Agenda – Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:
Ystafell Bwyllgora 3 – y Senedd
Dyddiad: Dydd Mercher, 7 Mawrth 2018
Amser: 09.30

I gael rhagor o wybodaeth cysylltwch a:
Claire Morris
Clerc y Pwyllgor
0300 200 6355
SeneddIechyd@cynulliad.cymru

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

2 Caffael Contract Ffamwaith Systemau Gwasanaethau Meddygol Cyffredinol – sesiwn dystiolgaeth gyda Coleg Brenhinol yr Ymarferwyr Cyffredinol a BMA Cymru

(09.00 – 09.30) (Tudalennau 1 – 19)

Dr Rebecca Payne, Coleg Brenhinol yr Ymarferwyr Cyffredinol

Dr Charlotte Jones, BMA Cymru

3 Ymchwiliad undydd i Restri Cyflawni Meddygol Cymru Gyfan – sesiwn dystiolaeth 1 – Coleg Brenhinol yr Ymarferwyr Cyffredinol a BMA Cymru

(09.30 – 10.15) (Tudalennau 20 – 61)

Dr Rebecca Payne, Coleg Brenhinol yr Ymarferwyr Cyffredinol

Dr Charlotte Jones, BMA Cymru

Egwyl (10.15 – 10.20)

4 Ymchwiliad undydd i Restri Cyflawni Meddygol Cymru Gyfan – sesiwn dystiolaeth 2 – Y Cyngor Meddygol Cyffredinol

(10.20 – 10.50) (Tudalennau 62 – 67)

Clare Barton, Cyfarwyddwr Cofrestru Cynorthwyol, Y Cyngor Meddygol Cyffredinol

Egwyl (10.50 - 10.55)

5 Ymchwiliad undydd i Restri Cyflawni Meddygol Cymru Gyfan - sesiwn dystiolaeth 3 - Deoniaeth Cymru

(10.55 - 11.25) (Tudalennau 68 - 71)

Yr Athro Malcolm Lewis, Deoniaeth Cymru

Egwyl (11.25 - 11.30)

6 Ymchwiliad undydd i Restri Cyflawni Meddygol Cymru Gyfan - sesiwn dystiolaeth 4 - Cyd-bartneriaeth Gwasanaethau GIG Cymru

(11.30 - 12.15) (Tudalennau 72 - 82)

Liam Taylor, Dirprwy Gyfarwyddwr Meddygol, Bwrdd Iechyd Prifysgol Aneurin Bevan

Dr Karen Gully, Cyfarwyddwr Meddygol, Bwrdd Iechyd Addysgu Powys

Dr Fraser Campbell, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr

Sandra Preece, Rheolwr Contractau Cymru Gyfan

Dave Hopkins, Cyfarwyddwr Gwasanaeth Gofal Sylfaenol

7 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod

8 Ymchwiliad undydd i Restri Cyflawni Meddygol Cymru Gyfan - trafod y dystiolaeth

(12.15 - 12.30)

Vaughan Gething AC / AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Aelodau'r Cynulliad
Cynulliad Cenedlaethol Cymru
Bae Caerdydd
Caerdydd
CF99 1NA

27 Chwefror 2018

Annwyl gyfaill,

Mae nifer ohonoch wedi codi cwestiynau ynghylch y broses gaffael ar gyfer systemau meddyg teulu yng Nghymru a gafodd ei chyhoeddi ddydd Llun 29 Ionawr 2018. Rwy'n ysgrifennu at bob aelod i egluro'r broses a'r penderfyniadau a wnaed. Mae'r rhan fwyaf o'r ohebiaeth wedi canolbwyntio ar y ffaith na fu cais EMIS i barhau i ddarparu gwasanaethau systemau meddyg teulu yng Nghymru yn llwyddiannus. Gan fod cyfnod segur gorfodol Acatel wedi dod i ben, gallaf roi mwy o fanylion nawr i egluro'r rhesymeg y tu ôl i'r penderfyniad ar ddyfarnu'r contract.

Cafodd y broses ei harwain gan Wasanaeth Gwybodeg GIG Cymru ar ran y Byrddau Iechyd, ac fe'i gweithredwyd drwy ddau strwythur er mwyn cyrraedd penderfyniad ynghylch pa ymgeiswyr i'w dewis.

Bwrdd Rhaglen Technoleg a Rheoli Gwybodaeth y Gwasanaeth Meddygol Cyffredinol fu'n gyfrifol am oruchwylio'r broses gaffael. Mae aelodau'r bwrdd hwn yn cynnwys cynrychiolwyr o Bwyllgor Ymarferwyr Cyffredinol Cymru, Coleg Brenhinol yr Ymarferwyr Cyffredinol, Rheolwyr Meddygfeydd a Llywodraeth Cymru.

Dirprwywyd cyfrifoldeb dros weithredu'r prosiect i is-grŵp o'r Bwrdd Rhaglen (sef Pwyllgor Gweithredol y Prosiect), sydd hefyd yn cynnwys cynrychiolaeth o Ymarferwyr Cyffredinol Cymru. Alan Lawrie, Cyfarwyddwr Gofal Sylfaenol a Chymunedol Bwrdd Iechyd Prifysgol Cwm Taf, sy'n cadeirio'r Pwyllgor hwnnw.

Gwnaed argymhellion gan Bwyllgor Gweithredol y Prosiect er mwyn helpu'r Bwrdd Rhaglen i wneud y penderfyniad terfynol. Cyflwynwyd y penderfyniad wedyn i Fwrdd Ymddiriedolaeth GIG Felindre iddo ei gymeradwyo.

O ran y penderfyniad y daethpwyd iddo, mae Gwasanaeth Gwybodeg GIG Cymru wedi dweud yn glir na chafodd hwnnw ei wneud yn seiliedig ar gost. Ystyriwyd ystod eang o fesurau sgorio fel rhan o'r broses gaffael, ac nid oedd ymateb EMIS Health Ltd yn dod yn agos at fodloni'r gofynion. Rwy'n atodi copi o'r llythyr a anfonwyd ar y cyd gan Wasanaeth Gwybodeg GIG Cymru, Pwyllgor Ymarferwyr Cyffredinol Cymru, a'r Bwrdd Rhaglen at yr holl feddygfeydd a oedd yn defnyddio EMIS i egluro'r rhesymeg y tu ôl i'r penderfyniad.

Bae Caerdydd
Caerdydd
CF99 1NA

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

Hyderaf fod hyn yn ddefnyddiol ichi ac yn dangos pa mor drylwyr oedd y broses gaffael o ran sicrhau'r gwerth gorau ar gyfer gwariant cyhoeddus, ynghyd ag ymrwymiad cadarn a'r gallu i fodloni gofynion y Gwasanaeth Meddygol Cyffredinol, yr agenda Gofal Sylfaenol ehangach a mwy o integreiddio â gwasanaethau digidol GIG Cymru.

Os oes gan feddygfeydd yn eich etholaethau ragor o gwestiynau ynghylch y broses gaffael a'i chanlyniad, hoffwn eich annog i'w trafod gyda Gwasanaeth Gwybodeg GIG Cymru drwy e-bostio [redacted]

Yn gywir,

Vaughan Gething AC / AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

At: Practisau Meddygon Teulu sy'n defnyddio systemau cyfrifiadur EMIS

9 Chwefror 2018

Annwyl Gyfaill

Caffael Contract Fframwaith Systemau Gwasanaethau Meddygol Cyffredinol

Yn dilyn ymlaen o'n llythyr dyddiedig 29 Ionawr 2018, ysgrifennwn atoch gyda mwy o wybodaeth am y penderfyniad yn ymwneud ag EMIS Health Ltd.

Rydym yn cydnabod fod newid cyflenwyr yn ymgymeriad sylweddol iawn ac mae'n destun siom fod EMIS Health Ltd wedi cyflwyno ymateb a oedd ymhell o fod yn bodloni'r gofynion, er gwaethaf cynnal deialog sylweddol yn ystod pob cam yn esbonio pam na fyddai eu newidiadau arfaethedig i ofynion GIG Cymru yn dderbyniol. Nid oedd y sefyllfa hon yn gyson â'r ymatebion gan Vision (InPractice Systems Ltd) a Microtest Ltd, a gafodd eu penodi i'r Fframwaith.

Canolbwyntiodd y gwerthusiad caffael ar sicrhau bod pob cyflenwr yn cynnig system a oedd yn bodloni'r gofynion gweithredol sylfaenol, yn ychwanegol at y cymorth ehangach, lefelau gwasanaeth, integreiddio gyda'r llwyfan technegol Cymreig, fforddiadwyedd, gwerth am arian, ac yn bwysig iawn, derbyn risg. Mae'r gofynion hyn yn adlewyrchu anghenion presennol Practisau Meddygon Teulu yn ogystal ag ymrwymiad i fodloni datblygiadau yn y dyfodol. Y gofynion na wnaeth EMIS Health Ltd ymrwymo i'w bodloni, yn fras, yw'r rheiny y maent eisoes wedi ymrwymo iddynt yn eu contract presennol gyda GIG Cymru.

Gallwch fod yn dawel eich meddwl fod GIG Cymru wedi cynnig pob cyfle i bob cyflenwr fodloni'r gofynion cyhoeddedig. Roedd hyn yn cynnwys ymwybyddiaeth o ganlyniadau tebygol peidio â bodloni'r gofynion yn llawn, a pheidio â chytuno i'r telerau ac amodau safonol, a ddefnyddir yn eang ledled y DU ar gyfer contractau TG mawr.

Yn fras, ni fyddai'r newidiadau yr oedd EMIS Health Ltd yn gofyn amdanynt, ym marn Pwyllgor Gweithredol Caffael Bwrdd y Rhaglen Rheoli Gwybodaeth a Thechnoleg, wedi gadael unrhyw fesurau o bwys i unioni methiannau a diffygion o fewn graddfa amser briodol, gan arwain at drosglwyddo risg annerbyniol, yn ariannol ac yn broffesiynol, i bractisau (a GIG Cymru).

Yn ogystal, ar adeg pan fo Llywodraeth Cymru a Chymdeithas Feddygol Prydain yn edrych ar ddiwygiad radical posibl i'r contract Gwasanaethau Meddygol Cyffredinol, roedd EMIS Health Ltd yn amharod i ymrwymo i unrhyw newidiadau gorfodol i systemau sy'n ofynnol i gefnogi unrhyw gontract newydd o'r fath. Roedd hyn yn amlwg yn annerbyniol o ran newidiadau strategol i wneud y contract Gwasanaethau Meddygol Cyffredinol yn addas i'r

dyfodol. Yn olaf, byddai nifer o ychwanegion allweddol, yn cynnwys ymarferoldeb llawn DocMan wedi bod yn gost ychwanegol i'r practis yn hytrach na chost wedi'i chynnwys yn unol â'r gofynion y cytunwyd arnynt.

Gyda'i gilydd, roedd gormod o feysydd lle'r oedd EMIS Health Ltd ond yn bodloni'r gofynion yn rhannol neu lle'r oeddent yn gwneud gormod o newidiadau i ddrafft y contract, a oedd yn cael effaith niweidiol ar GIG Cymru, neu'n cynyddu sefyllfa risg GIG Cymru. Mae rhagor o wybodaeth ar gael yn y ddogfen gysylltiedig Cwestiynau Cyffredin. Fodd bynnag, roedd y prif feysydd pryder yn ymwneud â'r canlynol:

- Nid oedd EMIS Health Ltd yn fodlon ymrwymo i'r lefelau gwasanaeth gofynnol a datrys problemau'r system
- Roedd EMIS Health Ltd yn cadw'r hawl i godi'n ychwanegol, a gohirio cyflawni nifer o ofynion swyddogaethol craidd
- Roedd EMIS Health Ltd am gadw'r hawl i wrthod ceisiadau am unrhyw newidiadau yn y system yn y dyfodol
- Roedd EMIS Health Ltd yn pennu cyfyngiadau ar allu GIG Cymru i reoli'r cyflenwr i gyflawni'r argaeledd a'r perfformiad gofynnol

Ar hyn o bryd, rydym eisiau darparu sicrwydd pellach y bydd adnoddau ar gael trwy gydol y cyfnod trosglwyddo er mwyn helpu pob practis i newid cyflenwr. Byddwn hefyd yn ystyried effaith unrhyw faterion yn ymwneud â chydweddoldeb meddalwedd trydydd parti er mwyn ceisio lliniaru unrhyw anfantais i bractisau.

