think anyway, and I think other people are beginning to see that.

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

[311] **Rhun ap Iorwerth**: I've been talking to one of your physician associated students—

[312] **Professor Williams**: You did, yes.

[313] **Rhun ap Iorwerth**: It's a postgraduate course, of course, and we have the issue in Wales of postgraduate loans not being available. I have the e-mail from Government that came a day after I raised this in the Assembly, so clearly taking all the credit, but—. How difficult has it been having that postgraduate course for jobs that we need in the NHS, but without having that student finance support in place?

[314] **Professor Williams**: Well, that last thing you particularly talked about, it's a struggle, really; she struggled hard with that one and is still struggling, I think, to some extent, which is why I'm very grateful that you've helped her with that. The money side is important, of course, because these guys are not earning a huge amount of money. The Government have given us fees, so they've paid for the course, which is great, so they're not out of pocket that much, but it's another two years on top of graduating, so there are financial penalties. But, of course, at the end, provided you get through the national exams and Bangor's exams, they have an opportunity to earn £30,000 or £35,000 a year, which is reasonable money for people who are coming out after five years. But the issue of costs is a constant pressure on all of them, apart from the privileged few who have enough money to one side. Most of them are watching their pennies, and it's not the best place to be. Of course, these jobs didn't come and go in handcuffs; my concern is they might disappear at the end. So, I've got to hope that the salary they get at the end is actually competitive with what they could get in England.

[315] **Rhun ap Iorwerth**: But, certainly, this announcement today is welcome.

[316] **Professor Williams**: Thank you.

[317] **Dai Lloyd**: Grêt. Rwy'n credu ein bod ni wedi gorffen y cwestiynau, so rydym ni ar ddiwedd y sesiwn. Diolch yn fawr iawn i chi, a diolch am y wybodaeth yn ystod y sesiwn yma a hefyd am y wybodaeth ysgrifenedig a gawsom ni ymlaen llaw. A allaf i jest gyhoeddi hefyd y byddwch chi'n derbyn trawsgrifiad o'r sesiwn yma i'w wirio i wneud siŵr eich bod chi'n hapus bod pethau'n ffeithiol gywir? Yn naturiol, allwch chi ddim o reidrwydd newid eich meddwl am unrhyw beth, jest gwirio y ffeithiau—bydd hynny'n iawn. Felly, gyda chymaint â hynny o ragymadrodd, a allaf ddiolch yn fawr iawn i chi am eich presenoldeb? Diolch yn fawr.

Dai Lloyd: I think we've come to an end with the questions, so we're at the end of the session. Thank you very much, and thank you for the information during this session and the information you sent us previously. Can I just also say that we will send you a transcript of this session so you can check it for factual accuracy? Of course, you can't change your mind about anything, but if you could just check it for the facts, that would be great. So, with those few words, may I thank you very much for your attendance? Thank you very much.

12:13

Papurau i'w Nodi
Papers to Note

[318] **Dai Lloyd**: Symudwn y pwyllgor ymlaen nawr i eitem 5. Mae yna bapur i'w nodi yn fanna. Fe fyddwch yn nodi llythyr gan y Weinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol ar Fil Iechyd y Cyhoedd (Cymru).

Dai Lloyd: We'll move the committee on then to item 5. There is a paper to note: a letter from the Minister for Social Services and Public Health on the Public Health (Wales) Bill.

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

Cynnig:

Motion:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

that the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[319] **Dai Lloyd**: Symudwn ymlaen i eitem 6, a chynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. Pawb yn cytuno? Pawb yn cytuno. Diolch yn fawr. Fe awn i sesiwn breifat.

Dai Lloyd: Moving on to item 6, a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. Is everyone content? Everyone is content. Thank you very much. We'll go into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:13.
The public part of the meeting ended at 12:13.