



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

Y Pwyllgor Iechyd a Gofal Cymdeithasol **The Health and Social Care Committee**

Dydd Iau, 29 Ionawr 2014
Thursday, 29 January 2014

Cynnwys **Contents**

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 2
Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 2

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 3
Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 3

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 4
Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 4

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 5
Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 5

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

Ymchwiliad i'r Gweithlu Meddygon Teulu yng Nghymru: Sesiwn Dystiolaeth
Inquiry into the GP workforce in Wales: Evidence Session 1

Ymchwiliad i'r Gweithlu Meddygon Teulu yng Nghymru: Sesiwn Dystiolaeth 2
Inquiry into the GP Workforce in Wales: Evidence Session 2

Ymchwiliad i'r Gweithlu Meddygon Teulu yng Nghymru: Sesiwn Dystiolaeth 3
Inquiry into the GP Workforce in Wales: Evidence Session 3

Papurau i'w Nodi
Papers to Note

Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o Weddill y
Cyfarfod ac o Eitem 1 y Cyfarfod ar 4 Chwefror 2015
Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from the Remainder
of the Meeting and for Item 1 of the Meeting on 4 February 2015

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir
trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In
addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Peter Black	Democratiaid Rhyddfrydol Cymru (yn dirprwyo ar ran Kirsty Williams) Welsh Liberal Democrats (substitute for Kirsty Williams)
Alun Davies	Llafur Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
John Griffiths	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Phil Banfield	BMA Cymru BMA Cymru Wales
Mary Beech	Deoniaeth Cymru Wales Deanery
Tina Donnelly	Y Coleg Nyrsio Brenhinol Royal College of Nursing Wales
Dr Rhid Dowdle	Coleg Brenhinol y Ffisigwyr (Cymru) Royal College of Physicians (Wales)
Rory Farrelly	Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg Abertawe Bro Morgannwg University Health Board
Philippa Ford	Cymdeithas Siartredig y Ffisiotherapyddion Chartered Society of Physiotherapy
Dr Sally Gosling	Cymdeithas Siartredig y Ffisiotherapyddion Chartered Society of Physiotherapy
Dr Peter Horvath-Howard	BMA Cymru BMA Cymru Wales
Dr Charlotte Jones	BMA Cymru BMA Cymru Wales
Dr Paul Myres	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Dr Rebecca Payne	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Dr Alison Stroud	Coleg Brenhinol y Therapyddion Lleferydd ac Iaith Royal College of Speech and Language Therapists
Dr Martin Sullivan	Deoniaeth Cymru Wales Deanery
Lisa Turnbull	Y Coleg Nyrsio Brenhinol Royal College of Nursing Wales
Ruth Walker	Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board
Dr Victoria Wheatley	BMA Cymru BMA Cymru Wales
Dr Phil White	BMA Cymru BMA Cymru Wales

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

Helen Finlayson	Ail Glerc Second Clerk
Sian Giddins	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Rhys Morgan	Dirprwy Glerc Deputy Clerk
Siân Thomas	Gwasanaeth Ymchwil Research Service

Christopher Warner	Clerc
	Clerc
Philippa Watkins	Gwasanaeth Ymchwil
	Research Service

Dechreuodd y cyfarfod am 09:02.

The meeting began at 09:02.

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome everyone to today's session of the Health and Social Care Committee, where, this morning, we'll be continuing our inquiry into Stage 1 of the private Member's Bill on safe nurse staffing levels? Can I welcome Peter Black, who's substituting for Kirsty Williams during this inquiry? Thank you, and welcome. Could I remind Members the meeting is bilingual? And if you wish for simultaneous translation from Welsh to English, it's channel 1. If you wish for amplification, it's now channel 2. There's no scheduled fire alarm this morning, so, if one does occur, please follow the directions of the ushers. Again, can I remind Members that mobile phones be switched off or on 'silent', or that any equipment that interferes with the broadcast equipment be switched off? Could I also remind people, if you've got your iPads, to make sure the pings are on 'silent', if possible, as well? We've not received apologies this morning, so, we will therefore move forward.

09:03

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 2 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 2

[2] **David Rees:** Can I welcome to our first session Tina Donnelly and Lisa Turnbull from the Royal College of Nursing? Before we go into it, can I offer the congratulations of the committee on your award of a CBE in the new year's honours list, Tina? Well-deserved and recognised, not for just your work at the RCN, but also, obviously, your work in Afghanistan as well—very well congratulated.

[3] We have the papers in front of us and, obviously, we thank you very much for your written evidence into this, but, clearly, there are questions we want to pursue into the purpose of the Bill and aspects that you think are important. So, we'll start off with Gwyn, please.

[4] **Gwyn R. Price:** Thank you, Chair, and good morning.

[5] **Ms Donnelly:** Morning.

[6] **Gwyn R. Price:** What's your understanding of how many local health boards are complying with the all-Wales staff nursing principles and guidelines as of January 2015?

[7] **Ms Donnelly:** From the evidence that we have, I would say none are fully compliant, and that's not without us seeking evidence from our members. But also, if I were to look at the expenditure on agency staffing and also the sickness levels, and I could extrapolate from that the amount of money that is spent in order to try to meet the staffing levels—and we have had some of our members keeping a day-by-day diary, submitting that to us with regard to the acuity level of patients, looking at the demands of those patients, based on the staffing levels that actually turn up for work, and also the skill mix—it makes some quite challenging reading. And also, when I look at the workforce plans, we challenge them on an annual basis,

based on the need to deliver against the strategic intent of the Welsh Government and also the delivery and operation of the healthcare delivery mechanisms. I fail to see how we have so many problems associated with sickness, which are often due to stress and nurses not being able to complete the tasks they were trained to do, because of insufficient staffing. And that's across the board; that's not just in medicine and surgery, but nevertheless the evidence that we've identified through some comparison work internationally and also some work undertaken by Anne-Marie Rafferty is that it is not acutely just the country of Wales, but I do think that more could be done in terms of actually recording the number of incident forms where staff report on a daily basis in most health boards where staffing levels do not meet the required standards. It will be interesting to see how that's reported at board, to see how much action has been taken on behalf of the health boards.

[8] I scrutinised the last six months of health boards' public minutes, and I find that, in some health boards, they apparently say—. I could give you an example from, let's say, Cardiff and the Vale. One of their board meetings says that they're actively holding on to vacancies. High vacancies due to planned service changes and needing to leave vacancies open for permanent staff was noted in the minutes in 2014. And then, when I look at the staffing levels, it says that appropriate establishment of well-trained, skilled and competent staff is classified as a risk on the corporate risk assurance framework in the same health board in November 2014. And then when we look with regard to the action plan for the emergency unit, it was noted that staff there were under great pressure and as yet had not been able to undertake training on learning disabilities, dementia and protection of vulnerable adults, according to the quality, safety and experience committee in September 2014.

[9] So, at the same time as acknowledging at board level that vacancies were being kept open, still, looking at the evidence—and this is taken from the board minutes—it's heightened on the corporate risk, and yet they don't seem to be able to recruit or actively plan for those pressures on an ongoing basis. And it's not alone. I could quote Betsi Cadwaladr. I could look at all of the minutes from there. I could look at the difference in terms of compliance with the chief nursing officer's guidance for nurse staffing, saying that there were still problems. I could look at Cwm Taf; I could look at Hywel Dda, Abertawe Bro Morgannwg, Powys Teaching—. All of those are trying to work towards—. But, nevertheless, it doesn't make comfortable reading when you see that health boards are holding on to vacancies for whatever reason and then acknowledging that they have to insert it on the corporate risk register.

[10] So, from that and the evidence that we've had from our members keeping diaries—and I'm sure that Lisa and I could read them out if you wanted us to, some of them, although it would take quite a while—it does make challenging reading, and that's why we're supporting this Bill quite strongly.

[11] **Gwyn R. Price:** Thank you for that.

[12] **David Rees:** For clarification, you've indicated that it's been put under corporate risk in one particular board's minutes that you've identified. Have you therefore got evidence that there are actually unsafe levels of nursing within the health boards in Wales?

[13] **Ms Donnelly:** If you look at what we mean by 'unsafe', there are several measures that you can use to determine what unsafe levels are. First of all, you're looking at the adequate number of staff, whatever that might be, and evidence that was taken and then given out in the chief nursing officer's guidance was that there should be one registrant to seven patients in the day and one registered nurse to 11 patients at night. I know and I could read some evidence of nurses giving us a day-by-day account when that fails to be the case. And I think the other concern we have is that, if you look at the throughput of patients, it's about acuity levels, but it's also about skill mix. So, the chief nursing officer's guidance says 60:40. So, that's 60% registered to 40% unregistered, because of the level of supervision and the

complexity of care. If that skill mix is not evidenced, you run the risk of failing to rescue, and what that means is that you have somebody who's going to do observations that are essential to premonitory signs of a patient deteriorating or life-threatening signs for modified early warning score systems who is not able to interpret those data, so you need an adequate skill mix in order to say that that patient's safe. And the complexity of that is saying that if we haven't monitored the patient throughput properly, and you're not putting up the premonitory signs early enough to denote a patient deteriorating, then you're having to deal with more sinister symptoms of a patient by failing to rescue. So, when you say 'is something unsafe?', there is a professional judgment on a daily basis as to the acuity levels of the patients that have been admitted to the wards.

[14] So, in the Bill, it does say that we look at the numbers of staff, plus the skill mix of staff, based on the number of registrants to the number of unregistered, because of the level of supervision. And it also looks at the ability of a senior member of staff at ward level to give guidance when you need to determine whether you're going to call in the help of other healthcare professionals, such as medical practitioners, physios or occupational therapists, because it's the nursing staff that have that day-to-day contact—hour by hour, minute by minute, hopefully. And I know that there are real challenges to nurses who go off on a regular basis in wards in Wales, and in other parts of the UK, saying, 'I wasn't able to do the care that I did do properly, or should do' and they go off and try and read up, just to try and balance out in their own minds how they cope with that. That's unsafe care. If you're having nursing staff going off—. I still practice and you've just alluded to the times I spent in Afghanistan, where we did have safe care, and we ended up with a 98% survival rate. We know that the evidence of unsafe care does increase mortality of patient, because of the failure to rescue agenda. And that's where the professional opinion comes in as to whether you've got enough staff on duty with the required skill mix to be able to supervise care, plus people don't often understand the complexities of trying to train student nurses as well. So, you've got students in training; you have got to deal with the complex nature of day-to-day management of patients, and you've also got to deal with lots and lots of audit, and lots of lots of paperwork. And when you put all that into context, I'd be saying, no, there is not sufficient evidence to demonstrate that, on every shift in those acute areas, staffing is safe.

[15] **David Rees:** Okay. We've got some questions now from Lindsay, Darren and then Elin.

[16] **Lindsay Whittle:** Thank you, Chair. I am particularly concerned at your evidence on agency staff, and thank you for providing the evidence that, in fact, NHS costs have increased by 43%. I think that's quite alarming, isn't it? Now, I recognise the need for agency staff. It's very necessary to cover sickness, absence for nurses through work-related injuries and times of crisis. But do you believe that, if this new staffing level comes into being, and I sincerely hope that it does, the new staffing structures should be adequately reflected in the budgets available to the health boards? It seems to me as though somebody somewhere is not actually managing these budgets very well.

[17] **Ms Donnelly:** That's really quite a difficult question to answer, because I would turn round and say that, if we were to look at the evidence that we've got in Wales where a health board has tried to cost what it would mean if you were to have safe staffing levels, Aneurin Bevan did some work when the current director general of the NHS in Wales was the chief executive, and looked at the perfect ward. For the first year, there was a 6% increase in staffing costs, and that tells me that that's to bring staff up to a safe level. Actually, when you look at the following two years, there was a marginal decrease in staffing costs, because there was a decrease in staff sickness levels, there was a decrease in infection, there was a decrease in slips, trips and falls—all the measurements on which nurses are held to account in terms of what safe care means—and the discharge was appropriate. So, when you're looking at cost, and is there sufficient cost to deliver the agenda, I'd be saying that, of the £10 million that the

Minister for Health and Social Services gave to increase staffing levels when the chief nursing officer introduced the recommendations in 2012, some health boards used that just to bring their staffing levels up to what should have been the level without actually looking at the appropriate skill mix. That was just to bring up the baseline upon which you then bring in the professional opinion and the acuity levels.

09:15

[18] So, I'd be saying that, if we actually got safe staffing right and cost-effective—. I estimate this year, based on sickness and staff fill rates, because we no longer keep, centrally, the actual expenditure—it's not as available as it was some years ago—on agency staff, that, if you look, about between £25 million and £30 million this year alone has been spent on agency, and, if you look at even a 12% commission fee on that, that's a heck of a lot of nursing staff.