Bydd Grŵp Cyfeirio Rhanddeiliaid yn cael ei sefydlu i helpu datblygu'r pecyn cymorth ac i gytuno ar y mecanweithiau gorau i helpu practisau drwy'r broses fudo. Os oes diddordeb gennych mewn cyfranogi yn y grŵp hwn, neu os oes unrhyw ymholiadau pellach gennych ynglŷn â'r caffael, anfonwch neges e-bost at [redacted]

Yn gywir

Alan Lawrie	Dr Charlotte Jones	Andrew Griffiths
Cadeirydd, Bwrdd Rhaglen Rheoli Gwybodaeth a Thechnoleg	Cadeirydd, Pwyllgor	Cyfarwyddwr

Gwasanaethau Meddygol Cyffredinol

Cyfarwyddwr Iechyd Sylfaenol,
Cymunedol ac Iechyd Meddwl,
Bwrdd Iechyd Cwm Taf

Meddygon Teulu Cymru

Gwasanaeth Gwybodeg
GIG Cymru

Royal College of General Practitioners
Coleg Brenhinol Meddygon Teulu
CYMRU WALES

30 January 2018

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

Changes to EMIS

Dear Dai,

As you will be aware EMIS will not be used in GP practices, following the latest round of the procurement process. Letters from NHS Wales explaining the developments are attached.

I am sure you will also be aware of the negative reaction to this from GPs. The news is an extremely worrying development for our members and RCGP Wales is concerned it risks pushing older GPs to an early retirement. We are also concerned that change on this scale could be detrimental to patient care. Our full response can be found here: http://www.rcgp.org.uk/news/2018/january/rcgp-wales-warns-change-to-it-system-could-be-detrimental-to-patient-care.aspx

As Chair of the Health Committee I hope you are able to consider the tools at your disposal to raise the importance of this on the political agenda.

Best wishes,

Rebecca Payne.

[redacted]

Dr Rebecca Payne
Chair
RCGP Wales

Royal College of General Practitioners Wales Regus House Falcon Drive Cardiff Bay Cardiff CF10 4RU
Tel [redacted] Fax [redacted] email [redacted] web www.rcgp-wales.org.uk

Coleg Brenhinol Meddygon Teulu Cymru Tŷ Regus Rhodfa'r Hebog Bae Caerdydd Caerdydd CF10 4RU
Ffôn [redacted] Ffacs [redacted] ebost [redacted] web www.rcgp-wales.org.uk

To: Health Board Chief Executives
Directors of Primary Community and Mental Health
Heads of Primary Care
Medical Directors
Assistant Medical Directors (Primary Care)
Assistant Directors of Informatics
General Medical Practitioners
Practice Managers
Local Medical Committee (LMC)

29th January, 2018

Dear Colleague

Outcome of GMS Systems Framework Contract Procurement

This letter confirms the outcome of the recent GMS Systems Framework procurement for the future provision of GP clinical systems and services to NHS Wales.

Following a robust and rigorous procurement, overseen by the national GMS IM&T Programme Board, it is the intention to award the contract for GP clinical systems and services to two suppliers - **Vision Health Ltd** and **Microtest Ltd.**

The successful tenders demonstrated a strong commitment and ability to meet core GMS clinical / technical requirements and the wider Primary Care agenda, as well as further integration with the NHS Wales' digital services platform and strategic requirements.

A third tender, submitted by EMIS Health Ltd, did not meet a number of the necessary evaluation criteria relating to the financial, contractual and functional requirements as set out in the procurement, including within the core GMS clinical / business requirements, support for the wider Primary Care agenda in Wales and further integration with the NHS Wales digital services platform and national systems. This means EMIS Practices will need to choose an alternative system.

The new GMS Systems Framework Contract is effective for a four-year period from award, with the option to extend for up to a further two years, and replaces the previous GMS framework agreement, which expired in July 2016.

It is planned that the first GP practices will migrate or upgrade to new systems in January 2019, with the final migration due to be completed by July 2020. Throughout this period,

until a practice migrates, GP practices can be assured that existing systems and services will continue to be supported by current suppliers under the existing contract arrangements.

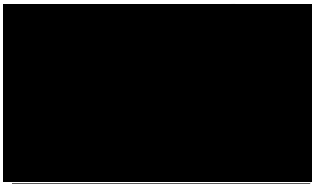
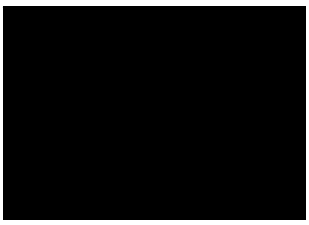
Road shows are scheduled during April 2018 to allow GP practices to evaluate and select their preferred GP clinical system under the new Framework.

All GP practices will need to choose either the Vision or Microtest product under the new contract. Recognising the potential impact on practice administration and resources for practices changing system, additional help and support will be provided to prepare for and manage the transition. GPC Wales and Health Board representatives are working with NWIS and Welsh Government colleagues to identify additional ways to alleviate pressures for Practices that will be migrating systems.

As part of the OJEU procurement process, we are required to allow a 10-day standstill period following notification to the suppliers. This is due to conclude at midnight Thursday 8th February, following which we will provide further information about the new Framework Contract, the supplier products, and transition and support arrangements for practices.

FAQs will be published and regularly updated at http://nww.primarycareit.wales.nhs.uk/gms-systems-services-framework. If you have any further queries please e-mail pct@wales.nhs.uk.

Yours sincerely

Alan Lawrie	Dr Charlotte Jones	Andrew Griffiths
		
Chair, GMS IM & T Programme Board Director of Primary Care and Mental Health, Cwm Taf Health Board	Chair, GPC Wales	Director NHS Wales Informatics Service

FREQUENTLY ASKED QUESTIONS

GMS Systems & Services Procurement

Version No. v2.0
Status: Final

Author: Project Management Team
Approver: Executive Committee

Date: 29/01/2018
Next Review Date: 29/02/2018

Tudalen y pecyn 9

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1 Procurement

1.1 Why has a new procurement been undertaken?

The previous Framework Contract under which GP systems and services were procured expired in 2016 and a new one is required to ensure continuity of services, prior to expiry of the support arrangements in 2020.

The expiry of the support arrangements will vary, and in most instances will be dependent on when the Practice migrated to their current clinical system. It is anticipated that Practices will be moved to the new contractual arrangements between January 2019 and July 2020. The provisional migration plan is published on the NWIS Primary Care Services website.

1.2 What is a Framework Contract?

Under European (and UK) Law, public bodies must procure goods and services in line with the EU Public Contract Regulations 2015: PCR15, which includes the use of Frameworks.

Framework Agreements provide a mechanism for sourcing goods and services in the public sector. A Framework Agreement is an 'umbrella agreement' that sets out the terms under which individual contracts (call-offs) can be made throughout the period of the agreement. These call-off contracts are referred to as Deployment Orders.

Frameworks do not guarantee that suppliers will get any business, but by being on a Framework they are in with a chance. For the GP Systems and Services Framework Agreement a call-off or mini competition will need to be undertaken by each Practice to select the supplier that best meets their needs.

1.3 How long will the contract last?

The Framework is for 4 years, with the option to extend for up to a further 2 years.

Each Practice will be part of a deployment order for the system and services, which sits under the main Framework Agreement. The Deployment Order will last 5 years from the date of go-live. There is an option to extend the Deployment Orders for up to a further 2 years.

After the Framework Agreement ends, no new Deployment Orders can be placed, but this does not affect any existing Deployment Orders, which will continue in force for the remainder of the term.

1.4 Who is running the GMS Systems & Services Procurement?

The NHS Wales Informatics Service has undertaken the procurement on behalf of the Health Boards.

Each Health Board will sign a Deployment Order on behalf of its Practices, with the relevant supplier(s), and is legally responsible for ensuring procurement regulations are adhered to.

Each Health Board will be responsible for ensuring that every Practice participates in the 'call off' or mini competition process.

1.5 What were the governance arrangements for the procurement? Were Practices represented?

The GMS IM&T Programme Board, on which there is representation from General Practitioners Committee (GPC) Wales, Royal College of General Practitioners (RCGP) and Practice Managers, has overseen the procurement.

A subgroup of this Board (Project Executive Committee), on which GPC Wales are also represented, has delegated responsibility to deliver the project. The Committee is chaired by the Director of Primary and Community Care for Cwm Taf University Health Board, Alan Lawrie.

There were four areas of contract delivery that were managed by work stream groups:

- Functional
- Technical
- Operational Governance
- Commercial/Financial/Legal

Practice representatives were involved in the functional, operational governance and commercial/financial/legal work stream areas, providing feedback on contract documents, participating in dialogue and evaluation sessions, and contributing to the drafting of the evaluation process that Practices will need to undertake.

1.6 What does the procurement mean for my Practice?

Procurement legislation introduced in February 2015 (Public Contract Regulations 2015: PCR15) means each supplier appointed to the Framework Agreement must be treated equally and have an opportunity to secure business.

The aim of the legislation is “To create a level playing field for all businesses across Europe”, and is based on four key principles:

I. Transparency
II. Equal treatment and non-discrimination
III. Proportionality
IV. Mutual recognition - giving equal validity to qualifications and standards from other Member States, where appropriate

Therefore, every Practice will need to participate in the mini-competition process. Practices will be asked to evaluate each of the clinical systems and services available under the new Agreement, and make a choice of system based on this evaluation.

A series of ‘Roadshow’ events will be held across Wales between April and May 2018, which Practices will need to attend to undertake the evaluation process.

2 Procurement Outcome

Following a robust and rigorous procurement, overseen by the national GMS IM&T Programme Board, it is the intention to award the contract for GP clinical systems and services to two suppliers - Vision Health Ltd and Microtest Ltd.

A third tender, submitted by EMIS Health Ltd, was unsuccessful.

2.1 How did you evaluate the suppliers?

The evaluation model forms part of the contract document set. It was drafted and approved by the Project Executive Committee and shared with the suppliers prior to commencing the competitive dialogue sessions.

A threshold methodology was used. This was to ensure that a supplier could not provide a large number of sub-optimal responses relating to the requirements, or make changes to the Authority Contract drafting that would have a detrimental impact on or increase the risk position of the NHS Wales, and still be appointed to the Framework Contract.

2.2 Why have Microtest and Vision Health been successful?

The successful tenders demonstrated a strong commitment and ability to meet core GMS clinical / technical requirements and the wider Primary Care agenda, as well as further integration with the NHS Wales' digital services platform and strategic requirements, within the existing budget.

2.3 Why has EMIS Health been unsuccessful?

EMIS Health Ltd did not meet some of the minimum threshold evaluation criteria relating to a number of the financial, contractual and functional requirements as set out in the procurement.

2.4 Can the decision be overturned? Is there any form of Appeal from a supplier?

The Public Contracts Regulations 2015 (PCR15) provides suppliers with a period of 30 days to start proceedings to challenge the procurement process that has been undertaken. The challenge would need to provide that [WE] did not follow the process stated or did not comply with the requirements of PCR15.

Throughout the procurement process [WE] have been supported by Legal and Commercial Advisors to ensure that the procurement is compliant and are assured that there is no plausible challenge in respect of this process that could be upheld.

2.5 EMIS is a long-established supplier with a big customer base – why is it not good enough for Wales?

As noted above EMIS were unable to meet a number of the minimum threshold criteria. Cumulatively there were too many areas where they only partially met the requirements and they made too many changes to the contract drafting.

2.6 Do Microtest have the software developed to allow immediate integration with the NHS Wales architecture? If not, how long will it take to develop the software?

Although Microtest are new to Wales they already offer much of the required software to NHS England (patient Access: MHOL, Summary Care Record: WGPR) which will require some development to meet the Welsh requirements.

Vision will also need to make some changes to their current software to meet requirements.

Suppliers will have 11 months from contract award to build, develop and test their services for deployment from January 2019. NHS Wales will provide the necessary resources to assist Microtest and Vision to develop and test NHS Wales National Services.

2.7 As Microtest are not currently in Wales how do we find out more about them?

You can visit the Microtest website: http://www.microtest.co.uk/about/

You can also visit the Vision Health website at: https://www.visionhealth.co.uk/

It is intended that more detailed information from both suppliers will be made available prior to the Roadshow events.

2.8 Microtest has a very small market share in England – will Vision become a single supplier for Wales by default?

Microtest have a relatively small market share of England but do support circa 100 sites across England today.

All Practices will need to participate in the Roadshow events, including current Vision users. The evaluation process will require Practices to score the supplier systems based on the presentations and information provided. Size of market share is not part of the evaluation criteria.

Vision and Microtest have indicated their commitment to work collaboratively with NHS Wales. Both suppliers provide an exciting opportunity to develop GP IT systems and services for Welsh Practices.

2.9 What will happen to services like My Health Online (MHOL)?

MHOL and all other national services will be provided and further developed by the two successful suppliers. Any migration activities will be planned, supported and undertaken as part of the new system migration process.

2.10 As nearly half the Practices in Wales use EMIS, how long will migration to a new supplier take?

Migrations will start in January 2019 and must be completed by the end of July 2020 – 19 months.

2.11 Does NHS Wales Informatics Service (NWIS) have sufficient support staff to help manage the migration process?

The NHS Wales Informatics Service will take on additional staff where required to support the migration process. In addition, we will work with Vision and Microtest to exploit available technology to make the process as smooth and cause as little disruption as possible. Many lessons were learnt as a result of the system changes and migrations that Practices undertook under the previous Framework, which also required a high number of system transitions, and these will be incorporated into the new migration plans and processes.

A Stakeholder Reference Group, led by Practices, will be established to agree the best mechanisms to provide support through the process.

2.12 When will the migration begin and when can each Practice expect to take on the new system?

The majority of Practices will take on the new system in line with current contract dates expiry i.e. 5 years after they went live with their current system. For Practices changing system, it is expected that the migration process will start approximately 3 months before the planned go-live date.

2.13 If we have to change system this will mean disruption and extra work for the Practice – will we receive financial support?

Following on from award of the contract there will be immediate discussions with the successful suppliers regarding the feasibility of increasing migration, training and post go-live support for Practices changing system, as well as looking at streamlining the migration process.

The NHS Wales Informatics Service will increase staff resource capacity to support the Practices with the planning, pre-go-live, go-live and post go-live administrative tasks.

GPC Wales and Health Board representatives are working with NWIS and Welsh Government colleagues to identify additional ways to support Practices during and following system change. Some of the options being discussed are financial support and suspending elements of contractual requirements. We will update Practices as soon as possible regarding these discussions.

A Stakeholder Reference Group, to include Practices' representatives, will be established to design and agree a full 'support package'.

2.14 As a Practice, we have invested in third party applications that work with EMIS Web. If these don't work with Microtest and Vision we will have lost our investment. How will this be addressed?

We are unable to confirm a solution at this early stage. However, it has been raised by stakeholder representatives that Practices who have invested in improving their IT services should not be disadvantaged by an enforced change. We will work with Microtest and Vision to explore options to migrate and support these applications. This issue will also be included in discussions regarding financial support.

2.15 My Practice wants to stay with EMIS – what are the options?

EMIS Practices will need to evaluate and choose either Vision or Microtest as their new supplier. There is no option to stay with EMIS.

2.16 Can I buy EMIS Web?

There is no procurement mechanism for a Practice to buy EMIS Web and continue using current NHS Wales IT services.

3 Practice Choice

3.1 What is the process for confirming our system choice?

The full process will be published in advance of the Roadshow Events. It has been reviewed and approved by Health Board, GPC Wales and Practice representatives.

3.2 When will we need to make our choice of system?

Practices will be asked to make their choice following the Roadshow Events and by the end of May 2018.

3.3 My Practice is happy with the current clinical system, and has invested a considerable amount of time and effort in developing its use. Will we be forced to change?

All EMIS Practices will need to change system.

Vision Practices will need to participate in evaluating all the clinical systems available even though their current supplier is part of the new contract. There is a legal obligation to ensure that providers are able to compete for business on an equal basis.

The evaluation process will provide Practices with the opportunity to identify the parts of the clinical system that are important to them and use this in the scoring process. Each Practice will be able to undertake their scoring independently, or as a Cluster where they choose to do so. Support and guidance will be provided by the NWIS Primary Care Services team throughout the process.

Practices will also be given information regarding the differences between the supplier offers, for example, where they are providing 'added value' functionality or services, or where the requirements have not been met in totality.

4 System Requirements

4.1 We responded to the Practice survey asking for our priorities – have these been included in the contract?

The survey responses have been collated and those clinical system requirements indicated as a high priority have been included as part of the functional requirements, where feasible.

4.2 What functionality will be funded as part of the new contract?

The functional requirements are split into two categories:

1. Baseline requirements – these cover the core system as accredited in England, plus Welsh national applications, such as GP2GP, My Health Online (MHOL), and Welsh Clinical Communications Gateway (WCCG) etc.

2. Outline requirements – these include some of the requirements that were identified by Practices via the recent survey and stakeholder engagement which we were able to specify in sufficient detail prior to the publication of the procurement. The intention will be to try and get these deployed within the first 12-24 months of contract award. These include the requirements that will enable the exchange of children's vaccination and immunisation information between GP systems and Child Health systems.

4.3 What other functionality is likely to be developed?

Developments identified from the survey/engagement and current NHS Wales strategies include:

1. Further integration and interoperability with national applications and systems e.g. Welsh Community Care Information System (WCCIS), Welsh Care Record Service (WCRS).
2. Functionality to support Federated Practice/Cluster and Multi-Disciplinary Team working, both in terms of information sharing and functional system use.
3. Further development of My Health On-Line (MHOL) services and wider integration with NHS Wales Patient Portal and shared Patient Authentication services.
4. Access to the underpinning data contained within GP systems. Data output required at Practice, Cluster, Health Board and national level to enable service planning and provision.
5. Consent and data sharing controls to support cross organisation working.
6. Systems to support cross border transfer of patient information.
7. Requirements to embed an electronic signature into a prescription.

4.4 What if other developments are identified once the contract is in place?

New requirements can be added through an agreed change control process with the suppliers.

4.5 Will we have access to functionality that will support cluster and multi-disciplinary team (MDT) working?

Both supplier systems will have the functionality to support cluster and MDT working. Detail will be provided at the Roadshow events.

4.6 What scanning solutions will be available?

Scanning and document management requirements have been specified as part of the baseline functionality. Practices will be able to assess the solutions as part of the evaluation process.

4.7 Are mobile versions of the clinical system funded as part of the new contract?

Mobile functionality will not be funded centrally at the present time. Suppliers will choose whether to include their mobile solution within the core system cost (no cost to the Practice) or to make available through additional funding. Detail will be provided at the Roadshow events.

5 Infrastructure Requirements

5.1 Where will patient data be hosted?

Suppliers will have a choice to host the system in England or Wales or a combination of both. They must meet NHS Wales' security and infrastructure requirements, e.g. a supplier may choose to provide national application services such as My Health Online in Wales but the main system in England. To note it is not permissible at the present time for a supplier to store patient data within the public Cloud.

5.2 How do we know that our patient data is secure?

Regardless of hosting location the supplier must meet the security requirements detailed in the Contract.

6 Service Levels

6.1 My Practice has experienced clinical system performance issues. How will such issues be addressed within the new contract?

Service levels remain largely unchanged from the current contract, however performance metrics have been included to address performance issues. We will also be working with the successful suppliers to implement reporting tools which will assist in diagnosing where issues lie and aid resolution.

Mae cyfyngiadau ar y ddogfen hon

Dr Jonathan Leach MB ChB MSc(Med) FRCGP DRCOG DIMC RCS(Ed)
Joint Honorary Secretary

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

15 January 2018

Dear Dr Lloyd

Performers Lists

Thank you for your letter of 28 Nov 17 to our President, Professor Mayur Lakhani asking for the views of the Royal College of General Practitioners on Performers Lists. I understand that this query is part of a wider inquiry into medical recruitment and I am replying on behalf of the Royal College of General Practitioners.

The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the 'voice' of GPs on issues concerned with education; training; research; and clinical standards. Founded in 1952, the RCGP has just over 52,000 members and our most recent data shows that there are over two thousand associates in training, members and fellows resident in Wales.

The NHS (Performers List) (Wales) Regulations 2004 came into force on 1 Apr 2004 with very similar arrangements in the rest of the United Kingdom. They were updated and amended in England in 2013, following the disestablishment of Primary Care Trusts and creation of NHS England. The regulations apply to the disciplines of general medical practice, general dental practice and optometry and an individual is required to have membership of the relevant list to work in the NHS. They do not apply to health professionals who work exclusively in private practice nor to members of HM Forces (unless the military doctor also sees NHS patients) who have their own regulatory arrangements. All of the Performers List Regulations are designed to ensure that individuals have the necessary qualifications and attributes to work in their relevant discipline and in broad terms are very similar to those that would be undertaken by a hospital human resources department if the doctor was applying for a hospital position. For example a doctor applying for the Medical Performers List in Wales is required to provide the following[1]:

- Letter from the GMC confirming receipt of Annual Retention Fee.
- Original letter from GMC confirming GP licence to practise status.

[1] See http://www.primarycareservices.wales.nhs.uk/apply-for-inclusion-in-the-medical-perfo accessed 27 Dec 17

Royal College of General Practitioners 30 Euston Square London NW1 2FB
Tel [redacted] Fax [redacted] Email [redacted] Web www.rcgp.org.uk

- Original Certificate of Prescribed/Equivalent Experience, a PMETB certificate (Postgraduate Medicine Education and Training Board) or a Certificate of Completion of Training (CCT). These certificates are not applicable to GP Registrars
- Original current Certificate of Medical Indemnity Insurance.
- Medical degree certificate and any other original certificates relating to your qualifications
- For UK citizens born in the UK, passport and birth certificate
- For UK citizens born outside the UK and for non UK citizens, a passport (birth certificate is not acceptable).
- English language competency certificate (only applicable to citizens of EEA countries whose first language is not English and were trained in countries other than the UK or Republic of Ireland).
- Completed Personal Superannuation Questionnaire
- For new UK residents, a translated police/other suitable body report from your previous overseas place of residence (this report should be less than 6 months old).
- Most recent Disclosure and Barring Service (DBS) Enhanced Disclosure Certificate confirming that both the Children and Vulnerable Adults Lists have been checked.
- Proof of immunity to relevant infectious diseases such as rubella, hepatitis B etc
- References from two referees willing to provide a clinical reference

The RCGP takes the view that the above "pre-employment checks" are needed and as described are almost identical to those that would be undertaken by a hospital human resources department or a hospital locum agency.

In your letter you pose three questions. I will take each in turn.

1. <u>The existence of separate Medical Performers Lists for England and Wales.</u> In principle it would be possible to have one UK wide Performers List for the relevant disciplines such as general medical practice as the necessary standards and approaches are very similar. However, health is a devolved government matter and thus it would need the agreement of all four governments to agree on both the principle and the application. Our recommendation is that a simpler and quicker approach would be to agree reciprocal agreements with NHS England and also with counterparts in Scotland and Northern Ireland that if a doctor was on a Performers List in other parts of the UK, then provided there were no concerns regarding performance, then automatic registration could take place and vice versa. An analogous system is already in place under the Responsible Officer (RO) Regulations 2012 whereby, for example the RO in the Midlands and East area of NHS England which contains the counties of Shropshire and Herefordshire and thus contains doctors who work routinely both in England and Wales, provides recommendations to the GMC on revalidation and performance. Such recommendations take place after consultation with the relevant Welsh RO with the opposite being place for doctors whose main place of work is in Wales. The RCGP view is that such a system would significantly speed up the application process, be cheaper and reduce barriers to applications.