[19] The issue also about agency staff is, whilst it's essential to try to put in the registered nurses that you've got to meet the criteria, actually, if you have an interest in supporting your staff and you increase your staffing levels so you don't need agency staff, you can then employ bank nurses that are part of the NHS contractual system, who actually are familiar with the policies and procedures of the NHS in Wales and don't have to spend so much time reorienting to a ward. I know, if I were to go on to a ward today, it would probably take three to four days for me to actually understand the nuances of that ward, the client group. So, agency staff, while they provide some immediate nursing skills they can undertake, there are some policies and procedures that they're not able to undertake. So, the cost is far more reaching that just the financial bill that I've already alluded to; it has ramifications for the safety of the patients.

[20] Again, in one of the diaries that I could read to you, it demonstrates that one agency nurse who doesn't even live in Wales, but lives in Bristol, was put in charge of a stroke ward and the junior nurses—one of whom was qualified a short number of months and one nine months—didn't have a sufficient knowledge base of some of the questions they needed answers to and neither did the nurse in charge, because she wasn't employed within the Welsh NHS. Now, from that perspective, that demonstrates that there's an unsafe measurement that is not always accounted for in terms of the importance of enabling people who understand the healthcare systems that they currently work in, and delivering on that agenda. So, the cost is more than just the financial outlay.

[21] **Lindsay Whittle:** Could I, Chair, then—? You also say in your evidence that, if we have additional nurses that would require, as well, additional pharmacists, speech and language therapists, physiotherapists and other associated medical experts, so, if the safe staffing levels come in, would it be an additional cost further down the line for other medical professions?

[22] **Ms Donnelly:** I think, when you look at—. The way in which I'd answer that is: if you have a surgeon, a surgeon operates, but he will need somebody to prepare that patient for surgery and also care for the patient afterwards and I think, from our perspective, the way in which nurses are the first person in contact with that patient, they determine, because they do the referrals to other health groups, they're there 24/7. If they were able to adequately spend time with their patients in an earlier stage within a continuum, then, actually, the converse is right. You would have an early referral to the appropriate other healthcare professional to be able to deal with the complexity that arises at that point in time, not waiting until it becomes a more sinister effect than you were seeking help in order to achieve, in which case, it leads to more intensive involvement by a physio or occupational therapist, because you've left it too long for the patient to actually enhance their outcome.

[23] So, from my perspective, obviously, if you increase the number of surgeons, you increase the number of patients that they're going to be dealing with and you will need a team to look after that. But actually, if you used your nursing staff appropriately with the right numbers, you can prevent harm. Having been in an operation environment where I had been in command of a very dynamic hospital, I know exactly the team working that can effect true patient outcomes if you go in to assess early enough.

[24] **Lindsay Whittle:** Okay. Thank you very much. Thank you.

[25] **David Rees:** Before I bring Darren in, can I just expand on one point you made? You talked about the fact that increasing staff levels would reduce the bank and agency nurses, probably, on wards. Most of the evidence that we've seen, actually, says that that's one of the major factors of the improved levels. In England, obviously, the National Institute for Health and Care Excellence has implemented its own guidance. Have you got any evidence from your counterparts in England as to whether the actual changing of staffing levels there has reduced the bank and agency nurses being used?

[26] **Ms Donnelly:** I think it's relatively early for the NICE guidance to determine outcome, because it's guidance, so it's not legislation. So, how it's actually rolled out, it's very early to determine whether that's having an effect or not. But, actually, research undertaken by Anne Marie Rafferty, where she repeated the work that Linda Aiken did in the States and in Europe, did demonstrate that, where staffing levels for registered nurses were implemented, there was a 26% reduction in mortality rate. That's a huge percentage reduction where you get the staffing levels appropriate. So, where the NICE guidelines identify that there's 8:1 patients to a registered nurse, if you hit that, you're unsafe, and you're supposed to red flag these issues; there are circumstances within the NICE guidance where you would look at the acuity levels of patients and you would red flag issues of concern. Then the employer, or the trust, as it would be, or primary care trust, the commissioning areas within England, would be saying, 'We have to do something around that'. We don't have those systems in Wales. I know the NICE guidelines were issued for England, and I know that we pay, I think, about £800,000—the Welsh Government pays—to NICE, to contribute to the NICE guidelines; but we're not even at that level to be able to pick up some of those initiatives.

[27] I'm going to say something that is very unpalatable, but I'm going to say it, which is that, in the strategic education development group meeting, where we give evidence year on year, two and a half years ago I looked at the workforce planning for paediatric nurses and I knew—. Because we've got a very high nurse membership in Wales, I could look at what the projections of those paediatric nurses would be three years down the line, and I questioned the availability of data and asked at SEDG whether the commissions that were being recommended to the Minister to commission for paediatrics would adequately staff paediatric wards, and I was told 'yes'. We then did some more intensive research and I submitted that to the chief nursing officer, with a consequential increase in paediatrics the next year because we were right: commissioning levels were low. Interestingly, there was legislation introduced, and this is about safe staffing, looking at international recruitment in 2012, whereby nurses who were coming into this country—to try to deal with the shortage in staffing, if we're not training adequately we need to recruit—from internationally recruited areas and those nurses would be able to stay for a period of six years, and stay after six years, provided they were able to attain a salary of £35,000 per annum. Now, at a recent SEDG meeting in December, I was asking, 'Where is the evidence for the knock-on effect of that in 2017, when that hits the internationally recruited nurses and they have to leave?' That would be the first cohort that would have to leave after that legislation, and the people who were advising didn't even know that that was actually live legislation and would potentially have an effect. Therefore, the internationally recruited nurses that we've got in Wales—. When we're looking at how we actually balance the safe-staffing levels or at how we workforce plan, we can employ nurses

from the European community, but how can we now recruit them from the international community? There are challenges. When I look at the guidance by NICE, it looks at how you actually recruit and train your nurses, and how you make sure that they're contemporary in their continuous professional development. But, amongst all of that, we're looking at workforce planning here in Wales that is not consistent with some of the changes that we know to be apparent, so I have got real questions on whether or not—. It's not just at ward level, the safety; it's actually the safety of the planning and preparation to deliver against Government strategy, and also to deliver against the healthcare needs of the populations in which we serve, based on training sufficient staff.

[28] **David Rees:** Thank you for that answer, which actually was quite different from what I actually asked, but—. Darren.

[29] **Ms Donnelly:** But it links into it.

[30] **Darren Millar:** If I can just pick up on one thing before I ask the question I wanted to, and that is the perfectly resourced ward pilots that you referred to: you suggested that it could deliver significant financial benefits in terms of reduction of agency and staff costs if that model were exploited elsewhere. The health board, though—Aneurin Bevan Local Health Board—said that the outcome of that pilot was financially inconclusive. It actually suggested that the control ward costs also reduced significantly over the same period as the perfectly resourced ward costs. So, it was therefore difficult to establish whether it was because of the fact that the ward was perfectly resourced and given extra complements of staff was actually responsible for the financial reductions. Do you want to just comment and respond to that?

[31] **Ms Donnelly:** I do. I think, Darren, in relation to any longitudinal study, I was quite clear in saying the first year showed a 6% increase, and then the next two reports after that showed there was a marginal decrease. And I think the issue around that is where there is a momentum within a ward and where those sisters come together to share that practice. I actually took the health Minister to that ward and we walked and talked and spoke to nurses. And the knock-on effect of when you're in a health board in a surgical community where you've got the senior nurses working collectively together is that they tend to learn from one another and they can see some of the systems and processes you've put in place to make that happen. The real agenda around that is whether that should be a longitudinal study that is put out to the whole of the health board to actually balance out whether there are nuances that will actually deliver on that. But actually what we're talking about here is mortality and morbidity, and the consequential—

[32] **Darren Millar:** I accept that; I was just focusing on the financial impact in terms of the question. But you accept that it's difficult sometimes to extrapolate the whole reason why financial costs actually fall during the pilot study.

[33] **Ms Donnelly:** If it's a pilot, then you will pick up those. I would say—. I could look at the three years and say, 'Well, the first year showed an increase, the next two years showed a marginal decrease', so, consequently, I'd be saying, 'Let's roll that out to the whole of that particular surgical directorate and compare like with like', because the ward that was a perfect ward was a ward that was high dementia, elderly patients that were also orthopaedic trauma—so, those in themselves are high areas of acuity and high dependency among the elderly population, and of vulnerability. So, if you're comparing like with like, that's where an accurate pilot—. And looking at the systematic reviews that have been done across the board in terms of the universities, they would say unless you do a randomised control trial—i.e., you have a control and you have some groups that you do the intervention on—. But you're playing around with patients' lives to be able to do that.

[34] So, the longitudinal studies are what we would be saying are effective, but I have no

confidence—I've been doing this job for 10 years—that the workforce planning agenda and safe staffing levels—. If I go back to Jane Hutt, when she was health Minister she asked health boards, 'If you had no problem with cost, how many nursing staff'—she also asked about other health professionals—'would you need by 2010?' and depicted that it would be 3,000 nurses. In 2010, we had a total increase of 1,200. So, even with that, even with health boards actually projecting forward based on need—. I mean, you could argue, 'What has changed?' Well, the strategy's changed, the way in which the Welsh Government deliver healthcare in terms of moving care into the community has changed, but the issue around that, Darren, is whether you're dealing with patients that have adequate access to nursing staff. And I have to say we don't.

[35] **Darren Millar:** I don't think you'll have many problems persuading the committee of the need for appropriate staff to patient ratios, or of the fact that the evidence does seem to demonstrate that adequate nurse staffing, safe nurse staffing, reduces mortality rates; I don't think there's any problem with that at all. I think the challenge, really, is to demonstrate that we need legislation in order to get there, rather than the guidance that has been issued—and we've seen guidance issued, NICE guidance, in England, which seems to be having the desired impact. Why isn't it having the same sort of impact in terms of the chief nursing officer guidance that's been issued in Wales? What are the problems? What are the barriers to health boards being able to implement that in Wales, which they don't seem to see elsewhere?

[36] **Ms Donnelly:** I'm not so sure—that was David's question earlier—that we have seen NICE guidance—. Because it's still relatively early on. We're a royal college for the UK's four countries, and I know that there's 20,000 nurses short in England, so they're having to increase and they've increased the commissions the same way that we have. The confidence that I have in the workforce planning—I said I've been doing this job for 10 years; prior to that I was a civil servant in here, doing workforce planning. And I know the issues that can be addressed, but I have no confidence in the way in which the relative changes that are required to deliver the nuances in change in health policy are actually properly planned for. And also if you look at the way in which—. I've just read you something about health boards saying they've got a large number of vacancies, yet still putting something on the risk—. It changes behaviour when you have legislation because, if you know that you're going to be accountable for it, then you will deliver on it and I don't see how we can actually, in Wales—.

09:30

[37] We've been very, very positive about the banning smoking legislation because it has an effect—that changed behaviour. We also had legislation for placing the cost of 5p on a bag and that changed behaviour because you see people now using their own bags for sustainability. The issues around whether or not somebody could comply or must comply is the difference between whether you try to mitigate the risk on the risk register and say, 'Well, we've put it on a risk and there are peaks and troughs; we might not always get it right', as opposed to having the accountability to say that if you don't get it right, you will have to have maybe a three-month sanction to make it happen.

[38] **Darren Millar:** But why is it that without this sort of legislation, other parts of the UK are doing better in terms of their nurse staffing ratios? Why is that?

[39] **Ms Donnelly:** If you look at Northern Ireland, Northern Ireland have historically had a higher nurse-patient ratio than the rest of the UK and that's because, if you look at where they put their emphasis, it's more difficult to recruit people across the water, so they train a lot more; so they don't have the ability to bring people, as we do, across the border, agency nurses in from England. So, Northern Ireland already have that. Scotland have a different agenda in terms of their safe staffing and the accountabilities via the chief nursing officer. Here in Wales, we have got a situation whereby we have an annual basis of workforce

planning, based on, I think, affordability of health boards to employ, as opposed to the actual needs of the service. I tried to confirm that when Jane Hutt was health Minister, seeking to say, 'So, the Welsh Government would get an estimate of what's needed'; the health board said, 'Yeah, we need 3,000 extra nurses.' If you were to ask that today, against affordability, they would see that they can staff up and staff down, they can push staff to the limit with regard to patient safety, by saying, 'I can't get you a nurse today; can you cope?', or when a nurse is on shift for eight hours, by increasing that day shift to 12 hours. So, there are complexities in the system that put staff under pressure to comply. In our own workforce survey, we know that, in Wales, nurses are doing approximately 7.5 hours unpaid overtime in order to comply with the safe staffing agenda.

[40] **Darren Millar:** Okay, so let me just get this right. So, you're saying that, essentially, it's down to money.

[41] **Ms Donnelly:** I'm saying it's not just down to money—

[42] **Darren Millar:** Okay.

[43] **Ms Donnelly:** Money is an issue—of course it is, because when you look at the size of the bill, you have to pay people, but the issue is also that it's an area whereby health boards can flex up and flex down, hold on to vacancies and control that finance without actually looking at the real consequences and trying to rationalise that by putting it on a risk register. That is not a good way to work.