2. <u>Ease of access to Medical Performers List registration for Doctors returning to Wales.</u> A common theme of the feedback the RCGP receives is the slowness of the application process. Information we have received is that the overall process would be considerably improved if there was a more proactive approach to supporting the doctor through the application process and assisting, if further information is required.

3. <u>How the Medical Performers List registration processes assesses the equivalence of medical training outside the UK.</u> The RCGP is working with GMC to simplify and speed up the processes that doctors undertake when applying from overseas.

However, the process to assess equivalence of medical training undertaken outside of the UK is not via the Performers List. This is done via a General Medical Council (GMC) legislative process with an application for a Certificate of Eligibility for GP Registration (CEGPR). The College's role is to evaluate the application on behalf of the GMC. Once a CEGPR has been issued, the doctor must then go through an induction period before they can apply to be added to the performers list.

The College is working on initiatives linked to international recruitment to improve processes. One of these is the curriculum mapping project, looking at countries with similar training and systems to the UK, which will provide us with the data and evidence we need to work with the GMC to develop a streamlined CEGPR process for these countries. The countries being considered first are Australia and New Zealand.

We have also recently reviewed the Portfolio Route, making it easier for UK trained doctors who have spent time abroad, to return and enter the Performers List quickly. Once the changes have been approved which will make this process easier and eligibility criteria more flexible; they will be implemented early in 2018.

There is useful information on CEGPR and performers list processes in the new Guide for Overseas Doctors: http://www.rcgp.org.uk/training-exams/discover-general-practice/overseas-doctors-guide.aspx

I trust that this information is helpful and if I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Dr Jonathan Leach
Joint Honorary Secretary
Royal College of General Practitioners

Cc
Professor Mayur Lakhani – President RCGP
Dr Rebecca Payne – Chair RCGP Wales

Royal College of General Practitioners
Coleg Brenhinol Meddygon Teulu

Performers List: Case Studies

To support this evidence session RCGP Wales would like to provide case studies of GPs' experience with the Performers List.

This document contains a summary of the experience of five GPs. The first relates to a GP with cross-border issues in the North-East Wales area, the second relates to a Locum GP looking to work in different areas within Wales, and the latter three relate to British trained GPs who moved overseas and sought to return.

While their circumstances will be recognisable to those who know them, we have avoided explicitly identifying them for this purpose.

The information below comes directly from information provided by them.

Case study 1

This GP was born, brought up and lives in North Wales but worked predominantly in West Cheshire, where his principal Performers List membership was. He describes how he decided to carry out some locum work in North East Wales – "out of affection for the area" – before facing "excessive hassle and delay". The process included form filling, a face to face appointment to confirm his identity, a repeat DBS check and a wait for information from NHS England, before having to send his CV, copies of his degree certificates and details of two referees. He said the result of this was that practices missed his availability for nearly three months.

Case study 2

This GP is a locum GP, based in the Abertawe Bro Morgannwg Health Board (ABMU), who was looking to do occasional work in Barmouth. He also got regular offers to work in Swansea which he intended to do as well. He was told that while he was included to work anywhere in Wales as a Locum, if he intended to do the majority of work in Barmouth he should change Performers Lists. To work within the ABMU area as well he was asked to send approximate locations and times to go with his review, and he was informed a decision may not be made for a while. He was prevented from working during this period.

Case study 3

This GP is a British trained GP who worked in the Netherlands for 12 years (including 5 years as GP partner), and looked to locum in Wales for a fixed period of time (just under 1 year). To do this she had to do 2 exams before a practice placement from 3-6 months, a

process which she said would take her towards the end of the period she was in the United Kingdom. This made her consider looking for an alternative to general practice during the time she was in Wales.

Case study 4

This GP was a Welsh-speaker who was trained in the UK before working as a GP partner in New Zealand for 6 years, before a planned return to the UK. In March 2014 she emailed the Wales Deanery for information and in May 2014 she received a reply advising her that "application to the GP Induction and Refresher Scheme would be advisable." The earliest date for MCQ assessment was September 2014, the earliest date for simulated surgery assessment was October 2014, no fixed timeframe was provided for feedback and planning for clinical placement, and no fixed timeframe was provided for placement in a further training practice in Wales.

She summaries her grievances as:

1. Protracted and uncertain timeframes
2. The training practice having to be an advanced training practice, limiting the options available and creating uncertainty around start dates in view of other requirements
3. Cost implication for exams and grant only for the training period

Case study 5

This GP went to medical school in Nottingham, completed her FY1 and FY2 years in England at the South Thames Deanery, before moving to Australia and qualifying as a GP there. She qualified in June 2016 and moved back to the UK in August 2016. She started the application process before moving back to the UK but could only submit it in person when in the UK.

She spent around 6 months collecting evidence for this application, which she estimated involved 4-5 kilos of paper evidence. To get her evidence properly validated each page had to be signed, dated and stamped by a GP or educational supervisor from her previous work in Australia. Supervisors had to sign and stamp each page with his full name and position written on every page, and when her supervisor only signed each page this caused further delays.

She received conflicting advice about what type of evidence was needed, leading to her paying staff in Australia to print and post evidence to the UK only to find out later that this was not necessary. She also had to provide 6 referees who were asked to provide long and detailed references.

Once evidence was submitted there was a 3 month wait before an MCQ exam, and a period of supervised practice for refresher training with an approved practice for up to 6 months.

She summarised her experience by saying the process was "too difficult and unreasonable", involving thousands of pages of evidence, when she was already a GP in Australia - "the standards to become a GP there are high". She said the process takes more than a year and half, and said with such a long time out of general practice she is more likely to need refresher training.

BMA

Cymru Wales

Y Gymdeithas Feddygol Brydeinig
Pumed Llawr
2 Pentir Caspian
Ffordd Caspian
Bae Caerdydd
Caerdydd
CF10 4DQ

British Medical Association
Fifth Floor
2 Caspian Point
Caspian Way
Cardiff Bay
Cardiff
CF10 4DQ

15 January 2018

Inquiry into the All Wales Medical Performers List

RESPONSE BY BMA CYMRU WALES

BMA Cymru Wales welcomes the opportunity to provide evidence to the Health, Social Care and Sport Committee's one-day inquiry on an All-Wales Medical Performers List.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. BMA Cymru Wales represents over 7,000 members in Wales from every branch of the medical profession.

We have made several previous representations on the performers' list system. This includes our written response to the Committee's recent inquiry on the *Sustainability of the Health and Social Care Workforce*[1]. We also submitted evidence to the House of Commons' Welsh Affairs Committee in 2014 on *Cross-border health arrangements between England and Wales* [2]. Given that many of the issues raised remain pertinent, links to these documents are included below.

[1] "Response from BMA Cymru Wales: Inquiry into the sustainability of the health and social care workforce" BMA Cymru Wales, 9 September 2016
http://senedd.assembly.wales/documents/s53974/WF%2029%20British%20Medical%20Association%20Cymru%20Wales.pdf

[2] "Cross border health arrangements between England and Wales: Written evidence submitted by BMA Cymru Wales" BMA Cymru Wales, 10 March 2015
http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/welsh-affairs-committee/crossborder-health-arrangements-between-england-and-wales/written/15814.pdf

We were asked to comment specifically on three areas, so will do so accordingly below:

- *The existence of separate Medical Performers Lists for England and Wales;*

We previously reported to the committee our views on the existence of separate lists and feel it is appropriate to repeat these views:

> *The existence of separate performers lists for England and Wales has a number of detrimental impacts. For instance, GPs on the English performers list may not be immediately able to take up vacancies that may exist within practices in Wales. In border areas, having separate lists can prevent GP colleagues in nearby practices, on either side, from simply being able to cover for each other in the way that might often happen between practices on the same side of the border. In the same way, the separate lists also limit the availability of locums for border practices.*[3]

We recognise that from an organisational standpoint that it may be clearer administratively to retain separate lists. However, this does not serve to facilitate cross-border movement and provide much needed support already hard-pressed services. At the very least, mutual recognition between the lists should be prioritised, with aligned standards of entry and consistent induction and refresher schemes to provide quality assurance. With the current system in mind, consideration also needs to be given to the process for ceasing to be on a certain performers list, which is known to hinder mobility

We would support the introduction of a true all-Wales performers list maintained by an appropriate body with a national remit. This could be a function of Health Education and Investment Wales as this would provide a link to existing appraisal systems and processes. A properly constituted national list would facilitate mobility across health board boundaries which the present system, with separate lists per LHB, is known to hinder. Were this robust all-Wales system to be introduced with appropriate national oversight, local processes around appraisal and performance could persist within current structures.

- *Ease of access to Medical Performers List registration for Doctors returning to Wales;*

We acknowledge that granting access to the Medical Performers List is a balancing act between providing public assurance and safety, employer assurance and allowing doctors to return. Given the current pressures within the system, we suggest that enabling individuals to re-enter the workforce is a key priority.

The Welsh General Practitioners Committee (GPC Wales) welcomed the reforms made in March 2016 to ease the administrative burden of inclusion on a LHB performers list, particularly for the those who are registered on a performers list within another home nation. The reforms allowed GPs already on another performers' list but wishing to work in Wales to have to provide their GMC registration number, a copy of their

[3] p24 "Response from BMA Cymru Wales: Inquiry into the sustainability of the health and social care workforce" BMA Cymru Wales, 9 September 2016

performers list inclusion letter, proof of qualifications, a recent criminal record certificate and consent for validation checks to be undertaken. We understand that NHS Wales Shared Services Partnership also agreed to undertake initial checks and inform the GP of their decision as to whether they could practice within five working days. However, members have informed us of cases whereby doctors wishing to work in Wales after a period working in England have experienced delays beyond this in receiving approval from the appropriate agency in NHS England, which has led to start dates being delayed. We would again encourage that steps are taken to enhance mutual recognition between lists.

- *How the Medical Performers List registration process assesses the equivalence of medical training undertaken outside the UK.*

It is important to recognise that the Medical Performers list is most important at the time of entry to the area in which the doctor wishes to work, ensuring a performers' eligibility and their compliance with regulatory processes. The regulatory processes concerning the recognition of medical training conducted outside of the UK, and thus entry onto the GP or specialist register, is a matter for the General Medical Council on a UK-wide basis.

Doctors who have trained in the European Economic Area (EEA) have legal rights of equivalence for their qualifications but are recommended to undertake an induction programme on applying to a medical performers list. Doctors who trained outside of the EEA wishing to practice as GPs in the UK must apply to the GMC for CEGPR (Certificate of Equivalent GP Registration), which is a lengthy and complex process. Unsuccessful applicants are often told to spend time working in a UK training practice before reapplying, but cannot do so due to the Medical performers' list regulations. These doctors must therefore "compete" against prospective GP trainees seeking entry to the UK GP speciality training programme. Once again, we acknowledge the importance of appropriate checks and balances to ensure patient safety is maintained, but we would encourage that measures are taken to address this on a UK-wide level given the present challenges in health systems across the nations, which could be further exacerbated by the impact of Brexit.

We trust that these comments are helpful and look forward to providing further observations during the oral evidence session.

Yours sincerely

Dr Charlotte Jones
Chair, GPC Wales

The existence of separate Medical Performers Lists for England and Wales.
Ease of access to Medical Performers List registration for Doctors returning to Wales
How the Medical Performers List registration process assesses the equivalence of medical training undertaken outside the UK.

Thank you for the opportunity to submit information to the committee. The existence of separate Medical Performers Lists for England and Wales in this day modern technology and secure central databases is a nonsense, fortunately at ground level this detail presents a just a bureaucratic irritation and suitably motivated individuals can place themselves on both lists. The subdivision of the Wales list managed by healthboards within Wales can present further of instances of headache amongst GPs already working in Wales.

In 2016, GP Hub Wales was a service that was developed by Dr Paul Williams providing phone consultations remotely for any practices in Wales. In practical terms this involves GPs and Clinical Pharmacists based in Cardiff to swansea region providing consulting patients as far west as fishguard. The Hub is a vital tool in helping to maintain a service where GP shortages are particularly acute. It also provides a flexible work pattern for GPs who unable work in a traditional surgery environment. There has been a rise in its popularity and as such we have been contacted by several doctors working outside of Wales who want to provide telephone consultations from their homes in England and other countries. As British qualified GP's, who are currently registered with the General Medical Council it seems a wasted effort to have to place themselves on the Welsh performers list just for this purpose.

It is without doubt a common sense approach to amalgamate the English performers lists with the Welsh performers list, Scottish performers list and Northern Ireland. This in theory will enable free flow of GP's to work in the UK. However given this fact, if it's the committee's expectation there to be an influx of GPs to Wales by innovating the medical performers list in this way I believe they will be disappointed. GP supply is at a critical low across the UK and this is particularly acute in certain pockets in Wales, evidence provided later on in the statement related to the ease of access to Medical Performers List registration for Doctors returning to Wales tattoos on the most significant reasons as to why general practice is losing GPs to other countries and two different careers.

Ease of access to Medical Performers List registration for Doctors returning to Wales

There is lack of clear information available to a doctor who has qualified in the UK that is subsequently working in a foreign country but who wants to return to the Wales to practice in primary care.
I would would challenge anyone get some clear guidance from organisations in Wales who have been touted as the place to contact for returning UK doctors. There are multiple websites and links that are unfortunately dead ends in the system or information that refers you to NHS England despite information in the Welsh websites that applications and processes are significantly different in Wales.
An example of a user's journey, go to

http://www.gpone.wales.nhs.uk/gp-returners

A dedicated Welsh website for primary care Leeds to

https://gprecruitment.hee.nhs.uk/Induction-Refresher/How-To-Apply

An English information resource.

Return to
http://www.gpone.wales.nhs.uk/gp-returners
Also leads to the Welsh Deanery website
https://gpst.walesdeanery.org/induction-and-refresher
Unfortunately again this led to
https://gprecruitment.hee.nhs.uk/Induction-Refresher/How-To-Apply
However it also did offer links for information as to the lead in coordination
“NHS Wales Shared Service Partnership (NWSSP) will coordinate the placement of each doctor including funding and other administrative support. For further information please go to the NWSSP website”
http://www.nwssp.wales.nhs.uk/gp-specialty-registrar
This link provides information as to the management of lists as well as some phone numbers to get further information.

[redacted]

If you were a GP currently working outside the UK and contacted this number wanting more information about the process involved in returning to Wales to work you would be or wanting to speak to someone about the process you would be referred to
http://www.trainworklive.wales/
The front page of this website provides the **same numbers as above on the nwssp website.**

Further information is sort and not found by clicking through “Refresher training (Wales Deanary)” link.

As it lands the user back to
https://gpst.walesdeanery.org/induction-and-refresher

Already the process to get some clear concise information has become a mind numbing frustrating process.
But if pressed on the phone, the user might be lucky enough to obtain a number which is usually not available or in the public domain to the Welsh Deanery.
Once answered and a situation explained, the enquirer will be sent an email with some links to resources (Email in Appendix) unfortunately these links lead the user to where they started in the first place.
https://gprecruitment.hee.nhs.uk/Induction-Refresher
https://www.walesdeanery.org/induction-and-refresher

This experience asks a number of fundamental questions.

1. Are the organisations responsible for processing tentative enquiries about GPs who want to repatriate back Wales effective in pursuing these leads?
2. With all enquiries being referred to England for processing applications, is Wales series grabbing potential GPs and placing them in Wales?

Several Doctors who qualified as a GP in the UK but are now subsequently working outside of the UK were canvassed for opinion.
A summary of response are collated below.

"Whilst I haven't considered returning, I have certainly been put off from remaining on a performers list due to the hoop jumping and requirements for me to do some practice in the UK. It just made no sense to me to do two weeks work in the UK each year when my life is now in Canada, just to remain on a performers list, so I applied for voluntary erasure."

Have you considered returning but have been put off by the logistics and further assessments of competencies?

See above. I can also practice Emergency Medicine here as a GP which I couldn't do in the UK

Do you feel that the pay to workload ratio is just not enough to justify returning?

"Unless life circumstances change, I wouldn't return to a career in GP in the UK being as I see around half the patients a day for twice the pay. There is so much hoop jumping in the UK just to stay on a performers list. "

What about the political situation? Does this play a part?

“As a physician in Canada I feel respected by patients, and the government. We aren’t painted as the bad guys in the media and by the health secretary. “

“As GP in Australia, we are accepted by the government and public as an essential part of the healthcare system. I feel sorry for my friends back in the UK, they seem to have to justify their existence on a weekly basis on the back of a shrinking take home pay.”

What country are you currently practicing in? Canada, Australia

What is your typical day like?

“Approx 20 patient contacts, 15 min appointments, no home visits. Fee-for-service work, compensated for time spent with a patient and medical complexity.”

How many patients do you typically consult in a day?
“20-25 a day.”

How many days do you work?
“4-4.5”

What is your renumeration for this work load?
“$400,000-$450,000 (Canadian) per annum.
$480,000 (Australian) per Annum.”

Appendix

From : [redacted]

Hello [redacted],

Following on from our conversation a moment ago, please find links below which will give you lots of information on the Induction & Returner (I&R) Scheme in Wales. If you do have any further questions please don’t hesitate to drop me an email.

https://gprecruitment.hee.nhs.uk/Induction-Refresher

https://www.walesdeanery.org/induction-and-refresher

Many thanks

Sophie

Eitem 4

General Medical Council

Gweithio gyda meddygon Gweithio dros gleifion

Swyddfa Cymru
2 Pwynt Caspian
Ffordd Caspian
Caerdydd CF10 4DQ

E-bost: gmcwales@gmc-uk.org
Gwefan: www.gmc-uk.org
Ffôn: 029 2049 4948
26 Ionawr 2018

Wales office
2 Caspian Point
Caspian Way
Cardiff CF10 4DQ

Email: [redacted]
Website: www.gmc-uk.org
Telephone: [redacted]

Dr Dai Lloyd
Cadeirydd Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Cynulliad Cenedlaethol Cymru
Bae Caerdydd CF99 1NA

Annwyl Dr Lloyd

Ymateb y CMC i ymchwiliad y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon – Rhestr Perfformwyr Meddygol Cymru

Diolch yn fawr i chi am y cyfle i ymateb i'r ymchwiliad un dydd i'r Rhestr Perfformwyr Meddygol Cymru (MPL).

Cyn darparu'n sylwadau i'r ymchwiliad, hoffem ail-adrodd rôl y CMC. Mae gennym swyddfa yng Nghymru ers 2005. Rydym yn gorff annibynnol sy'n helpu diogelu cleifion a gwella addysg feddygol ac ymarfer ar draws y Deyrnas Unedig.

- Penderfynwn pa feddygon sy'n gymwys i weithio yma ac arolygwn addysg a hyfforddiant meddygol y Deyrnas Unedig.

- Gosodwn safonau mae rhaid i feddygon eu dilyn, ac yn sicrhau eu bod yn parhau i gwrdd â'r safonau hyn trwy gydol eu gyrfaoedd.

- Gweithredwn pan gredwn gallai meddyg fod yn rhoi diogelwch cleifion, neu hyder y cyhoedd mewn meddygon, mewn perygl.

▪ Dylai pob claf gael gofal o safon uchel. Ein rôl yw helpu cyflawni hynny drwy weithio'n glòs â meddygon, eu cyflogwyr a chleifion, i sicrhau bod yr ymddiried sydd gan gleifion yn eu meddygon wedi'i gyfiawnhau'n llwyr.

▪ Rydym yn annibynnol o'r Llywodraeth a'r proffesiwn meddygol ac yn atebol i'r Senedd. Rhoddir ein pwerau i ni drwy'r Ddeddf Feddygol 1983.

Cydnabyddwn fod y Pwyllgor yn cynnal yr ymchwiliad hwn fel rhan o'u gwaith ehangach i recriwtio meddygol yng Nghymru. Mae problemau recriwtio i ac yn cadw'r gweithlu meddygol yng Nghymru yn effeithio ar berfformiad y GIG yng Nghymru ac ar ddiogelwch cleifion. Dylid archwilio unrhyw fesurau i wella llenwi swyddi gwag, yn arbennig mewn arbenigeddau prin, megis Ymarfer Cyffredinol, a chymeradwywn y Pwyllgor o ateb yr her hon.

Mae'r Rhestr Perfformwyr Meddygol yn erfyn pwysig i sicrhau gellid gosod sancsiynau ar lefel leol, yn gyflym ac fel bo angen. Yng Nghymru, delir y MPL gan Fyrddau Iechyd Cymru ac nid y CMC. Fodd bynnag, mae rhaid i feddygon teulu fod ar restr meddygon teulu'r CMC a'r MPL er mwyn ymarfer; mae cofrestriad fel meddyg teulu (h.y. Cael eich cynnwys ar Gofrestr Meddygon Teulu) yn un gofyniad ar gyfer mynediad i restr perfformwyr meddygol ar gyfer meddygon teulu.

Mae'r CMC yn hapus i archwilio ffyrdd lle gellid lleihau'r baich a osodir gan brosesau cymhleth a hir ar feddygon teulu (ac arbenigwyr), a thrwy hyn ateb diffygion mewn recriwtio a chadw meddygon. Credwn gall ddiwygio deddfwriaethol, pe'i mabwysiadwyd, fynd ymhell i symleiddio trefniadau heb beryglu diogelwch cleifion.

Mae'n hymateb i ymchwiliad y Rhestr Perfformwyr Meddygol yn dilyn cylch gorchwyl y Pwyllgor. Rydym hefyd yn falch o ddarparu tystiolaeth lafar i'r Pwyllgor. Os oes gennych unrhyw gwestiynau uniongyrchol neu gallwn fod o gymorth pellach, peidiwch ag oedi cyn cysylltu â fi.

Katie Laugharne

Pennaeth Swyddfa Cymru
Cyngor Meddygol Cyffredinol

Bodolaeth Rhestrau Perfformwyr Meddygol Gwahanol ar gyfer Cymru a Lloegr;