[44] **Darren Millar:** And you made comparisons with Scotland. How are the Scottish health organisations more accountable to the chief nursing officer for their staffing arrangements?

[45] **Ms Donnelly:** If you look at the way in which Scotland identified their workforce planning agenda, and they often do some of the pilots because they have a larger workforce and they also have the borders with England, the way in which they work—and you will be hearing from Rory Farrelly, who worked in Scotland—they did quite a lot of work on acuity levels before we did and we're only now in catch-up. So, the acuity levels demonstrated—albeit there were some issues with their acuity levels—that if you really assess a patient's dependency based on the clinical-need environment and you produce that as evidence, then you increase the nursing level. They also have an issue whereby they train people and they offer a year's contract to the registrants immediately after training, which stabilises the workforce, so you're not waiting for those peaks and troughs at the end of every three-year training. So, they're able to better plan for the numbers of nurses who are coming out of training who they deal with.

[46] **Darren Millar:** But that is about workforce planning and not about legislating for safe nurse staffing rations.

[47] **Ms Donnelly:** Yes it is.

[48] **David Rees:** Elin.

[49] **Elin Jones:** Could I ask you whether you would like the committee to consider placing on the face of the Bill safe staffing requirements for other nursing places, such as community hospitals—there still are some—and nursing in a community setting, because it's obviously not on the face of the Bill, although there are enabling requirements? Do you think it would be useful for this committee to consider actually strengthening the Bill by placing that as a requirement on the face of the Bill?

[50] **Ms Donnelly:** I think, from my understanding of the Bill, that there is the opportunity to add to the Bill as evidence comes. I wouldn't be sitting here advocating 'yes' straight away to community nursing because we don't have the evidence in community to be able to prove that at this point in time, but I would be wanting a greater emphasis placed on collating that evidence to demonstrate. It's one thing to say you've got sufficient evidence now for acute areas where you can affect outcomes for patients and save lives. That's the evidence. That's the unequivocal evidence in our view to be able to legislate, because we know it makes a difference. If I look at the community workforce plans now, of course I would say, wouldn't I, that you have got to have appropriate staffing levels, safe staffing levels in the community? But, again, we have just had a primary care strategy launched. We also had a community care strategy, where we had difficulty in looking at the costed plans at health boards of what it would be to implement that. So, I would certainly not be advising from our perspective to move down that line without strong evidence. The evidence is the key issue here in relation to acute care. But, I would certainly be saying that we've got to start looking at the evidence because patients in the community are equally as vulnerable. But, it would be wrong of me to say that we've got conclusive evidence because we haven't and that is because it's an area that is untapped and unevaluated.

[51] **Elin Jones:** Do you recognise the concerns that other submissions have given to us that there could be an unintended consequence on community nursing? For example, a local health board has a statutory requirement for safe staffing on an acute ward, and this Bill would provide that that same local health board employs nurses in the community. Is there a danger of the unintended consequence that the health board would prioritise its nursing to meet the legislative requirement to the detriment of numbers in community nursing?

[52] **Ms Donnelly:** Part of that question I would answer by saying that if you get the in-service care right, where you actually get the interventions—the acute care intervention in acute care hospitals—right and you get the appropriate level of care ready for discharge, then you will have patients discharged appropriately into the community where their risk level of discharge should not be as great as it is currently, because we are pushing patients out of the NHS because of the failure to rescue, because there is inadequate staffing and because when a patient comes in on that pathway, you are preparing for discharge from the moment that patient comes in. So, you do an assessment of that patient, determining how you are going to discharge that patient. If you find that you are—and this is where it gets technical from a nursing perspective—because of inadequate staffing not doing a full assessment, you will not be able to appropriately plan for the appropriate time of discharge at the appropriate level of independence. Therefore, you are pushing patients out in the community because they are not ready and then, when you get them into the community, you are having to deal with more acute patients still in the community because of the inappropriate management of those patients in the acute care sector.

[53] However, I know that if you were talking to GPs, they would be saying that district nursing is under threat and the ability of district nurses within the community to go out and do that assessment within the community to determine the appropriate level of care, because we started to deplete the number of absolutely qualified district nurses as opposed to healthcare workers within the community for the same reason. The acuity level and that assessment of that patient's needs in terms of determining their whole care pathway is so, so important and vital for you to get that intervention right. You wouldn't think of a surgeon coming and saying to you, 'Well, I think I'll take you down to surgery and I might remove your leg, I might remove a portion of your leg or I might remove your feet', because he has to categorically be very, very real about what that patient needs to sustain life. That's the same issue for nursing. You need to have the time to actually assess that patient appropriately within the healthcare setting to determine what their level of need will be. It's right to discharge if they're discharged appropriately. I hope that I have answered your question, Elin.

[54] **David Rees:** Lynne wanted to come in on this point and then I'll bring Elin back.

[55] **Lynne Neagle:** I wanted, on the theme of extending the Bill, to ask about children, because one of the things that attracts me about this Bill is that it does kind of try to nail things down and deal with the implementation gap we've seen between policy and delivery on the ground. We know that, in some areas, there is that gap in relation to children if you look at things like neonatology, where there are very long-standing difficulties with staffing. Do you think we should be looking at recommending that children are brought within the scope of the Bill?

[56] **Ms Donnelly:** You've picked on neonatology because that's where there is the one-to-one ratio, which has to be in place for neonates. It is also on the Home Office list of shortage professions, so we can still recruit those internationally. The difficulty that you have with children, because you could look at the children coming in, is that there is sufficient staffing in our view if you were to put children into a children's ward and manage that within that children-care framework. The difficulty we have is where children are actually having to be looked after in areas that are akin for adults, like accident and emergency, where you might not always have a paediatric nurse. You might look at areas whereby, at the latter end, a child in the teenage years, still under the classification of being a child, may have to be put into an adult ward. So, we currently have in Wales that children must have access, and you can call in paediatric nurses. Of course, we would advocate, and I'm sure the children's commissioner would advocate, that children should be cared for appropriately and have the choice of where they are cared for.

[57] So, it is challenges like that within a healthcare system. If they are short because of the demand, you might accept. But, in the longer term, I would be saying, again from our perspective, you need to have the appropriate skill mix to look after the level of age groups that you are dealing with, not just children, but also when you look at mental health and you also look at some of the other challenges that we see when you have people with learning disabilities cared for in a general ward, if you don't have that skill mix. That's where I would be arguing that professional opinion and judgment, within this Bill, enables that process to happen. So, currently we have got the requirement of a 1:1 neonatal nurse. That is already there, it has to be met. Health boards have to meet that, but they don't have to meet it for children currently. I'd be saying that, in an ideal world, of course we should be saying that, but I think the professional judgment there will kick in quite dramatically, and usually does within Wales.

[58] **David Rees:** Elin, did you want to come back?

[59] **Elin Jones:** Not on any of these issues, no.

[60] **David Rees:** Okay. John.

[61] **John Griffiths:** My question really, Chair, is in terms of the appropriate evidence base that we can draw on in coming to a view and making decisions on these matters, particularly the international evidence that is cited. Do you see problems in directly applying some of that evidence to possible minimum staff ratios in Wales, in terms of the differences in the healthcare systems? Are there any issues there for you in terms of directly applying that evidence given those differences?

[62] **Ms Donnelly:** Firstly, John, I wouldn't be talking about minimum staffing levels; I'd be talking about 'safe', and I think that that is an important distinction. Safe staffing levels just doesn't talk about numbers, whereas minimum does. I think, if I were to look at Aitken's work, it was replicated by Anne Marie Rafferty in England and Scotland. So, I'm confident, in looking at the systematic reviews that were done, whilst you can't prove absolute cause and

effect, you can't prove cause and effect in a number of other studies. For example, we had to do *longitudinal* studies on heart disease, and their associations, rather than absolute cause and effect, until we get to—. That is a scientific question. So, I'd be saying, if you look at the interventions by nursing staff, it doesn't really matter whether you're in a healthcare system in the States or in Australia, because those interventions are still the same at the bedside. Therefore, the applicability of transferring that information is not just about the healthcare system; it's about the delivery during that in-patient episode. Those are very, very similar.

[63] Having worked with international nurses from the States and from different parts of the world when I've been on ops, the actual care given is very, very systematic in the way in which it's delivered, and those ideas of patient safety are akin across the whole of the nursing profession, not peculiar to the healthcare delivery systems that you might be having, because the patient's journey is very similar in many instances. So, I would say you can extrapolate the exact same references in terms of mortality and the effectiveness, and where it's proven successful in Victoria or other parts of Australia are ramifications of what we could do here if Wales bit the bullet and went for legislation in this area.

09:45

[64] **Ms Turnbull:** If I could just also add that I think what is very useful as well is looking at the potential unintended consequences question. Where you actually have seen some of these laws brought in in situations where there is a more market-based system, what's actually very useful to see is that there hasn't been any sudden dramatic impact on the financial viability of the operation. There hasn't been any sudden dramatic shift in staff moving around. Given that the system is perhaps more market based, if you were going to see any of those consequences, you'd see them there, because it would be easier for those consequences to impact, and that hasn't been the case. In fact, the evidence shows a very beneficial outcome all round, both from the patient's perspective, which is the most important, but also in terms of the sustainability of the actual system. So, I think it's quite a useful example in terms of looking at the policy consequences.

[65] **David Rees:** Peter.

[66] **Peter Black:** Thank you. Just following on, in a sense, from Elin, because she talked about the impact on community nursing, we've had evidence from the Welsh NHS Confederation, and they say that arbitrary ratios could limit the way we use the skills of other staff, like physiotherapists and occupational therapists. The Chartered Society of Physiotherapy say there could be a negative impact on health professionals not protected by the legislation. Obviously, that's going to be a concern, so how do we address those particular points?

[67] **Ms Donnelly:** I don't think there's a hierarchy of professional delivery. You know, I think, when you look at the patient's journey, you're looking at the team, effectively, of that care. I would be saying that I've read the chartered society's evidence. What I'm saying in response is that we have substantial evidence to demonstrate that a safe staffing level reduces mortality. I would be saying that nurses are there 24/7, notwithstanding what I've just said about a hierarchy between professions, because every single one has a team effect. Actually, when you're in clinical practice, it's the nurse who sees the patient right at the door, to be able to do the assessment to refer to medical staff. It's the nurse who does that initial assessment to determine whether or not you do a referral to a physiotherapist or an occupational therapist, or to a pharmacist or a dietician, and the consequences of that are that you're then professionally accountable for that assessment. So, the areas where I would be saying it is that, when you work collectively as a team, also, some of the evidence that we've demonstrated is that, if you get that assessment right, and you get the interventions early enough, you can prevent, or have to prevent, the immense workload that has to be done. If you don't assess, let's say, a

patient's mobility right at the commencement, the more intensive physio would be needed if you put them in bed for two or three days and they lose that ability to mobilise, and the confidence to mobilise, especially in the elderly care population that we've currently got within most of our wards in Wales. So, I'd be saying that a more systematic approach will evolve, because you will have, if the legislation is passed, a duty on the health boards to ensure that you've got the appropriate levels of skill mix and numbers of nurses to be able to do a full assessment of those patients and refer those on, to get your team to work collectively together. That's where I see the effectiveness of appropriate safe staffing levels. That's been also identified by Linda Aitken in some of the work that she did about the knock-on effect to other healthcare professionals. That hasn't had that untoward, negative impact. In fact, it's cohesively worked better, because physios and OTs have been able to interject earlier appropriately, and they balance that out.

[68] **Peter Black:** Okay. So, given that, if this Bill is passed, we're still struggling, as it is now, to meet the levels that the chief nursing officer has actually recommended, how do we ensure that with this Bill, if it is passed, the safe nursing levels are complied with, and what mechanisms are available to us to enforce those particular levels?

[69] **Ms Donnelly:** I've already mentioned about the change in behaviour of health boards. Currently, I don't feel that it is appropriate just to put on a risk register to say you've read the risk and you've mitigated it. That is a way out, currently, for NHS boards. I also think that it should be a full accountability of the board, not just the nurse director. Let's face it, when you get evidence of poor care, or when you're looking at areas whereby patients' relatives have complained about care, it's the nurse director who's called to account, when in actual fact, the board has the total responsibility for that. So, I would be wanting to see the implementation felt by the accountability, in terms of their corporate accountability. That's what they're employed to do. That's what the officers of the board are employed to do; that's what the non-executive or independent directors are there to scrutinise. I would expect that the board should be receiving, on a regular basis, any breaches and putting action in to prevent that. Similarly, where you have Healthcare Inspectorate Wales going in, they should be scrutinising where there is evidence of high levels of sickness or where there's a high level of complaints, whether that is down to staffing levels. Often, that is not reported appropriately. It's commented on, but there's no deep-dive investigation as to why that is the issue. If there was legislation, there would be a duty on the health board to do that and rectify it. That is a real omission, I feel, in terms of the management of the potential systematic failures that we currently see in people saying, 'Our sickness levels are going up; we've got recruitment problems because people don't want to stay'. If you don't have that scrutiny, you won't have confidence that the board understands what you're actually trying to achieve, and then you won't have people working or continuing to work in that environment.