1. Mae rhaid i feddygon teulu, meddygon locwm a chofrestrwyr sy'n dymuno gweithio yn y Deyrnas Unedig fod ar Restr Perfformwyr Meddygol Sefydliad Gofal Sylfaenol (PCO) er mwyn ymarfer. Mae i bob gwlad yn y Deyrnas Unedig ei PCOau ei hun ac felly ei rhestr ei hun, a lywodraethir gan drefniadau rheoleiddiol ar gyfer y wlad honno. Yng Nghymru, llywodraethir y rhestr gan Reoliadau'r Gwasanaeth Iechyd Gwladol (Rhestri Perfformwyr) (Cymru) 2004 (diwygiwyd yn 2016). Yng Nghymru, y PCOau perthnasol yw'r Byrddau Iechyd.
2. Mae rhaid i feddygon teulu wedi eu cofrestru yn Lloegr ac yn chwilio am waith yng Nghymru ymuno â'r rhestr yng Nghymru ac mae'r un peth yn wir am feddygon teulu o Gymru sy'n dymuno gweithio yn Lloegr. Mae'n werth nodi bod hyn yn wir am y Deyrnas Unedig gyfan; byddai angen ar feddygon teulu sy'n dymuno gweithio ar draws unrhyw un o ffiniau'r Deyrnas Unedig gofrestru yn y wlad lle oeddent wedi bwriadu ymarfer.
3. Mae'r ffin rhwng Cymru a Lloegr yn hir ac yn boblog iawn, sy'n arwain at lefel uchel o symud rhwng y ddwy wlad a mwy o ryngweithio ar draws y ffin. Codwyd pryderon ynglŷn â bodolaeth dwy restr ar wahân ar gyfer Cymru a Lloegr yn 2015 ac yn fwy diweddar yn 2017. Cyhoeddwyd adrodd yn 2015 gan y Pwyllgor Dethol ar Faterion Cymreig ar y cyfyngiadau a wynebai dwy system gofal iechyd yn effeithio'n uniongyrchol ar ofal dros y ffin. Datganodd dystion i'r ymchwiliad bod rhestr ar wahan ar gyfer Cymru ac i Loegr yn niweidiol i recriwtio a'u bod yn effeithio ar symudedd y gweithlu ar y naill ochr i'r ffin. Mae swyddi gwag yn anodd eu llenwi yn amserol oherwydd y broses ymgeisio hir. Effeithiwyd ar argaeledd meddygon locwm ar gyfer practisiau ar y ffin yn ogystal. Awgrymodd y Pwyllgor Dethol i'r Adran Iechyd Prydeinig weithio gyda'i chymeiriaid yn y gweinyddiaethau datganoledig er mwyn sefydlu un Rhestr Perfformwyr ar gyfer meddygon teulu ar draws y Deyrnas Unedig.
4. Yn 2017, cododd y Pwyllgor hwn y mater eto yn eich ymchwiliad i Recriwtio Meddygol, gan argymell dylai rheoliadau alluogi meddygon i fod ar y ddwy restr, sydd, yn ôl beth rydym yn ei ddeall, yn ffurfio sail yr ymchwiliad unigol hwn.
5. Cydnabydda'r CMC y cyfyngiadau a'r effaith mae'r system bresennol o gyfnifer o restrau yn ei gael ar recriwtio, nid yn unig ar y ffin rhwng Cymru a Lloegr ond drwy Gymru. Byddem yn croesawu cyd-weithio mwy clòs rhwng gwledydd a theimlwn gallai'r pedair gwlad ystyried trefniant cilyddol rhwng y pedair MPL.
6. Credwn fod bodolaeth rhestrau ar wahân yn arddangos problem posibl o ddiogelwch cleifion gan y gallai arwain at fwlch llywodraethol neu wybodaeth rhwng y sefydliad lle mae'r meddyg teulu'n gweithio, a'r hyn i ba MPL y mae'r meddyg teulu'n perthyn.

Cymhlethir hyn gan y gofyniad i bob meddyg ar ein cofrestr gysylltu â Swyddog Cyfrifol at ddibenion llywodraethu ac ailddilysu. Mewn theori, gallai'r Swyddog Cyfrifol (SC) gael ei leoli mewn sefydliad gwahanol, gan greu llif gwybodaeth fwy cymhleth gyda'r tebygrwydd o wybodaeth am bryderon ddim yn cael eu rhannu'n briodol. Deallwn fod yr un mater yn berthnasol pan fydd meddygon teulu'n symud i Fwrdd Iechyd gwahanol tu mewn i Gymru ac angen newid eu hardal MPL – yn anecdotaidd rydym yn clywed bod hyn yn broses faith a di-angen o fiwrocrataidd, tra gallent yn hawdd gysylltu â Swyddog Cyfrifol gwahanol trwy ein system ar-lein.

7. Mae gennym enghraifft o gŵyn mewn perthynas â mater diogelwch cleifion yn un o'n Byrddau Iechyd yn cael ei rheoli gan sefydliad yn Lloegr gan fod y meddyg teulu ar eu MPL nhw. Mae hyn yn gadael y SC Cymreig o bosibl heb allu gweld ar fater o ddiogelu'r claf oddi mewn i'w sefydliad. Nid cydnabod MPL unigol yw'r unig ateb yma, credwn dylid archwilio unrhyw beth a allai cael ei wneud i symleiddio a chyflymu'r prosesau hyn er budd diogelwch cleifion.

Rhwyddineb mynediad at gofrestriad Rhestr Perfformwyr Meddygol ar gyfer meddygon sy'n dychwelyd i Gymru;

8. Mae rhaid i Sefydliadau Gofal Sylfaenol wneud nifer o wiriadau cyn derbyn meddyg ar y Rhestr Perfformwyr Meddygol, ac er bod y gwiriadau hyn yn hanfodol, gall hyn fod yn broses hir a drud. Gall meddygon teulu sy'n dychwelyd i Gymru oddi mewn i ddwy flynedd geisio i ddychwelyd i ymarfer. Mae rhaid i feddygon teulu nad ydynt ar y Rhestr am fwy na dwy flynedd hefyd gwblhau Cynllun Ymsefydlu a Diweddaru'r Ddeoniaeth. Er ei fod yn angenrheidiol, mae'n gosod rhagor o gyfyngiadau amser, costau ac oedi.
9. Mae'r CMC yn dadlau'n gryf o blaid pwysigrwydd meddygon yn dangos eu bod yn gyfredol yn eu hyfforddiant ac felly'n addas i ymarfer oddi mewn i'r Deyrnas Unedig. Cydnabyddwn gyflymder newid yn y maes hwn a'r agweddau diwylliannol ehangach sy'n rhan annatod o ymarfer meddygaeth yn y Deyrnas Unedig, ac mewn gwirionedd, cynigiwn ein rhaglen 'Croeso i Ymarfer y Deyrnas Unedig' ein hunain ar gyfer meddygon sy'n newydd i'r gofrestr. Ar yr un pryd, rydym yn ymwybodol gall nifer o'r prosesau'r mae meddygon yn mynd drwyddynt fod yn llafurus, biwrocratig ac araf. Gobeithiwn bydd diwygio deddfwriaethol, a gynigir gan yr Adran Iechyd, yn y pen draw'n symleiddio beth sydd ei angen gan ymgeiswyr.
10. Ar hyn o bryd, mae'r CMC yn gweithio gyda NHS England a Health Education England i symleiddio ceisiadau i'r Cynllun Ymsefydlu a Diweddaru ar gyfer meddygon teulu, Rhestr Perfformwyr a chofrestr y CMC trwy leihau'r gofyniad o gyflwyno'r un dogfennau i fwy nag un sefydliad. Gobeithir gallai NHS England ddibynnu ar wiriadau'r GMC i gymeradwyo meddygon ar y Rhestr Perfformwyr, yn hytrach na

gofyn i feddygon teulu darparu dogfennau i NHS England yn uniongyrchol.[i] Pe bai proses newydd yn arwain at welliannau, byddem yn croesawu trafodaeth â'r GIG yng Nghymru gyda golwg o addasu proses debyg yng Nghymru.

11. Gall hefyd fod cyfleoedd i archwilio synergeddau rhwng ein prosesau ar gyfer meddygon sy'n ildio eu trwydded ac wedyn i gael hyn yn ei ôl, a phrosesau cysylltiedig ar gyfer gadael ac ail-ymuno â'r MPL.

Sut mae'r broses gofrestru Rhestr Perfformwyr Meddygol yn asesu cyfatebiaeth hyfforddiant meddygol a ymgymerwyd tu allan i'r Deyrnas Unedig

12. Er nad ydym mewn sefyllfa i sylwi ar brosesau'r MPL, rydym wedi disgrifio isod ein prosesau ar gyfer asesu cyfatebiaeth a byddem yn falch o drafod ymhellach unrhyw bosibilrwydd o symleiddio'r prosesau, o fewn y ddeddfwriaeth a ddisgrifir isod.

13. Mae rhaid i feddygon sydd wedi eu hyfforddi tu allan i'r Ardal Economaidd Ewropeaidd (AEE) a chan hynny heb fynd drwy raglen o hyfforddiant confensiynol sy'n arwain at y dyfarniad o dystysgrif o gwblhau hyfforddiant (CCT), ond sy'n dymuno arddangos bod ganddynt wybodaeth, sgiliau a phrofiad cyfwerth er mwyn cael mynediad i'r cofrestrau arbenigwyr neu feddyg teulu, geisio i'r CMC am Dystysgrif Cymhwyster ar gyfer Cofrestriad meddyg teulu Cyfwerth (CEGPR). Mae angen "Cyfwerthedd" os ydynt i fod yn gymwys i fod yn ymgynghorydd GIG neu feddyg teulu. Rydym yn derbyn tua 850 o geisiadau'r flwyddyn yn y Deyrnas Unedig drwy'r llwybr hwn ar draw ymarfer cyffredin ac ymarfer arbenigol. Mae tua 60% o'r rhain yn llwyddiannus.

14. Rheolir y ffordd yr ymdrinnir â'r ceisiadau hyn gan is-ddeddfwriaeth. Mae'r ddeddfwriaeth hon yn gyfarwyddol iawn o beth sydd ei angen gan ymgeiswyr a sut mae rhaid inni eu hasesu. I gydymffurfio, yn arferol, mae angen i ymgeiswyr rannu dros 1,000 o dudalenau o dystiolaeth wedi'i dilysu â ni. Gall y broses hon gymryd llawer o fisoedd ac mae'n costio tua £2,000 yr ymgeisydd i'w chwblhau.

15. Y canlyniad yw system sy'n araf, biwrocrataidd ac anghymhedrol o feichus. Ond mae'n un na allwn mo'i newid heb ddiwygio'r gyfraith.

16. Fodd bynnag, nid y baich biwrocrataidd yw'r broblem, er ei fod yn sylweddol. Yn bwysicach, mae goblygiadau i recriwtio'r gweithlu sy'n risg a waethygir yn dilyn ymadawiad y Deyrnas Unedig â'r UE. Ar hyn o bryd, mae gennym tua 1,3000 o feddygon y flwyddyn (1,377 yn 2016) o'r AEE yn dod i'r Deyrnas Unedig yn mynd yn syth ar gofrestr arbenigwyr neu gofrestr meddygon teulu trwy gydnabyddiaeth awtomatig. Pe bai cydnabyddiaeth awtomatig o hyfforddiant meddygon yr AEE yn dod i ben yn dilyn gadael yr UE, byddai angen i'r meddygon hyn geisio am

gofrestriad meddyg teulu neu arbenigwr gyda ni drwy lwybrau cyfwerth. Byddai hyn yn ychwanegu at broblemau recriwtio'r GIG.

17. Fel arall, gall Brexit greu'r cyfle o ddiwygio deddfwriaeth a fyddai'n helpu ateb rhai o broblemau cyflenwi gweithlu'r Deyrnas Unedig, gan gynnwys rhoi'r hyblygrwydd i'r CMC gydnabod hyfforddiant o wledydd lle gallwn fod yn sicr o hyfforddiant meddygon a'u haddasrwydd i ymarfer.

18. Mae'r CMC wedi dadlau'n hir am wella'r fframwaith deddfwriaethol o fewn yr hyn rydym yn gweithio. Beth rydym ei angen yw model sy'n gweddu i ddatblygiadau yn y dyfodol sy'n rhoi inni'r hyblygrwydd a'r ymreolaeth fel nad ydym ond yn rhoi clwt ar broblemau heddiw bob yn dipyn, ond yn gallu ateb anghenion sy'n newid yn y system yn y blynyddoedd sydd i ddod.

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i Datganiad Bwriad y CMC 2016 er mwyn osgoi dyblygu.

Inquiry into the All Wales Medical Performers List

It may be useful to provide some context for the Wales Deanery. The Wales Deanery is responsible for the management and quality management of education and training of over 3000 Doctors and Dentists in Wales and, for General Practitioners and Dentists, their continuing professional development in line with the requirements of the General Medical Council (GMC) and the General Dental Council (GDC). Our client group includes Foundation, General Practice, Specialty Training grade doctors and Dental Vocational Trainees. The Wales Deanery also has a role in relation to overseeing the provision of Continuing Professional Development for General Medical and Dental Practitioners across Wales. Our goal is to deliver excellence in postgraduate medical and dental education for Wales by ensuring that all training grade doctors and dentists in Wales have access to high quality postgraduate facilities and educational support so that they can achieve their potential in service provision to the NHS in Wales.

In November 2016, the Cabinet Secretary for Health, Well-being and Sport in Welsh Government, announced his intention to set up a single body to commission all health-related workforce education and training, mapped to an agreed, nationally-coordinated NHS workforce strategy: Health Education and Improvement Wales (HEIW).