[70] That was another part of the work undertaken by Linda Aitken. In Australia, where they did introduce legislation, they found that there was a high proportion of nursing staff who'd left the profession who returned to practice because they felt that they were going to be able to deliver care appropriate to patient care needs and not put their livelihood or their profession at risk, let alone putting their patients at risk. So, the knock-on effect could be that you could be bringing in people in Wales who've left the nursing profession because they don't feel they've had adequate support at board level. So, legislation, I feel, would change the behaviour of the board and also change the inspectorate in actually doing a deep dive on safe staffing levels when they know that there are other indicators that can demonstrate that they are down to safe staffing.

[71] **Peter Black:** I mean, clearly, some nurses—and you referred to the ones who've left the profession—have been unhappy about the pressures they're being put under at the moment. Obviously, they are feeding that back to the board, in one way or another. Are there sufficient reporting processes in place to ensure that, if this legislation is passed, where there

are breaches, staff feel that they're going to be able to report back and have their concerns listened to, or are boards going to have to address that mechanism, as well?

[72] **Ms Donnelly:** I think they're going to have to be more transparent in the number of instances where nursing staff fill out a Datex referral to say that there's been inadequate staffing. Often, when nurses come to us and say, 'How many more times have I got to fill in a form on a daily basis to say that staffing levels are short?', they're not often fed back to as to the action by the board. We've scrutinised board minutes to find out whether Datex referrals are recorded; they're not, in a large number of instances. So, if you're looking at the number of instances where nursing staff report short staffing, an inadequate skill mix, or indeed where people have said, 'Can you just cope with this shift, or can you work an extra four hours on top of your 12-hour shift just to give me some cover?', that is not good enough for that to be on such a regular basis that the board are not intervening and actually taking hold of the problem and making sure that things are put right. I've gone on to a ward, where I was shown a six-month off-duty with electronic rostering, where people who were on long-term sick were still being rostered. If you look at that, you would see two of the registrants were supposed to be off sick—and they were on long-term sick—but they were still being registered, or put on the roster. So, the nursing staff knew that, when those two individuals were still on the roster, they would be two nurses down. When I asked for an explanation of that from the board and the chief executive, I was told, 'Well, we still have to pay people who are off sick'. I said, 'Yes, but you can put in systems within the IT infrastructure to take them out so they're not rostered, and then you'll get an accurate level'. But then, when you're reporting the sickness level in that Gaussian curve, those extreme outliers are brought in to the average, and you're not seeing that.

[73] **David Rees:** I think we're going beyond the—[*Inaudible.*] I'm conscious of the time now. So, I have John, who wants to come in with one question, Elin wants one question. Tina, if you could be quick, because of the next session.

[74] **Ms Donnelly:** Okay.

[75] **John Griffiths:** We've heard about the possibility of unintended consequences and that's always a major factor when thinking of passing legislation, I think, that legislators have to bear in mind. We've heard about the possible impact on other health professionals, and we've received evidence from the NHS Confederation about OTs and physios, for example. But another aspect, perhaps of unintended consequences, is the wider team: those who provide support to nurses, and do work that doesn't require nursing qualifications but is nonetheless very, very important, and makes them very important components of the overall team. I wonder whether you've given any thought to the possibility that better ratios for nurses might result in reductions in those support staff and the impact that would have on nurses who would then be required to do the work that those support workers are currently carrying out.

[76] **David Rees:** In answering that, I understand that you've already answered questions about the healthcare professions, so in a sense, we're talking about support staff here.

[77] **Ms Donnelly:** I know that Unison have expressed issues with regard to support staff, such as portering services. Without a doubt, if you have an increase in patients, then you will need increase in portering services. The difficulty we've got is delayed discharges, or delayed transfers, notwithstanding what's in the community. Inappropriate holding on to patients does increase demand, and I would say that there does need to be adequate workforce planning across the board, and I'm sensitive to the concerns raised by Unison about what effect that might have. Nevertheless, let's be clear here that a nurse's registration's on the line if she doesn't get staffing levels rights, and the care she delivers—that's her job and her livelihood.

[78] **David Rees:** Okay. Elin has the last question.

[79] **Elin Jones:** Just quickly, do you think the Bill would be improved if there was a requirement on local health boards to demonstrate that they were meeting safe staffing by the use of permanent staff rather than temporary agency and bank staff, so that they would be required to demonstrate that?

[80] **Ms Donnelly:** I do believe that if you increase the number of permanent staff, you will have a knock-on effect on the outcomes for patients. However, it would be remiss of me not to say that you'll always have peaks and troughs in healthcare, and you would need the bank staff to be able to flex up appropriately. So, I would be looking to advocate that your bank staff are increased, which means that you can still work within your financial constraints to be able to deal with that, but you're not putting patients at risk by bringing in people who don't really know the system, as valuable as they are. To try and keep the numbers up, you really have to increase the number of permanent staff, so the answer would be 'yes'.

[81] **David Rees:** Okay. Thank you. Our time is up. I'm just going to thank you very much for your evidence session this morning, and you will receive a copy of the transcript to check for any factual inaccuracies, for correction. So, thank you very much once again.

[82] Members will be aware that we're moving on to the next item, which is evidence from the representatives from the nursing directors. I remind Members that these are representatives of the directors of nursing within health boards, not health boards themselves. The LHBs will be coming to another session.

09:59

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 3 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 3

[83] **David Rees:** Good morning, and welcome to the Health and Social Care Committee. Can I welcome Rory Farrelly, who is the nurse director for Abertawe Bro Morgannwg University Local Health Board, and Ruth Walker, who is director of nursing at Cardiff and Vale University Local Health Board?

[84] **Ms Walker:** Yes, thank you.

[85] **David Rees:** Thank you very much for your attendance this morning. Clearly, we've received evidence from the NHS Confederation in relation to some of the points, and we appreciate that you're actually here representing directors of nursing and not local health boards. So, I think that's an important point to stress, in one sense. I also remind Members again of that point. So, if it's okay with you, we'll go straight into questioning. Gwyn, do you want to start?

10:00

[86] **Gwyn R. Price:** Thank you, Chair. Good morning to you both. To what extent are local health boards currently complying with the existing all-Wales nursing staff principles and guidelines? And, what are the barriers to achieving full compliance, in your opinion?

[87] **Ms Walker:** Good morning, Gwyn. I'd like to just make—before we start answering your questions—a bit of a comment from the nurse directors, collectively. The nurse directors are keen that the committee understands that we fully support safe nursing and midwifery staffing levels across all aspects of the care areas where we deliver care and we commission

care. We recognise that there may be a need for legislation and we're keen that we assist and engage with you on the concerns that we have around how we might be able to implement that. I think that leads us nicely into trying to answer the question.

[88] So, I think it's really important that committee understands that we've been working hard over the last two years to look at how we implement the CNO's principles. In Cardiff and Vale University Local Health Board, we set establishments on an annual basis, so we're very clear for them to be signed off professionally and operationally, so they deliver the service that is required of them, but also that the money aligns with that establishment, so they all line up together. That's really important, because, actually, if you don't do that, we start talking about apples, pears and bananas. So, we talk about are we allocating the right amount of money, rather than do we have the right nurses there?

[89] So, the challenges we face are not around whether or not there's enough money to care for those patients properly with the right staffing. It's often about the availability of the staff to be able to do that. So, if you look at our current use of bank and agency as an example, we have gaps that we need filling to ensure that the staffing is right on that ward. So, if you take two surgical wards that sit together, one surgical ward is receiving, on a Monday morning, new patients, because it's been closed over the weekend, so on a Monday morning, all the patients are new and fresh, they've had their pre-assessment work, so they're not requiring a significant amount of registered nurses first thing in the morning. The ward next door, that's been running over the weekend and has had patients going to theatre and patients due to go to theatre that morning, will have a higher acuity, so you're going to need a greater number of nurses on that ward—registered nurses—to care for the acuity of those patients. So, two surgical wards based next door to one another have core staffing, laid out in the CNO's principles, but actually, the allocation of the staff may need to change and move about to meet the needs of the patients.

[90] So, in relation to how we allocate our staff, sometimes, it's outside of just those two wards. We need to work across the spectrum to ensure that we can deliver safe staffing in all of our clinical areas. The challenge we have with the gaps—often, the gaps are there because we have maternity leave, or sickness leave, or special leave, or study leave—some of that is built into the establishment with the 26.9% uplift, but sometimes, we have levels where there is absence higher than that. And that's when you use bank and agency, or when the acuity of care is higher and you need to bring in staff to ensure that you can give the right care to patients at the right time.

[91] **Gwyn R. Price:** So, flexibility, in your opinion, is essential.

[92] **Ms Walker:** Absolutely crucial. Yes. And, in somewhere like my service where we have tertiary care, minimum standards are not always the right standard for safe care.

[93] **Mr Farelly:** I think it's also important, from my experience, the CNO's principles of guidance take a triangulated approach, so it's not about actually a number; it's looking at clinical outcomes and it's also looking at skill mix. Undoubtedly, certainly, from the board perspective I'm in, in relation to mapping the CNO's standards, we still require further investment to meet those standards. Actually, that's part of the integrated medium term plan within the board and actually doing that. But we still need the flexibility to make sure that we can flex up and flex down staff.

[94] It also sees a requirement—and certainly, the work that all the nurse directors have done across Wales have mapped those principles—of increasing numbers of pre-registration nursing. So, for example, in ABMU health board, I have increased the commission around pre-registration nursing, because actually, the work I had done identified there were some gaps around the principles. Therefore, in order to fulfil that, we need to actually plan that in a

workforce perspective. I think it's really important that members of the committee are aware that the triangulation around workforce is crucial. It is not about a number; it's actually about safe staffing and safe services, rather than minimum staffing. I think it's really, really important that, actually, you know, that is understood. From my own experience of actually looking at triangulation over the years and professional judgment, it's pivotal that that bit of it actually is right. But, certainly, some boards have seen investment on the back of the CNO standards. There will be still some further investment because some of the arenas haven't met that, and I'm speaking from a board perspective at the moment, where I work, and that's part of investment in going forward.

[95] **Ms Walker:** So, you ask the question: why aren't we able to do that now? So, there is the complexity point that we've just made but also the availability of staff. We took a straw poll of what the current position was on nursing vacancies in our NHS organisations across Wales over the last month and a half. We found that there were 700 to 800 nursing vacancies. We heard Tina speak, and she's absolutely right in relation to the question: do the workforce plans fit the requirements now? So, it's about understanding what staff we have available to fill those gaps and to ensure that our vacancies are filled.

[96] Tina also mentioned that, sometimes, we hold vacancies. We have an organisational arrangement that is agreed across Wales that, if you are moving staff around because of service redesign, you have to hold vacancies in order that you can move staff into those gaps. So, those gaps have to be filled by using temporary staff whilst that reorganisation takes place, and it's a very fine balance, hour by hour, to ensure that, on the professional judgment of our staff at the front line who are telling us that, actually, the acuity of these patients is growing, we have a flexible enough workforce that we can move around to meet that, but also that we have an available workforce. So, two years ago in Cardiff we did a lot of work around how we make sure that our establishments are set and filled so that the vacancies are filled. When the vacancies were filled, we did see a decrease in bank and agency utilisation and the cost of that. So we do know that, actually, when we are able to fill all the vacancies, we do not use as many temporary staff, but we still use them, and that's appropriate in managing the resource effectively.

[97] **David Rees:** I've got Alun, who wants to come in on a supplementary on this, and then we'll move on.

[98] **Alun Davies:** Thank you for that. I have to say to you that I don't really buy the argument about complexity. Nothing you've said is novel or new or unknown. Nothing you've said is unique to the NHS. In managing any large organisation, you'd have the levels of complexity that you're describing there, and I thought the whole point of having senior managers in position was to deal with that.

[99] **Ms Walker:** I think patient care is unique. Every one of us in this room—

[100] **Alun Davies:** Sorry, you didn't describe patient care. What you described was the complexity of managing rotas—and, frankly, if there are managers in the NHS unable to do that, that's a significant question in itself—and the complexity of having a mix of different skills available. Now, that is not novel.

[101] **Ms Walker:** So, managing rotas and managing acuity come hand in hand, but in order to manage a rota in relation to direct patient care you have to manage the acuity and take into consideration the professional judgment of the nursing staff. Now, we could all be patients on a ward today and our acuity would be very different. We could be patients on the same ward the next day and the acuity will be different. So, actually, it isn't the inability to manage rosters. My sisters and charge nurses are very good at that. It is the ability to manage the acuity of the patient at that time to ensure we have the right staff there. So, yes, there is

some predictability around that. If you've got a surgical ward and you know that five of your patients are going to theatre that afternoon you will know that you require this many nurses. But, actually, if you then admit another five patients who are as acutely ill as the five who are going to theatre, the acuity will change, and you need flexibility to be able to do that.