The creation of HEIW represents a new strategic approach to developing the healthcare workforce across Wales for now and in the years to come.

It is planned that staff in the Wales Deanery will be transferred under the Transfer of Undertakings (Protection of Employment) (TUPE) arrangements out of Cardiff University and into this new body, a Special Health Authority (an NHS organisation), with a view to HEIW being fully operational by October 2018.

The Wales Deanery welcomes the opportunity to provide comments on this important inquiry and to attend the event on 7th March 2018. We will be represented by Professor Malcolm Lewis, Director of General Practice and Revalidation.

The Wales Deanery does not have any direct or legal authority over the management or nature of the Medical Performers List (MPL) in Wales. However, there are indirect links in a number of contexts:

- Currently, doctors in GP training programmes must be entered on the MPL for the GP attachment component of their training. Given the general governance issues that embrace GP trainees, including appointment processes, educational and clinical supervision and annual reviews of competency progression, there is a strong argument for not requiring doctors in GP Training Programmes to be entered on the MPL.

- Doctors coming to Wales to continue GP training on the inter-deanery transfer scheme must currently apply to a Wales MPL even though they are already under the above level of scrutiny and on an MPL in England.

- It is not unusual for UK qualified GPs to spend long periods of time out of practice. This may be to live/work abroad, because of illness or because of prolonged or repeated maternity leave or other caring roles. At the time of return, a period of re-entry in a supervised and supporting environment is valued both by GPs to facilitate their own return to confident practice and by Health Boards (HBs) as providing a degree of assurance of patient safety. The Wales Deanery has a long established network of Further Training Practices (FTP) which provides this returner facility for a wide range of needs. This was established f or this purpose some 14 years ago and was the first network of its kind in the UK. Other parts of the UK have since developed similar processes and we now have a consistent approach across most of the UK (certainly England and Wales) in delivering assessments and placements for this category of doctor.

- Non-UK doctors who qualified as GPs in other EEA jurisdictions have a legal right of entry to the GMC's register as fully registered doctors and with entry to the GMC's GP register. This makes these doctors legally eligible to work as GPs in the UK. However at the time of entry to the MPL, there will usually have been no clinical experience in the UK NHS and certainly not in UK General Practice. The Wales Deanery has recognised this as a potential patient safety risk and has for the past 14 years, advised HBs and previously LHBs that this group of doctors should undergo an induction programme, similar in structure to the returners programme. Again this is now a UK wide programme allowing for consistency of approach.

- In order to remain on an MPL, GPs must undergo annual appraisal and part of their contract, as well as contributing to the revalidation cycle. The Wales Deanery has a major role in supporting this process for all doctors in Wales and in and delivering the appraisal of all GPs in Wales in a consistent and quality assured environment. The web-based Medical Appraisal and Revalidation System (MARS) is central to this activity and is an essential resource for Responsible Officers in all Health Board to facilitate the revalidation recommendation.

Although other issues will undoubtedly arise during discussion and through submissions, the focus of the consultation is on three key questions.

- *The existence of separate Medical Performers Lists for England and Wales;*

During the process of developing the MPLs it would have been clear that the four countries would develop their own processes. If only for political reasons as part of the devolution process, this would have made sense. However, the underpinning regulations were barely, if at all different. Additionally, the standards of entry and standards of practice in UK General Practice are consistent across the 4 nations, regardless of which NHS a GP works in. Increasingly, there have been differences in the approach to patient delivery systems but this does not change the fundamental principle that the standard must, and in reality is, the same.

The continued existence of separate lists therefore only seems to exist as a hindrance to movement of doctors across the border.

At a time when Wales had developed its own Induction and Returner (I&R) programme and England was less consistent, it would be of concern that a lesser standard was being applied and that patient safety issues might arise which would require a mutual recognition agreement. An example would be in the context of EEA GPs coming to England and working in an out of hours setting without the scrutiny that we were then applying in Wales – specifically the case of Dr Ubani in 2009 (as reported in the Telegraph : *Dr Daniel Ubani was told he had not passed the language exam in June 2007, but a month later successfully applied to a different trust for formal registration as a GP. The Cornwall and the Isles of Scilly PCT did not enforce the test because he was an EU doctor and subsequently placed him on the nationwide performance register*). This GP would not have been placed on a MPL in Wales at that time.

So in order to successfully apply a mutual recognition agreement, both parties would need to be clear that the correct approach to Induction and Returner processes were being applied.

- *Ease of access to Medical Performers List registration for Doctors returning to Wales;*

We acknowledge that granting access to the Medical Performers List is a balancing act between providing public assurance and safety, employer assurance and allowing doctors to return. While we recognise that given the current pressures within the system, the emphasis

on enabling individuals to re-enter the workforce might take priority, we would say that this cannot be at the expense of patient safety.

- *How the Medical Performers List registration process assesses the equivalence of medical training undertaken outside the UK.*

The assessment of non-UK qualified doctors works at several levels.

Non-EEA medical graduates. The General Medical Council makes assessments in terms of entry to the register. Most would be required to undertake the PLAB exam. Entry to the GMC specialist register or GP register is by the 'equivalence route' – Certificate of Equivalent Specialist Registration of all specialties other than General Practice and Certificate of Equivalent General Practice Registration (CEGPR) for General Practice.

In the past few years the GMC established an Equivalence Advisory Group, chaired by Professor Malcolm Lewis of the Wales Deanery, to further progress the recommendations of an earlier working group. A range of agreements have been reached and many of the recommendations implemented. For General Practice, an outstanding problem is that it is not possible to obtain workplace experience in the specialty under current legislative restrictions.

The only doctors allowed to work in UK General Practice are those on the GMC's GP register - through UK Certificate of Completion of Traiting (CCT), EEA rights or CEGPR; or those in an approved training programme. This explains why the number of CEGPR entries to the GP Register is disproportinately low compared to the CESR entrants to the specilist register – all of who can work in staff grade positions to gain experience and undergo workplace assessments under the proposed changes agreed by the EAG

(https://www.gmc.uk.org/16 Annual report of the Equivalence Advisory Group.pdf 62067971.pdf)

It may be that consideration of how to work around this restriction would be of value in creating opportunities to increase the number of potential CEGPR applications in Wales (or UK). Options would include a change to the Medical Act – on which the MPL criteria are based or to create 'programmes' for CEGPR candidates that would need to be approcved by the GMC. The latter would require involvement of the Wales Deanery (or Committee of General Practice Education Directors on a UK level) and the Royal College of General Practitioners to allow access to e-portfolios and the Applied Knowledge Test and Clinical Skills Assessment.

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee inquiry into the All Wales Medical Performers List.
Contact	Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation. [redacted] Tel: [redacted]
Date:	22 January 2018

Introduction

1. We welcome the opportunity to contribute to the Health, Social Care and Sport (HSCS) Committee inquiry into the All Wales Medical Performers List. Our response has been developed with our members, including Medical Directors and Deputy Medical Directors.

2. The Welsh NHS Confederation represents the seven Local Health Boards (LHBs) and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Overview

3. This inquiry is timely because it follows the previous HSCS Committee inquiry into medical recruitment, which was conducted from October 2016 to the report launch in June 2017. During the previous inquiry the HSCS Committee put forward a recommendation in relation to the Medical Performers List: "*The Welsh Government should: continue discussions with the UK Government on performers list regulation with the aim of enabling doctors to be on the performers list in both England and Wales*" (recommendation 8).

4. The separate Medical Performers List operating in England and Wales has previously caused administrative and practical issues for General Medical Practitioners (GPs) and General Dental Practitioners. Historically, if a GP and Dental Practitioners were on a Performers List in England and they wished to work in Wales, either permanently or on a sessional or locum basis, they had to apply separately for inclusion on a Welsh Performers List. However, action has recently been taken to make it easier for GPs, based in England, to work in Wales.

5. A new streamlined Performers' List application form for GPs already listed in the Performers List in England (and the other countries) has been in operation since October 2015. The new streamlined Performers List application form substantially addresses concerns, raised predominately by GPs, about a lengthy bureaucratic administrative process to be included in the LHBs Performers Lists.

6. In addition, the administrative burden in applying to be included on a Performers List in Wales has been further reduced following the amendments to the NHS Performers List (Wales) Regulations 2004 on 1st March 2016. The regulatory changes allow a GP to be listed immediately with the LHB on receipt and consideration of their application and to be able to work in Wales with minimum delay whilst NHS Wales Shared Services Partnership (NWSSP) undertake further checks. The Department of Health supports these actions and has agreed to discuss a single performers list should these actions prove to be unsuccessful.

Existence of Separate Medical Performers Lists for England & Wales

7. As highlighted above, the NHS Performers List (Wales) Regulations 2004 (as amended in 2016) governs the eligibility of General Dental Practitioners and GPs to provide general dental and medical services respectively in Wales. It is important to appreciate the potential impact on both professions when considering any revision to the Regulations, unless the approach is to creates separate Regulations. LHBs also maintain Performers Lists for Optometrists, but these are governed by separate legislation and Regulations.

8. The Performers List Regulations in England were revised in 2013 through the **National Health Service (Performers Lists) (England) Regulations 2013**. They relate to General Medical Practitioners, General Dental Practitioners and Optometrists. Although they are similar to the Welsh Regulations, there are a number of distinctions.

9. The changes in recent years to NHS Performer List (Wales) Regulations 2004 reflect progressive measures previously undertaken to make movement of practitioners between the other UK countries and Wales easier than before. We believe that this has significantly reduced the bureaucracy, delays and frustration for applicants.

10. While there have been improvements, experience across Wales suggests LHBs encounter more issues in including dentists on the Performers' Lists than with general medical practitioners. This is because it is more common for dentists applying to be included in the Performers List to have undertaken the required postgraduate training outside the U.K. It is rare for GPs applications to take more than three months from the time of original application to full inclusion. Furthermore, for the vast majority provisional inclusion, which can typically be effected within seven days of receipt of the required information, will allow them to work through almost all of this three-month period, if it takes that long.

11. Current arrangements that allow provisional inclusion are; access to a Disclosure and Barring Service (criminal record) certificate within the past three years; regulatory registration and List Inclusion; and evidence of current and adequate indemnity. This evidence is sufficient to allow this provision inclusion decision to be reached whilst further evidence is sought and suitable safeguards to identify and manage practitioners over whom there may be concerns is provided. While medical qualifications are not part of the initial application for provisional inclusion they are undertaken during the subsequent

checking processes under Regulation 4A (8A) (a) of the NHS Performers List (Wales) Regulations 2004, as amended.

12. The safeguards in the current application process allows the NWSSP, on behalf of LHBs, to make enquiries about and source a concurrent completed declaration of relevant facts from the comparable primary care organisation (for applicants from England this would be from the NHS England Area teams). This reduces the risk of practitioners with known concerns or risks being fully included without appropriate conditions being attached (conditional inclusion) where this is considered necessary.

13. The number of dentists with conditional inclusion considerably exceeds the number of GPs with conditions when GPs are moving from other U.K. countries.

14. The LHBs appreciate the rationale for a wider UK or England/Wales Joint Performers List but would wish to ensure that communications regarding concerns about practitioners were notified promptly across the NHS in the UK. We would also wish to develop improved mechanisms to understand where practitioners are working or have worked, particularly for locums. In the past, there have been some difficulties obtaining reciprocal information from England, particularly where information systems have been outsourced to third party organisations. There have also been concerns in relation to the loss of information regarding practitioners' history from antecedent Primary Care Organisations in England and the current arrangements between NHS England Area Teams and external providers of back office functions.

15. As well as a UK or England/ Wales Joint Performers List, a 'Locum Passport' system has been discussed previously. This would provide a continuous record of employment and could facilitate collation of governance concerns where needed. The introduction of this would require legislation and investment in IT infrastructure as well as consultation with the profession.

16. The establishment of a single Wales Performers List would not be radically different to how arrangements work at present as teams within individual LHBs administering this communicate effectively across LHB boundaries. However, the existence of Area and Locality/Cluster teams and the varying size of LHBs does make it difficult for responsible medical managers to be familiar with several hundred practitioners and their previous performance history.