[102] **Mr Farrelly:** I think the other thing is that, as a board nurse director, we've an accountability around nursing, midwifery and health visiting and the landscape of services around health and social care is changing. So, it is becoming complex in relation to how some of those pathways are, and planning a workforce for a health and social care service for the future is more complex now than it was. And that's not about saying that people are not doing their job—we absolutely are doing our job—but the reality is that that landscape is changing. I have an accountability around workforce—nursing, midwifery and health visiting for the whole board—so I need to take the accountability of that to the board as nurse director, which I do and which the other nurse directors do. Actually, we have to do that in the changing landscape of services, which is right because, obviously, by shifting the balance of care we are going to see more care in the community. Actually, that is really important. I think that that's the complexity in the system as well. So, I wouldn't like committee members to think that, actually, managers or us are not doing our jobs. We are very clear about our jobs; we are very clear about our accountability, but that is the complexity in there.

[103] **Alun Davies:** Which is what you're paid to manage.

[104] **Mr Farrelly:** Yes, absolutely.

[105] **David Rees:** I will move on, because we're here to look at the Bill and not necessarily the roles of the directors of nursing. Elin.

[106] **Elin Jones:** I wanted to continue on the theme of flexibility and to ask you, why do you see that this Bill doesn't allow flexibility to judge on a shift-by-shift basis, on the acuity issues that you've described that can change and be dynamic? Because, from my understanding of the Bill, what it will require you to do is to assess, as you do now, the safe staffing level on a ward, but be transparent about that, and where you're not able to meet it, it will have to be recorded. It may be for a variety of reasons that you've been unable to meet it. I can't see that this Bill, as it's now outlined or drafted, in any way allows you not to be flexible. It just means that you have to be transparent. Can I just ask one further question, which is slightly different?

[107] **David Rees:** I will let you come back in; honestly.

[108] **Elin Jones:** Right. Okay.

[109] **Ms Walker:** To answer your first question, I don't think we are saying that the legislation won't allow us to do that. I think we're delighted to have the opportunity to engage with you to help understand the complexities of what we deal with hour by hour, day by day, so that we can have—if legislation is the way forward—a Bill that allows us to do that. What we don't want is a very valuable resource of nurses having to fill in lots of documentation that takes them away from caring for patients. So, we would need to have an infrastructure that will allow sisters and charge nurses, or the nurse in charge of the ward, to be able to state what's in their head and they're articulating to their senior nurses into a record so that we can be transparent. We do report, as Tina has alluded to, incident reports when the staff feel that staffing could be improved, and we do look at those, but we don't all report them to boards. So, there are ways in which we can do that. Maybe, across Wales, we could collectively agree how we would do that, so that we can be transparent, but at the same understand, if we don't feel that the staffing's right, what the consequences are to our patients, because that's the key.

[110] **Elin Jones:** Yes. Okay. That's useful. Could I ask a question about the consequences of having a legislative requirement, as you would have as nurse directors, to meet safe staffing ratios on acute wards, and any concerns that you have as to the consequences that that could have in other nursing scenarios that you're also responsible for—community nursing, community hospitals, district nursing? Do you think that there could be, despite all your best efforts, a draw into acute wards of nurses, given that there's a shortage of nurses, which you've outlined, from the community, and whether the fact that we're just legislating for one aspect of nursing could have that unintended consequence?

[111] **Ms Walker:** As nurse directors, we would want, and we would work really hard, to make sure that it was right and safe across the board. But I think your point is extremely well made. I think if we are legislating in one area only, that would be potentially the board's focus. Particularly if we're moving to community and increasing primary care, actually, maybe that's where we should be focusing. We don't have a tool yet. We're working collectively across Wales and testing tools to try and find a tool that helps us understand what the resource is that we require for district nursing services. But, we would say, irrespective of where our patients are, they should be having safe nursing care. So, we have to try to get the staffing levels right across the board. Of course, we are professionally accountable for that. Therefore, that's what we do.

[112] **Mr Farrelly:** The other thing is that the Bill talks about professional judgment, and at the end of the day, nurse directors will have to make a professional judgment on staffing right across the board. Where there will be tools, you can use the tools to help inform professional judgment, but you need to take that triangulated approach, linked again with clinical policy outcome measures, and actually see the picture and the totality of it together, presenting that picture to the board in relation to staffing right across the arena. So, the Bill does talk about that triangulation and professional judgment in there, which will cover that, because at the end of the day, it's really important that, actually, as nurse directors, we're able to make a professional judgment about the staffing that is required in areas where there may not be a tool.

10:15

[113] Because, let's be clear: in 1948, there weren't any tools. You know, matrons, and over the years, directors of nursing, made professional judgments based upon experience and based upon clinical quality outcomes. The challenge here is there aren't any stand-alone nurse-sensitive indicators, because actually the quality indicators are about a team approach. It won't just be a nurse who will actually contribute to certain things, it'll be how the team work together to deliver that. Actually, the clinical quality indicators are crucial from a team perspective.

[114] **Ms Walker:** And, of course, professional judgment is made based on how ill the patient is, or how complex their needs are, but it's also based on, 'How many doctor ward rounds am I having today; how junior are the rest of the team that I'm working with; how many students require supervision in this clinical area today?' So, all of those things have to be taken into consideration for professional judgment. It's quite complex.

[115] **Elin Jones:** And those issues are in the—. Many of those are covered in the Bill.

[116] **Ms Walker:** Yes.

[117] **David Rees:** Darren.

[118] **Darren Millar:** Thank you. Can you tell me what the staff ratios are on your wards at the moment?

[119] **Ms Walker:** I can, actually. I can tell you that, in relation to the ratios in the medical and surgical wards, three quarters of the wards in medicine are getting there. Actually, the ratio is right by day, but it's not by night; and, with surgery, that is a greater number. So, we will be providing further information to you, David, across Wales, as part of where we are.

[120] **David Rees:** Just to let Darren know, we have written to the health boards for an up-to-date set of figures.

[121] **Ms Walker:** There is a difference between how many people are on duty and the number of people, and the allocation of money and establishment that we have given. So, our greatest challenge, in ensuring that we have the right number of staff available on the day, relates to the availability of the staff. So, for example, we've had a very successful two-weekend recruitment campaign, and we've got another one coming on Saturday, where we've been able to recruit over 70 nurses into Cardiff and Vale. This is an ongoing challenge for us, and we do know that some of the arrangements around recruitment across Wales have brought us some challenges with being able to recruit nurses. But also, we know that the number of students qualifying will not meet our current demand. So, with winter pressures being very high, we have more capacity open; more capacity open means that we have to have more nurses available to care for those patients.

[122] **Darren Millar:** And how about you, Mr Farrelly?

[123] **Mr Farrelly:** Fifteen wards in ABMU health board don't meet the CNO standard. When I came into post, it was a lot more.

[124] **Darren Millar:** Fifteen out of how many?

[125] **Mr Farrelly:** Fifteen out of 115, across mental health and, obviously, secondary care. I've obviously taken a paper to our executive team, identifying that gap, which is part of the intermediate-term planning for investment of the £1.7 million. As a board, we're also sitting on 140 vacancies for registered nurses. So, there's a plan in place about how we close that gap, but obviously some of that is about increasing the commissioning numbers, which I've done, but that might take three years to have an effect, so we need to look at a plan to close that gap.

[126] **David Rees:** Can you clarify when you say 'sitting on'?

[127] **Mr Farrelly:** Sorry: 'vacant'. We're not holding any vacancies, so thank you, Chair, that's important. I have clearly instructed our board to recruit to all vacancies, so we're not holding any. The reality is there are not enough nurses in Wales, folks. The commissioning numbers obviously have been increased, which will obviously have an impact three years down the line. So, we need to be looking at plans about how we close that gap between now and then.

[128] **Darren Millar:** So, what you're suggesting is that we've had a failure in our workforce planning, which has given rise to these gaps and is contributing to the pressures—yes?

[129] **Mr Farrelly:** I can only speak for the fact in relation to—. I came into post in June, and I increased the commissioning numbers based upon the piece of work I had done. I think, also, we know a lot more about it, because, obviously, of the CNO principles and the tools that have been developed, and the workforce that is required from that. So, I can speak in that context, and I know other nurse directors will have done the same.

[130] **Darren Millar:** You were nodding.

[131] **Ms Walker:** I was nodding. I think we need to understand that it takes three years to train a nurse, as you are all very aware of, and a lot longer to get the nurse to the skill level that we require of them in certain areas. So, what we need to understand is, at the time, three years ago, when we were workforce planning, we were workforce planning for the models that we then had and the number of staff that we felt we required. I think there is a difference regarding what we now require. We were having conversations about having fewer wards open three years ago than the ones we have now.

[132] **Darren Millar:** And in terms of your accountability arrangements, you've both mentioned that you're the accountable people in your boards for the delivery of the nurse staffing ratio that's recommended by the CNO. Who is holding you accountable for that? You say that you're reporting to the board and you've done a paper for the board. Do they request papers on a monthly basis? Do they request your attendance? Do they ask how—. Do they hold your feet to the fire, as it were, at those board meetings? Who's holding your feet to the fire?

[133] **Mr Farrelly:** I think it's clear both the through the public board meetings and also our public quality and safety meetings that our non-officers actually are holding us to account as executive directors and an executive team, because this will also be a team approach with nurse, doctor and manager because it's about how a team works, and undoubtedly how to account around the elements of what my role is in relation to that. So, I think we are held to account in relation to those levels.

[134] **Darren Millar:** So, you are challenged by your boards to deliver against the CNO recommended staffing levels, and we'll see evidence of that in the board papers.

[135] **Mr Farrelly:** Quality and safety you will, yes; that'll be in some of the board papers.

[136] **Ms Walker:** The quality and safety committee is where we discuss staffing levels. Also, 'people performance and delivery committee' is the title of our committee in Cardiff and the Vale. I'm held accountable professionally for the number of staff available to provide safe care. My workforce director is accountable for ensuring that we have the right workforce available. Our board is responsible for safe care. So, actually, this is a board responsibility, so we ask lots of questions to ensure that we are delivering safe care to our patients.

[137] So, do we have a way across Wales where we all report in the same way, the same information that can be scrutinised by our boards and by our public? No, we don't. And is that something we should be thinking of? I think as nurse directors we would agree. But we would also say it's not just about nurses and midwives, because the workforce and the way in which teams work is actually vital to the quality and the safety of the care that we provide for patients, and particularly for nursing, because we are seeing more and more nurses expanding their role, and they work in advanced practice, so, actually, they are taking on duties that we would have seen junior doctors do in the past. So, we are seeing the model of care changing and the approach to care. So, it's understanding what is the resource required for the new way of working, or the model of care being provided, and is the entire workforce—the workforce required around the patient needs—there to deliver safe care. They're the conversations that we should be having at board.

[138] **Darren Millar:** And in terms of accountability to the Welsh Government, obviously, the chief nursing officer issues these ratios, but there's not much point in doing that unless there's some firm accountability line to the chief nursing officer for the delivery against them. So, how regularly would the chief nursing officer be contacting your board and contacting you individually to ask about your compliance with these recommended staffing levels?

[139] **Ms Walker:** We have been asked by the CNO on a regular basis to provide updates of where we are, and to explain, if we're non-compliant, our rationale for non-compliance.

[140] **Darren Millar:** And is that, again, consistent? Is there a rhythm to the contact from the Welsh Government?

[141] **Ms Walker:** There is. We work with the Welsh Government also to design and develop the tools that we require in order to inform that. And we as individual nurse directors have regular meetings with the CNO to talk about the issues that are specific to us as a health board. It is not part of our performance management arrangements currently.

[142] **Darren Millar:** Right, and I think therein possibly lies the problem. You're aware that reference has been made to nurse staffing ratios being better elsewhere in the UK. What's different about the accountability arrangements? Is there some learning we can bring to Wales from Scotland, from England or from elsewhere?

[143] **Mr Farrelly:** I spent 10 years in Scotland, and that 10 years was 10 years of also developing workload workforce tools for secondary care, primary care, mental health, midwifery, paediatrics. Obviously, 10 years will tell you that a lot of work went in to actually developing those tools on a triangulated approach, because it's not just about actually numbers—it's about the triangulated outcomes and, obviously, skill mix. One of the things that happened once those tools had been developed—and they'd been done in partnership; there was a lot of piloting done across NHS Scotland—was that they were mandated to be implemented. So, the director general wrote to all of the chief executives to say, 'These tools are mandated and need to be actually implemented and reported at least six monthly to the board meetings'.

[144] Obviously, at the time, certainly I was at the middle of a number of the workload workforce tools in Scotland, because it's about workload and workforce. So, the workload, obviously, sometimes identifies—. We may have nurses doing tasks that you don't need to be a nurse to do. You might require a support worker or you might require an admin person and, actually, you know, it's pivotal that workload tools look at workload and not just the number. They were mandated for implementation across NHS Scotland and through that mandated approach, we saw agency significantly reduce, but at the same time, we had commissioned our numbers to actually go up, so certainly the build-up and lead-up to it saw us actually increase our commissioning numbers and pre-registration programme, and we saw agency nearly being eradicated, particularly within secondary care.

[145] **Darren Millar:** Just a final, follow-up question, then; in that case, would you like to see mandated arrangements in Wales, rather than a legislative approach, because you can mandate without the need for this legislation?

[146] **Ms Walker:** As nurse directors, we would like to see safe staffing levels everywhere, across all of our services. Whatever tools are required to help us to get that, to do the right thing for our patients, is what we would require.

[147] **David Rees:** That's a very good political answer. We now have follow-ups on that. Alun, Peter and Lynne, following up on that.

[148] **Alun Davies:** I just wanted to go back to something Mr Farrelly mentioned, just for my own clarification. You said that you had 140 vacancies at present. Can I just clarify that they are live vacancies that you are seeking to fill?

[149] **Mr Farrelly:** They are indeed, yes.

[150] **Alun Davies:** They're not vacancies from an establishment that you are keeping vacant in order to save funds.

[151] **Mr Farrelly:** No, absolutely not.

[152] **Alun Davies:** So, you are out recruiting at the moment.

[153] **Mr Farrelly:** We're out recruiting at the moment.

[154] **Alun Davies:** And, are you having difficulty recruiting?

[155] **Mr Farrelly:** We are indeed. There is a cohort coming out of the university in January of 80-plus, which will take up a chunk of that, but will still leave us with 60 vacancies. And we've put out an advertisement UK-wide and also in the Republic of Ireland.

[156] **David Rees:** Okay. Peter.

[157] **Peter Black:** Just following on from that, I may have misunderstood, but when the RCN gave evidence before, they said there were more registered nurses than are currently in post in LHBs, and that if a safe staffing level was mandated through legislation, a lot more nurses might want to come back to working on the wards because it would be a different environment to the one they may have left. Is that something you recognise or is that something that might help?

[158] **Mr Farrelly:** It may do. One of the things we're obviously doing, certainly across NHS Scotland, is we've put out a number of ads to do return-to-practice, so nurses who have actually decided to either, you know, go and deal with family life—. Actually we have put out advertisements around actually doing return-to-practice courses. I have to say our experience in Abertawe Bro Morgannwg University Local Health Board is that we've only had 13 nurses come forward around that, but it could quite well be that we might see, if the staffing level for that changes—. But based upon what I've seen so far, only 13 have come forward.

[159] **Peter Black:** Is that possibly because of the issues around ABMU that might be putting people off?

[160] **Mr Farrelly:** Undoubtedly, that may have an impact. I don't know. However, I'm very clear, when you look at some of the real stuff around patient experience in our health board, it has improved. So, there's something about how actually we pick that up with people who want to come and work with us.

[161] **Peter Black:** I'm talking about perceptions rather than—. I know things have improved.

[162] **Ms Walker:** Certainly, when I walk my wards and talk to my staff, they do correlate the higher pressure areas where the acuity is higher and the staffing is not as it should be, that actually they're not areas where people want to stay. I would agree with Rory: in the last three years, we have trained 25 return-to-practice nurses, which Cardiff University—which covers both Aneurin Bevan Local Health Board and Cardiff and Vale University Local Health Board. We've recruited only 10 of those return-to-practice. So, they're small numbers, albeit very valuable, and often they're people who've had a lot of experience prior to them taking a gap in service. But, we would need to see a significant increase in numbers because, as I said earlier, if the picture across Wales is 700 to 800 vacancies, that's an awful lot of nurses that we would be short, and if we're then saying that actually we would see an increase in staffing if it was legislative, then actually that would mean more nurses, and three years to train nurses

means we have a big gap between now and when the legislation could potentially come in.

[163] **Darren Millar:** Can I ask a direct question on nurse recruitment issues?

[164] **David Rees:** I've got Lynne coming in first; I'll come back to you, Darren.

[165] **Darren Millar:** It's just as a point of information, which I'm sure will be useful to all committee members. I've just looked on your website, Mr Farrelly, and there are only 19 nursing and midwifery jobs actually advertised. Why is that?

10:30

[166] **Mr Farrelly:** Nineteen nursing and midwifery jobs?

[167] **Darren Millar:** Nineteen. I've just gone on to the health board website and there are 19 nursing jobs. You're telling us that you are trying to recruit far more than that.

[168] **Mr Farrelly:** Yes, because the advertisement for the Republic of Ireland closed, actually, in early January, and the UK one went out in the RCN bulletin and that closed in December.

[169] **Darren Millar:** Why aren't they on your website?

[170] **Mr Farrelly:** They were on the website, but the date has closed.

[171] **Darren Millar:** But why?

[172] **David Rees:** The closing date has gone.

[173] **Mr Farrelly:** Yes. The closing date for applications. So, what we will do is we will resurrect another advertisement in relation to actually—.

[174] **David Rees:** That's right. So, at the moment you are processing the applications you've received.

[175] **Mr Farrelly:** Yes.

[176] **Darren Millar:** So, when was the closing date?

[177] **Mr Farrelly:** The closing date for the—. It was December; I can come back to the committee with the exact date.

[178] **Darren Millar:** You say you had 13 applications. So, you clearly weren't going to fill them, and yet you've only got 19 posts advertised.

[179] **David Rees:** He didn't say that he had 13 applications.

[180] **Darren Millar:** I thought you did say you had 13.

[181] **Mr Farrelly:** No, I never said that.

[182] **Darren Millar:** Sorry, I apologise. How many applications have you had then?

[183] **Mr Farrelly:** How many applications—? I'd have to go back and check. Okay?

[184] **Darren Millar:** Okay.

[185] **David Rees:** But I think the point has been made clear—

[186] **Mr Farrelly:** Certainly from the university, we had 80 applications, but I would need to check on top of that. Okay?

[187] **Darren Millar:** Okay.

[188] **David Rees:** Perhaps it is one of those problems of technology in our committee rooms; you actually can get instant information, sometimes.

[189] **Darren Millar:** Instant information—it is eye-opening, isn't it?

[190] **David Rees:** It is an important challenge. Lynne.

[191] **Lynne Neagle:** I just want to go back to what Ruth said about the process with the chief nursing officer holding you to account. You said that you have to justify yourself to the CNO when you're not complying with the guidance. Can you just tell us a bit more about that, and maybe give us some examples of where you haven't been able to comply with the guidance? I'm also interested in what level of challenge there is from the CNO. So, is it just a question of her saying, 'Well, oh, okay. Well, you know, that's a pity', or does she say, 'No, I'm not happy with a, b, c, d and e here and can you go back and look at it again?'

[192] **Ms Walker:** Well, we would write to the CNO in response to a formal request, so, 'What is your current position?' What we're also feeding in, however, is the work that we have been doing on the acuity tools. So, I have been leading on an all-Wales basis the implementation of the acuity tool for Wales for medical and surgical wards, which is based on the principles. The acuity tool was piloted earlier last year and we tested it for the first time in June and July. We found that we had lots of information, but actually it was not very helpful in telling us what was happening on the ground and really interpreting it was very difficult. We're repeating that exercise now this month in January. When we provide information to the CNO, we try to be very clear about what it is she is asking us for. So, are we saying, 'Have we got an establishment allocated?', so, 'Is the board committed to delivering the principles?' So, does the sister and charge nurse know that this is what you require to run your ward based on CNO standards? Is the money allocated to that and will that deliver the level of activity? That is different to, 'How many people have you got on shift day after day?' So, we are having conversations to say, 'We have the commitment; the challenge is about how we get the staff there'. So, we have conversations with the CNO about: how are we going to improve recruitment? How are we going to get workforces that are fit for purpose, so we actually have enough nurses to fill these gaps? Why have we got a sickness rate? Yes, is this about stress? So, if it is about stress, what are we doing to support our staff? Is it about a policy that actually does not encourage staff to come to work? Or is it about the fact that we have got higher infection prevention control and staff can't come to work because they've got diarrhoea and vomiting, and we wouldn't want them to come to work? So, it is about understanding what the reasons are, and actually starting to action those reasons. So, we've spent a considerable amount of time at nurse directors' meetings with the CNO looking at why the new approach to shared services hasn't quite delivered in the way that we would our recruitment policies. We've found that there have been some delays in the way in which we recruit and we're trying to do a lot of work around how we improve that. I just gave some examples about the weekend recruitment approach that we have taken in Cardiff and I know that colleagues have taken a similar approach elsewhere.

[193] **Lynne Neagle:** So, are you saying that the CNO doesn't monitor the detail then of your compliance with these acuity tools? It is more a broad-brush approach that she takes.

[194] **Ms Walker:** Yes. We don't have a conversation about ward C7, and why that is not complying with the rules, when A6 is. We don't have that level of discussion, not currently, no.

[195] **Lynne Neagle:** Okay. Thank you.

[196] **David Rees:** Can I take this, before I call John in, a little bit further? You indicated that your boards are actually supportive of trying to meet the CNO guidance figures.

[197] **Ms Walker:** Cardiff and Vale University Local Health Board are and, on my understanding, so are others.

[198] **David Rees:** I am sure that other boards are, in a sense, and you are having difficulty recruiting to those levels.

[199] **Ms Walker:** Yes.

[200] **David Rees:** If the Bill comes in, which has a sort of mandatory duty upon you to actually meet certain levels, and you say there aren't enough nurses out there, is there going to be a problem in actually delivering and meeting those levels because of a recruitment issue, a workforce availability issue?

[201] **Ms Walker:** Yes.

[202] **David Rees:** And, as a consequence of that, is there a likelihood there'd be a problem with other areas within the board, because they will be forced to meet a legal requirement in the acute in-patient wards?

[203] **Ms Walker:** If we had legislation today, we know that we would not be able to fulfil the requirements of the legislation. We, as nurse directors, would be concerned that we would then be expected, potentially, to be pulling staff from elsewhere to meet the legislation in one area. It would not be something that we, as nurse directors, would be comfortable with. We would not be prepared to compromise patient care elsewhere.

[204] **Mr Farrelly:** I suppose one of the things that would need to happen is that we would need to work up exactly the impact of this Bill and start planning that into actual workforce planning. In reality, that would be the important part of actually trying to understand what the impact would be in two or three years' time around that, and I think that's pivotal. Some of that work's already started because of the CNO principles. So, if you look at the commissioning numbers for pre-registration nursing, that has increased this year across NHS Wales, and that's on the back of the CNO principles. So, all of that work is preparation work if this was also to become legislation.

[205] **David Rees:** So, the commencement date of the Bill, if it was legislation, would actually be a very important aspect.

[206] **Mr Farrelly:** Absolutely.

[207] **Ms Walker:** We also need to, even if we increase the numbers of student places—. I currently have, in Cardiff and the Vale, 917 students training with me at different stages of their three-year training. They are allocated to work in these clinical areas. So, actually, we would need to think very carefully about how we could increase that without putting extra pressure on the staff that are already there, when we don't quite have the staffing as we would wish it to be.

[208] **David Rees:** John.

[209] **John Griffiths:** We're always concerned with unintended consequences when thinking about the value of proposed legislation. It strikes me it's very much a team effort in terms of delivering healthcare in our hospitals and on our acute wards. I know that you've expressed concerns in your evidence regarding the potential effect on other health professionals, such as physios and OTs, for example. But you mentioned, Rory, that there is also a support team that does very valuable work that sits underneath, in a way, what our nurses do on those acute wards. I wonder if you could tell us a little bit more about the concerns that you might have in terms of the effect of this legislation, were it to result in a diversion of resource towards nursing ratio staffing levels to the detriment of the support team, which might actually result, for example, in nurses carrying out tasks, to a greater extent than they currently do, that are not really tasks for qualified nurses.

[210] **Mr Farrelly:** I think, as I said earlier on, it's really important that, when we look at the workload workforce tools, we look at the overall workload and be clear what tasks, within any of the tools, don't need to be done by a registered nurse and may be done by a healthcare support worker, or may need to be done by a pharmacist. And, actually, that tool should be pulled together in the overall workforce planning for the health board. I think there is an opportunity to look at the workforce planning in its totality, and, actually, this Bill would not see that you would just look at it in isolation, you would see it in its totality, and be clear that this is the number of nurses you require, because, actually, that is what's needed in these arenas, and these are the number of porters or admin staff or whatever. It would be important that, as boards, we integrate all of the workforce plans around that. I think that then would not see anybody being disadvantaged through it. But that is making sure that, actually, all of those plans are pulled together and each of the relevant directors, at board level, actually pull that together.

[211] **John Griffiths:** Is there then, do you think, a danger that this legislation, were it passed, could actually make it more difficult or less likely that that total picture would be the driving force for staffing levels in the acute wards?