17. The existence of a Single Wales Performers List would probably still rely on individual LHBs ownership of governance responsibilities and would require clarity as to which LHB has responsibility to take forward, investigate and manage individual performance concerns. Under current arrangements the Medical Director of the LHB in whose Medical Performers List in Wales a GP is included is also ordinarily the Responsible Officer for that GP (unless the GP is also included in the Medical Performers List in another U.K country where someone else may act as the practitioner's Responsible Officer). Each doctor can only relate to a single Responsible Officer. The introduction of different (e.g. pooled) arrangements would require legislation and new governance arrangements.

18. It will be very important to retain organisational memory over any historical concerns in any process to unify administration of a Single Performers List. Medical and dental practitioners in Wales can work across Wales whilst managed within a single LHB list so, albeit infrequently, cases may arise where the performance concerns can arise in the jurisdiction of a separate LHB to that where the practitioner is included. There is a regulatory requirement, under Regulation 18, that practitioners will not transfer to a different LHBs' Performers List until such matters are resolved. This also facilitates the options to apply conditions to a practitioner's Performers List inclusion when the practitioner subsequently transfers to the Performers List of a different LHB without a more cumbersome requirement, as might apply to a Single Performers List in Wales, for screening and reference panels to be held to achieve the same outcome through contingent removal. Clarity of such procedures is helpful before issues are identified.

19. Some practitioners may have been on a Performers List for years, rolled forward through 'grandfather' arrangements into the Performers List when established in 2004. The opportunity to require an application and provide more contemporary information, including an enhanced DBS criminal records certificate, does assure LHBs regarding the applicant practitioner's current performance and any risks that might arise from their inclusion. It also allows the LHB to have available information regarding the practitioner's previous professional experience.

Ease of Access to Medical Performers List registration for Doctors returning to Wales

20. This question has in part been covered in the previous question above. If a GP wishing to return to Wales is already on a Medical Performers List in another U.K. country, they can return under the Regulation 4A process within the NHS Performers List (Wales) Regulations 2004.

21. If they wish to return to general practice in Wales and are not currently on a Medical Performers List elsewhere in the U.K, but have not been out of U.K practice for more than two years, they can make a full application to return to practice. The numbers in this situation who have voluntarily removed themselves from any Medical Performers List and then wish to return in that timescale is not significant. Those who have been out of U.K practice (whether due to career break or working overseas) for more than two years can return to practice via the Induction and Refresher Scheme operated consistently between the Wales Deanery General Practice department at Cardiff University and Health Education England.

22. For any GPs that have not worked within the NHS for two years or more they will need a period of supervised return, the duration of which will be guided by the results of an assessment. The assessment is managed by the GP National Recruitment Office and they run this scheme for England and Wales. The link to their website explains the process of what needs to be undertaken **https://gprecruitment.hee.nhs.uk/Induction-Refresher**

23. The GP will also need to apply for inclusion on the Medical Performers List but will not be included in the list until they have gone through the assessment process and have been allocated a returner placement post in a GP Practice.

24. Given the wide scope of General Practice and continuing developments in many aspects of care, this is considered a valuable requirement. However, it is important to ensure that recognition of equivalent experience is accepted.

25. The number of returners into practice through this scheme is not significant as a proportion of those taking up training placements in Wales. The salary on offer whilst in these schemes to returners may act as a deterrent.

How the Medical Performers List registration process assesses the Equivalence of Medical Training undertaken outside the UK.

26. This activity for applicants wishing to come to work in Wales is undertaken by the Wales Deanery after the doctor has already registered with the General Medical Council (GMC) and demonstrated their equivalence of GP training to the satisfaction of the GMC. Such doctors would also participate in the Induction & Refresher Scheme if they have not worked in General Practice in the UK at any point during the previous two years. The Scheme provides a standardised assurance for practitioners and the length of time practitioners spend within these arrangements, and under assessment, will depend upon how similar their approach is to current UK general practice, whether or not they qualified in the UK, the EU or further afield.

27. Depending on the outcome of the UK leaving the EU, Brexit could have significant implications for healthcare professionals trained in a EU country outside of the UK. Across the UK, the NHS is heavily reliant on EU workers. Currently healthcare professions, namely general practice nurses, dentists, doctors, midwives and pharmacists, have a special status under the Recognition of Professional Qualifications Directive 2005/36/EC which makes their mobility easy and safe. The legislation also enables students of those professions to benefit from educational systems other than that of their home country. These arrangements are reciprocal so that UK-qualified practitioners can also practise relatively easily elsewhere in the EU, although the outbound flow is less.

28. At the same time, patients and consumers are adequately protected by an alert mechanism established by the Directive. This allows the competent authorities of all Member States to quickly warn each other if health professionals have been prohibited or restricted from practicing the profession in one country or have used falsified diplomas for their application for the recognition of their qualification.

29. This framework allows a high degree of professional mobility without jeopardising patient safety and quality of care. Patients and professionals benefit from this transfer of knowledge and Specialised expertise which contributes to continuously improving the quality of healthcare in Europe. As a member of the Brexit Health Alliance, the Welsh NHS

Confederation and other members of the Alliance, are highlighting these issues with the UK Government.

30. In relation to the NHS workforce our priority in NHS Wales will be to ensure a continuing 'pipeline' of staff for the sector. The immigration system that is in place after the UK leaves the EU will need to ensure that, alongside our domestic workforce strategy, it supports the ability of our sector to provide the best care to our communities and people who use our services.

Conclusion

31. In conclusion, across the NHS in Wales, as in other health organisations throughout the UK, there are workforce shortages which are never far from the headlines. While the movement of practitioners between the other UK countries and Wales has become easier, it is important that this continues to ensure that patients receive high-quality services in the future. Following the Parliamentary Review of Health and Social Care in Wales report we now have an opportunity to put forward a long-term vision for the health and social care workforce, delivering new models of seamless services closer to people's home.

NHS WALES SHARED SERVICES PARTNERSHIP- PRIMARY CARE SERVICES

INQUIRY INTO AN ALL WALES MEDICAL PERFORMERS LIST

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Gofal Sylfaenol
Shared Services Partnership
Primary Care Services

1. PURPOSE

Following an invitation to provide evidence to the Health, Social Care and Sport Committee regarding the formation of an all Wales Medical Performers List, the NHS Shared Services Partnership-Primary Care Services (NWSSP-PCS) submits the following response to the areas of concern raised under the head 'Terms of Reference.

2. AREAS OF CONCERN

2.1 THE EXISTENCE OF SEPARATE MEDICAL PERFORMERS LISTS FOR ENGLAND AND WALES

On 27th November 2017 the WG issued a consultation document identifying a number of options for simplifying the process for performers already included in a Performers List of a Primary Care Organisation (PCO) applying to practise in Wales (Annexes A & B refer). The closing date for the consultation is 8th February 2018.

Of the options detailed within the consultation document, the NWSSP-PCS consider Option 7 to be the most appropriate way forward as it will give Health Boards the assurances they need with regard to the suitability of those performers working in their areas whilst maintaining a streamlined administrative process which is not overly burdensome on the applicant.

2.2 EASE OF ACCESS TO MEDICAL PERFORMERS LIST REGISTRATION FOR DOCTORS RETURNING TO WALES

There are different processes for dealing with applications from performers wishing to practice in Wales, dependent upon whether they are already included in the Medical Performers List of a Primary Care Organisation in the UK or if they are new or returning to general practice in the UK following an extended absence of 2 years or more.

2.2.1 Doctors included in the List of a Primary Care Organisation applying for inclusion in Wales.

If a performer is registered with another PCO in the UK and wishes to apply for inclusion in the List of a Health Board in Wales the applicant will be asked to complete a short application form, produce an original enhanced criminal record certificate (less than 3 years old) and provide evidence of appropriate medical indemnity. The performer will also be asked to give

consent for the NWSSP to undertake further checks with their host PCO (ie confirmation that satisfactory clinical references have been provided, details of the applicant's medical qualifications and professional experience). Upon receipt of this documentation and consent from the applicant s/he will be granted provisional inclusion in the List of the appropriate Welsh Health Board for a period of 3 months whilst further checks are undertaken. This streamlined process (which was introduced in Wales in March 2016) allows for the processing of complete applications within 5 working days.

2.2.2 Doctors returning to Wales following an absence of 2 years or more.

Doctors returning to Wales after a period of absence from the UK of 2 years or more, or doctors who have not worked within the NHS GP practice setting for more than 2 years may be asked to undergo refresher training. In such instances, a copy of the applicants C.V. will be sent to the Director of Postgraduate Education for General Practice who will give a clinical opinion as to the necessity for refresher training.

If the Director of Postgraduate Studies considers a period of refresher training to be appropriate the doctor will be signposted to the 'Induction and Refresher Scheme', which is run by the GP National Recruitment Office (based in Edgbaston, Birmingham) for England and Wales. An assessment will be undertaken, the results of which will determine the duration of the required training. Placements in general practice can last between 3 – 6 months. At this stage the performer will be asked to complete a full application form and all necessary checks will have to be successfully completed before inclusion in the Medical Performers List can be considered. Where induction or refresher training is required the performer will be conditionally included in the Medical Performers List (ie. the condition being that their practise is restricted to the GP training practice with which they have been placed and that they will successfully complete the GP Returner Scheme). If the performer successfully completes the course the conditions will be lifted and the doctor will be able to provide unrestricted services but if the performer is not successful, the Health Board can take steps to remove the doctor from its' Performers List.

Further information in respect of the GP Induction & Refresher Scheme can be found at:

https://gprecruitment.hee.nhs.uk/Induction-Refresher

For information please see the number of 'Returner' applications received by Health Boards in Wales during 2016 and 2017:

Number of GP Returners Applied to Medical Performers List

Health Board	**2016**	**2017**

ABMU HB	1	0
Aneurin Bevan UHB	1	1*
Betsi Cadwaladr UHB	0	0
Cardiff and Vale UHB	0	2
Cwm Taf UHB	0	0
Hywel Dda UHB	1	0
Powys TLHB	0	1
Total	**3**	**4**

* GP withdrew application as failed I&R Induction Assessment

3 HOW THE MEDICAL PERFORMERS LIST REGISTRATION PROCESS ASSESSES THE EQUIVALENCE OF MEDICAL TRAINING UNDERTAKEN OUTSIDE THE UK.

The National Health Service (Performers Lists) (Wales) Regulations 2004, as amended, lists the required criteria for entry to a Medical Performers List in Wales. Numerous checks are undertaken, one of which is a requirement to ensure that the applicant is registered in the GP Register of the General Medical Council (GMC). Doctors are entitled to have their name included in the GMC's GP Register if, in addition to being a registered medical practitioner, they:

- Hold a Certificate of Completion of Training (CCT) in general practice
- Are a national of a relevant European State, or have the EC rights and hold qualifications in general practice (as listed in the Directive on Recognition of Professional Qualifications)
- Have an acquired right to practise as a general practitioner in the UK
- Fall within such other categories provided for in the GMC (Applications for General Practice and Specialist Registrations) Regulations 2010.

When a doctor applies to join a Performers List in Wales the NWSSP (on behalf of the relevant Health Board) is required to check the GMC's List of Registered Medical Practitioners to ensure that the doctor is on the GP Register and is therefore, eligible to practise in the UK.

Overseas doctors that have never practiced in the UK before may be required to undergo 'Induction' training. Please refer to the process outlined in point 2.2.2 above for further information on how to access the 'Induction and Refresher' programme. As with the 'Returner' Scheme, any doctor accepted onto an induction programme will be conditionally included in a Medical Performers List (subject to all other checks being satisfactory and a suitable placement being found with a training practice) until the successful completion of the course. The relevant Health Board will then consider fully including the doctor (ie without restriction) in its List.

4. CONCLUSION

The Committee is asked to note the content of this report.

5. ANNEXES

Letter - Claire Cullen to LHBs, SSP

Annex B - PCS Response.pdf