[212] **Mr Farrelly:** Again, I would be clear in my responsibilities board wide, and I would say what I said earlier on that, actually, as nurse directors, we have an accountability around primary care, secondary care, mental health and children's services, and, actually, we have to make that judgment right across the board. Undoubtedly, we would have to be very clear to the board about, actually, our responsibilities around that, and the board then collectively make those decisions to move forward.

[213] **Ms Walker:** I think we also need to think about what staffing is required around the needs of the patient. If you were to take a stroke ward as an example, yes, of course, nursing staff would be the fundamental 24-hour caregivers within that environment, but actually work very closely with other professionals, such as physios and OTs; you cannot deliver the service without that. So, having them as part of the core service, and having healthcare support workers that cover the breadth of the OT, physio and nursing skills, would actually bring something different to that environment. So, we have got to really start to think about what the needs of the patient are and who are the best skilled, qualified and competent people to provide that care for the patient, which is a different way of thinking to when we do it in individual professional groups. However, it is the nurses that are there—and the midwives—24/7.

[214] **David Rees:** Can I ask a question? Obviously, you've talked about the skill mix now. I think that that's a critical aspect, and the Bill does include also the ratio of registered nurses to support staff as well. Does this Bill strengthen your position as directors of nursing to

actually ensure that the levels of nursing are at the appropriate levels, and that the mix is at the appropriate levels, or because of the consequential sort of aspects of the areas and the wards that are not included—the areas of care that are not included—does it actually make it far more difficult to actually deliver across the wider range of services that you provide?

[215] **Ms Walker:** I think, when you've got legislation or things like tier 1 priorities or mandatory ways in which we report things, it shines a light and gives more attention to that. So, as nurse directors, being asked to bring to the board specific information in the level of detail that we're talking about is always helpful.

[216] **David Rees:** Okay. In this sense, can I ask about the compliance and monitoring aspects? We talk an awful lot about the actual purpose of the Bill, but section 3, if I remember rightly, is actually looking at the compliance of the aspects and the monitoring. Do you actually keep a lot of that data as it is now, or is it going to be additional information that you'll be required to develop?

[217] **Mr Farrelly:** I think that one of the things that I would say at the moment is that we have to take the data from a number of sources. So, I think that it would be important that, if this was to become legislation, we would need to think of a very clear IT system that would capture the data all at once. Certainly, when you look at some of the systems—they have implemented this in Australia and parts of the States, and they have got an IT infrastructure behind it. One of the things that I would be very keen—. I hear very clearly from our front-line teams, 'Don't give me any more data burden', so it would be really, really important that we record this information, record it once, and it feeds into a system. So, I think that the clinician would need to understand how that would happen, because I certainly think that we, as nurse directors, would be very keen that we just capture the data once and they are used everywhere and, actually, we don't have to pull them from several different sources. At the moment, if I look at, certainly, my experience at ABMU, I have to pull data from several different sources, and I think that we would need to actually get an IT system—I know that it sounds easier said than done, but an IT system that would actually do this once and would not mean any more data burden for front-line staff, because that would be my anxiety here, that we'd end up generating something that we'd have to report on, and front-line staff would have to do more data stuff. And I'm hearing the clear message from them, 'Absolutely not'. We need to stop some of the data burden that's there already. So, I would make a plea for the committee to, you know, try to understand how that would happen.

[218] **Ms Walker:** I would reinforce that message. We don't want expensive, very skilled staff coming away from caring for patients to fill in something that becomes a burden. We need them to remain at the front line with their patients. Certainly, as nurse directors, we would also feel that there is a great opportunity, if we were to gather those data, to then triangulate them with other things, such as incident reporting, patient complaints, patient satisfaction, because those things are actually what really tells us what it's like to be a patient on the ward, and that's important. Staffing is key to that, but we need to triangulate the other information also because then the board and us as nurse directors have a much better picture of what's happening in that clinical area. Leadership is fundamental to that. So, we have to be sure that our sisters and charge nurses feel empowered that the way in which we are asking them to collect data is going to be useful for them.

[219] **David Rees:** Okay. Do any other Members have questions? If not, could I thank you very much for your attendance this morning? You will receive a copy of the transcript for any factual inaccuracies. So, thank you very much indeed.

[220] **Ms Walker:** Thank you.

[221] **Mr Farrelly:** Cheers. Thank you.

[222] **David Rees:** We will now have a break for 10 minutes. Come back at 10:55. We'll start at 10:55.

*Gohiriwyd y cyfarfod rhwng 10:44 a 10:53.
The meeting adjourned between 10:44 and 10:53.*

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 4 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 4

[223] **David Rees:** Can I welcome Members back to this morning's session and we move on to our third panel this morning? Can I welcome Dr Wheatley and Dr Banfield from the BMA, and can I welcome Dr Dowdle from the Royal College of Physicians? Can I thank you, first of all, for your written evidence, which obviously has given us food for thought? But, we will go straight into questions, if that's okay with yourselves. The first question is from Gwyn Price.

[224] **Gwyn R. Price:** Thank you, Chair. Good morning, everybody. In your opinion, are there unsafe nursing staffing levels in Wales?

[225] **Dr Banfield:** The evidence that we have comes directly from our members and we are getting a lot of feedback that, with the pressures that are on the NHS in Wales at the moment, our members are finding themselves working on wards with acute staffing pressures. We are having it reported that nurses are going off sick with stress in increasing numbers and that greater distress is being caused by this. This has also been reported back from the reports that have been published on the NHS in Wales. So, it's of serious concern to our members, and, yes, they're very keen to support our nursing colleagues in order to get the right number of nurses to provide safe care.

[226] **David Rees:** In that sense, do they believe that the legislation will be a means by which they can actually achieve the right number of nurses on the wards? We are initially talking about only adult acute in-patient wards.

[227] **Dr Banfield:** Well, I think, from their point of view, what they're seeing is inactivity among the health boards in introducing the nursing numbers that have been promised, both through the chief nursing officer's recommendations and from the National Institute for Health and Care Excellence. So, they are struggling with that gap between what should work in theory and what's happening in practice, and, hence, I think, this is why they're hoping to turn to legislation.

[228] **David Rees:** Dr Dowdle, the same.

[229] **Dr Dowdle:** I think you will have heard from the RCN earlier this morning that the guidance is not being universally applied across the piece, and certainly on the wards, we miss the presence of nurses on ward rounds routinely. We work as a team with our nursing colleagues. If we don't have enough nursing colleagues, the team is depleted and we are not as well informed as we might be. So, if you're talking about safety as being an issue of compliance with defined standards, then that isn't happening.

[230] **David Rees:** Okay. Lindsay.

[231] **Lindsay Whittle:** We've heard evidence this morning that if the ward staffing levels are brought up, staff might be brought in from other sort of specialist parts of the NHS and that's not going to do any good at all, really, is it? I'm wondering, if nursing levels are

increased, what impact that would have on other health services, like speech and language therapists, physiotherapists and other medical professions, because you'd have to increase those as well. The idea of having more nurses, clearly, is to get the patient home more quickly, I would've thought, but that's not going to work if we don't have other—

[232] **David Rees:** Dr Wheatley?

[233] **Dr Wheatley:** Well, I think the first thing is that there is quite clear evidence about nursing staffing levels improving patient outcome, and where there's clear evidence, I think that ought to be paid attention to. If there's clear evidence that extra speech therapists or extra pharmacists also improve patient outcomes, then you may need to either amend this Bill or have another Bill. But, at the moment, we're looking at nursing numbers for which there is evidence.

[234] I think the worry about everything being okay in the acute sector, with the depletion of teams in other settings, is very valid. I work in a health board where they've tried really hard to follow the guidelines from the chief nursing officer, but that means that, in my community hospital, we are repeatedly facing insufficient nursing numbers. So, the last time that happened on my ward, a nurse, in the course of a 12-hour shift, on 10 separate occasions, had to walk down the stairs in order to give medication to patients who were dying, and on each of those 10 occasions, the medication was delayed because the nurse wasn't available on the ward. She had to come from another ward, and while she was on the stairs, she wasn't providing care to any patients. So, that is why part of what the BMA evidence suggests is that, as well as supporting the acute sector, you need to put in place provisions that make sure that other areas of healthcare are not depleted and that there are adequate nursing numbers everywhere.

[235] **Lindsay Whittle:** You mentioned yours is a community hospital, so the increase in nursing staff should apply to community hospitals as well.

[236] **Dr Wheatley:** Well, there is less clear evidence about actual numbers for other settings than acute, but I think it's fair to say, you know, that you could put in provisions that worked. So, the thing that we've suggested is that no clinical areas should have fewer than two qualified nurses, and there should be provision for them to take their breaks as necessary. You know, those are the sorts of things that aren't happening in many settings, even those very basic things.

[237] **Lindsay Whittle:** Could I ask a very quick question about nursing at night, because a friend of mine who was recently hospitalised said that the nursing during the day was superb, but at night it was grim?

[238] **Dr Wheatley:** Well, patients are sick and sick people don't always sleep all through the night, whether they are acute or slightly less acute. So, again, if there is evidence that certain levels are needed, and that these levels are different day and night, then that needs to be paid attention to, but, again, it is basic minimums. You know, if you need two nurses, you need two nurses, and they still need to take a break if they're doing a 12-hour shift at night, and then somebody needs to replace them when they're on their break.

11:00

[239] **David Rees:** Dr Dowdle.

[240] **Dr Dowdle:** I think that of the best two aspects of this Bill, one is the minimum level required, but the second is the acuity-related level. If you have a ward where there are many acutely ill people whose acuity is raised, the minimum isn't good enough. You need the

acuity-related level, and I think this is something we have to be clear on. There is a baseline standard below which we should never fall, but there is an appropriate standard, which is the acuity-related standard, and we must pay homage to both.

[241] **David Rees:** I think, to be fair, the Bill focuses on safe levels, taking away the word ‘minimum’, because the concern would be that if we say ‘Nothing below that’, I’ve known in the past that, once you hit a level, that becomes the target level. Darren?

[242] **Darren Millar:** Yes, I just wanted to ask about one possible consequence of this Bill. If a ward is deemed to have unsafe staffing levels, or to prevent unsafe staffing levels, isn’t there a risk that patients will be turned away, not admitted into wards and potentially left at even greater risk outside of the hospital setting, or putting an even greater burden on some of our GP and community workforce?

[243] **Dr Wheatley:** I think there are significant numbers of nurses working for each health board who don’t have regular patient contact, and if the health boards are not prepared or are unable to employ sufficient numbers of nurses who are having patient contact all the time, there is a resource there for them to use. If a member of my team goes off sick, I cancel the meetings and I go and look after the patients, and that can include tasks that very junior doctors would do, but if that’s what the patient needs that’s what the patient gets. That isn’t practice that happens through the nursing profession, and there are large numbers of nurses who aren’t having regular patient contact. So, the decision to close wards is not necessarily the only outcome from legislation.

[244] **Darren Millar:** But, come on, let’s be real. We know there are massive financial pressures in the NHS at the moment, don’t we? Therefore, isn’t it extremely likely that, any excuse a health board gets, they’ll close a ward in order to reduce costs and therefore not admit patients, potentially putting people at risk of harm? Come on, Dr Banfield, you know that’s the case, don’t you?

[245] **David Rees:** Dr Dowdle’s indicated he wants to answer.

[246] **Dr Dowdle:** Well, I’d just say that this depends upon how any legislation is framed. You don’t have to have a knee-jerk reaction: if there’s one nurse short, we shut the bed. You can have a timescale with people coming in from outside to support—. But then you can also try to encourage trusts and health boards to be more proactive. In Salford, Salford Royal Hospital has, outside every ward, a board stating how many patients and how many nurses they have and how many nurses they should have. That’s public knowledge, every shift, every day; it is made available. That kind of pressure, I think, will encourage health boards to implement what we want and not just to say, ‘Oh, we’ll close’.

[247] **Darren Millar:** But that’s been achieved without legislation there, hasn’t it? I mean, they’re doing that just because it’s good practice and it holds people accountable for not meeting the targets. You know, there is no legislation behind the arrangements in England. It’s guidance, and they seem to be better at implementing it for whatever reason.

[248] **Dr Dowdle:** I think it’s an encouragement to meet legislation.

[249] **Darren Millar:** Yes, but there’s no legislation on minimum staffing ratios or safe nurse staffing ratios in England; it’s guidance that is being implemented—

[250] **Dr Dowdle:** Or not.

[251] **Darren Millar:** So, is guidance required? You know, is it just guidance that can achieve this, with some improved mechanisms, or do we really need the legislation that is

before us?

[252] **David Rees:** Dr Wheatley.

[253] **Dr Wheatley:** With Dr Dowdle's example whereby you have a board that says how many nurses you ought to have and how many you have, I don't suppose the hospital guaranteed that those two numbers were always the same—

[254] **Dr Dowdle:** They're not.

[255] **Dr Wheatley:** So, whilst they're displaying publicly their shortcomings, it doesn't mean they're following the guidance, does it?

[256] **Darren Millar:** Well, no, it doesn't, but it shows an attempt to hold themselves accountable, and, you know, it seems from the evidence that we've received so far that there are other parts of the UK that seem to do better in holding themselves accountable and therefore achieving levels in terms of the guidance that has been issued, but Wales doesn't seem to be able to manage that. Can I just go back to this issue of risk, though? So, you cannot foresee beds being closed because there is an unavailability of nurses to be able to staff up to the safe nurse staffing levels that might be agreed and required.

[257] **Dr Banfield:** Well, I think, as Victoria said, the presumption that, if you fall below the safe nursing level, your hospital has to close rather than you having to find appropriate senior people to staff it—. You know, if there's an extra caesarean section to do at 4.00 a.m., I go to do the extra caesarean section. You know, this is really about health boards being under financial pressure and therefore using vacancy controls to close beds. So, we've got a perverse situation where there's an acknowledgement that there aren't enough beds, but we've got five beds in six-bedded wards under the claim that there aren't the nursing staff to staff them. It's been suggested to us that we can't recruit and we're having to go to Spain to recruit nurses when, clearly, the training of nurses is within the gift of the universities of Wales. You know, this is about capacity planning. I'm slightly confused as to why there is a presumption that, if you have nurses in place X, that they are fewer in place Y, when we know that our health service in Wales is wildly over-managed, and a substantial chunk of health service money goes into staff who have nothing to do directly with patient care or helping or supporting the people who do care for those patients. So, I think this is quite a complex area, and I think that you cannot ignore the nurses who are reporting that they feel unsafe, exposed and unsupported, and that their concerns are not taken seriously. They're fed up of filling out Datex forms to say, 'This is unsafe'. Their professional judgment should be listened to.

[258] **David Rees:** Can I ask a question to clarify the position that we are dealing with? You indicated that there are a lot of nurses who are not actually doing patient contact. Is it that they are either doing administrative work or they are doing meetings and—?

[259] **Dr Wheatley:** Well, I'm comparing my experience of the NHS from my previous experience of working in voluntary sector hospices. Whilst they're smaller organisations, each of those will have a director of nursing and the large ones will have a deputy director of nursing. When there is a 'nursing crisis', a shortage, or when somebody calls in sick, if they aren't able to get one of their standard band 5, band 6 or band 7 nurses to come in to cover the shift, often—and it's what's expected—the senior nurse at the hospice will put on a pinny. She'll usually have a uniform hanging on the back of her office door and will come to do the shift and will come to do the drugs rounds. There is no evidence that that happens in the NHS. It's the nurses who have patient contact who are exposed to the risk, and they are responsible, in a moral and professional sense, for the patients in their care, but nobody who is in an office upstairs, who has nursing registration, is, you know, in a position or willing to come down to

do the work. That is in contrast with how, you know, other professions, as you've heard, medical professions function.

[260] **David Rees:** In relation to—you have talked about this before—temporary, agency or bank nursing, is there a likelihood to increase that number in the first instance, if a Bill is introduced, to meet the levels of the statutory obligations? And, as a consequence of the illness we tend to see with nurses, and stress, there is a growing demand for this. Is this Bill going to increase that demand, or is it actually, as some of the research shows, that, once this is established, there is a likelihood that the people will come back because it is a better, easier working environment?

[261] **Dr Dowdle:** I think we have parallels in medicine, whereby we know that, in medicine, the medical registrar's role has changed massively and it's now a very onerous one. Recruitment into that grade has fallen dramatically. There is evidence, as you allude to, that in America and Australia, where they have implemented mandatory nursing levels, the number of returnees to what are now attractive jobs has filled those posts and taken away the need for temporary staff, who are very expensive, unfamiliar with the ward and, perhaps, not the best-placed people to nurse.

[262] **David Rees:** Does the BMA have the same view on that? Okay. Peter.

[263] **Peter Black:** Yes. In terms of the reporting mechanism, you were talking about nurses having a duty to report and that sort of thing; to what extent are they actually listened to? And to what extent does that actually get through to senior management, when a nurse reports that they feel there is something unsafe? Do you think, when this Bill comes in, there will be a need to change those reporting mechanisms to make sure that that will actually work better?

[264] **Dr Banfield:** I mean, this is part of the wider issue about making the whole of the NHS in Wales more open and transparent and responsive to complaints. Do I think that it will make a difference? Sadly, people tend to respond to legislation better than voluntary codes. You've seen it with seat belt law, you've seen it even with things like the tax on bags that's come in to Wales—people are using their own bags now. So, the evidence would suggest that legislating for what are minimum numbers—. These are not terribly onerous numbers; these are the minimum. You know, you can have as many nurses as you think are appropriate for the acuity on the ward. So, I don't see why there should be an argument about this.

[265] **Peter Black:** Do nurses feel at the moment—? I mean, obviously, none of you are nurses, but do you think nurses feel at the moment they are able to raise these concerns, or feel that they are actually being listened to when they raise their concerns?

[266] **Dr Banfield:** Are they able to raise concerns? Yes. Are they being listened to? No.

[267] **Peter Black:** Do you think this will change if there's a statutory provision?

[268] **Dr Banfield:** I think that the ability of the board to not listen will be severely curtailed.

[269] **Peter Black:** Okay.

[270] **David Rees:** In the main, you represent the doctors on the wards, effectively, and, Dr Dowdle, you've already indicated the concern you have over the rounds and the lack of support you have. Are you regularly seeing, at this point in time, difficulties in your colleagues actually undertaking their duties because of the shortage of nurses, which you've seen on the wards?

[271] **Dr Dowdle:** This is such an issue that the college has produced a paper on how to do a ward round, and one of the things specified is that you should have a nurse with you. The fact that you have to specify it is something that wouldn't have happened 20 years ago. It was practice that the nurse came with you on the ward round and was the patient's advocate. They're with the patients all the time and they know what's going on; we are with the patients some of the time. They speak to us on the patient's behalf in language that we understand. I think not having that facility, routinely and as a standard practice, cannot enhance patient safety. It can only devalue it.

[272] **David Rees:** That's right. Dr Wheatley.

[273] **Dr Wheatley:** I mean there are other examples whereby you, you know, ask for a particular investigation or a particular set of observations, or for, you know, transport to be arranged, and the nurses are so busy that you come back the next day and none of that has happened. Therefore, if the test hasn't been arranged, you know, and there's a 24 or 48-hour delay before the test even reaches the lab, then that's a 24 or 48-hour delay before you can make a judgment about what's right for that patient. Because we work as such a close-knit team, you know, if something needs doing, it doesn't mean it needs to be done in the next five minutes but it might well be appropriate to do it in the next four hours, rather than the next 24 hours, which is what happens repeatedly and frequently.

[274] **David Rees:** Okay. As I said in previous sessions, we tend to focus very much upon the actual particular role of safe levels, but the Bill actually also talks about the monitoring and compliance aspects. Are you able to identify whether the aspects in the Bill in that area actually are appropriate to be considering whether safe levels are being achieved or not? Are they appropriate for reporting back on safe levels of nursing, for example readmission rates? We're all here aware of the mortality rates, but are the others appropriate for this particular Bill, or are there some that are very difficult and complex to actually associate with any particular aspect of a patient's care?

[275] **Dr Banfield:** It's difficult because IT information about what is going on in the NHS in Wales is generally poor in relation to supporting activity on wards. Certainly, in maternity care, there are acuity tools used all the time. We would not advocate anything that becomes overly complex. We're trying to get carers caring rather than filling out forms all the time. A starting point would be to have the notifications of unsafe levels being taken seriously and acted on. It wouldn't necessarily take any vast monitoring process to do that.

[276] **David Rees:** Can I ask a question—? Dr Dowdle.

[277] **Dr Dowdle:** Just to come back to the Salford analogy, if they can display, for every shift, their status on every ward in the hospital, then that's achievable. It has been achieved and, therefore, it is achievable now. So, the basic data are there. Whether they are as robust and as detailed as the Bill requires, that's—[*Inaudible.*] But, I'm sure our nursing colleagues have spoken on that.

[278] **David Rees:** I suppose I'd also come back to the definition of safe and unsafe. We're not using the minimum levels because, clearly, it's important to be safe, and I've heard very often what is unsafe. Do you have any indication as to what is unsafe and are we operating unsafely today?

11:15

[279] **Dr Banfield:** I think that that's where the professionalism aspect comes in, both from a medical point of view and a nursing or midwifery or any other professional point of view. It

is—. The way that the health service has improved is the joint team working between doctors, nurses and allied professionals. And they are very much now in a position where we talk as a team and it's quite easy to find sometimes a consensus that we are unsafe. I do this regularly, managing a labour ward, for example. You can just have the wrong number of very sick women coming in for a particular time even though you've got beds, and you make a decision to say, 'Actually, our labour ward must close because we are unsafe'. That kind of professional review can be escalated and taken across other specialties and other situations.

[280] What tends to happen is that, when those concerns are escalated, at the moment the response is, 'Well, we don't have anyone that can help you', and we need to fundamentally shift that response to being, 'We will find a way of making this safe for you again'.

[281] **David Rees:** And just out of curiosity, again, obviously, that's the nursing side of the aspects. How often do your colleagues and members actually raise those issues alongside the nursing to indicate that the words they work on need to be addressed? Do you have feedback from that side of it?

[282] **Dr Wheatley:** I mean, I think nursing colleagues clearly can fill out the relevant forms and Datex, and stuff, but they often come to medical colleagues—the consultants, in particular—and say 'Look, I'm not getting anywhere with this; can you help?' Because certainly, traditionally, the consultant voice was supposed to carry more weight—I'm not clear that it does any more—but at least then the consultant colleagues and the medical team will then be raising the same concerns and, you know, the noise about it gets louder. So, yes, members have been asked to raise concerns on behalf of their nursing colleagues.

[283] **David Rees:** Okay. Dr Dowdle.

[284] **Dr Dowdle:** I suspect there's substantial under-reporting, because the very time when you're supposed to be filling the form in is the time when you're hard-pressed to deliver patient care. Which is your priority: the patient or the form?

[285] **David Rees:** Okay. Do any other Members have questions?

[286] **Janet Finch-Saunders:** Can I just ask, this Bill, as it's currently drafted, is it going to deliver the policy objectives that we're looking for?

[287] **Dr Banfield:** I think the technical problem is that, without the Bill, there is no evidence that the policy objectives will be delivered.

[288] **Darren Millar:** Well, there is though, isn't there? It's happening in England.

[289] **Dr Banfield:** But it's not happening in Wales, and I think that's where the gap has come.

[290] **Darren Millar:** Okay.

[291] **David Rees:** Okay.

[292] **Janet Finch-Saunders:** I wouldn't mind the opinion of all three, if that is okay.

[293] **Dr Dowdle:** I think it would be good for Wales to lead on this. I mean, we have identified a problem, we've faced up to it, I think, with open eyes and open minds. I think that, if we were the first nation within the UK to take this forward on a formal basis, that would put us ahead of the game, not behind it. I think the evidence that it is robustly in place in England is not great. I think they have problems with it as we had—after all, mid Staffs

was in England.

[294] **Darren Millar:** [*Inaudible.*]

[295] **David Rees:** Before we talk about—, I want to make sure that we talk about a lead on this. The question is that we want to lead if it's appropriate; that's the question, I think: is it appropriate?

[296] **Dr Wheatley:** Well, I mean, you're talking about should we legislate or not—

[297] **David Rees:** Yes.

[298] **Dr Wheatley:** But we don't have anything on the table about what the 'not' would look like apart from where we are now, which isn't working. So, if it's a choice of where we are now and legislation, then yes, you know, we should legislate. If you can come up with some system that isn't where we are now and isn't legislation but that will work, then, you know, that's a different kettle of fish, but there's nothing on the table. I know since the NICE guidance, I have certainly found I have had more confidence and my colleagues have had more confidence in saying, 'We are not meeting the NICE guidance'. You know, whilst I appreciate that the NICE guidance doesn't actually, you know, necessarily apply to Wales, it would be really hard to defend if there was a fall on the ward and somebody broke their hip and we weren't meeting the NICE guidance. So, that has helped a bit, but legislation would, you know, give everyone more confidence and would support clinicians when they want to say, 'Look, this is unsafe', or, 'This is wrong'. They would then have that extra confidence and that extra backing, and it would be harder for the board to ignore what was being said.

[299] **Janet Finch-Saunders:** Okay; and I'm pretty keen, when we are passing legislation, that it does address as many of the fundamental issues as possible. Are there ways in which this Bill could be strengthened?

[300] **Dr Wheatley:** I think there are quite a lot of recommendations in what the BMA have said, making sure that there are provisions for non-acute wards, you know, to make sure that you're not robbing Peter to pay Paul. We need the detail of which acuity tool we're going to use, because if you've got lots of very sick ladies, the safe staffing level that's set up in the Bill is not relevant.

[301] **Janet Finch-Saunders:** Thank you.

[302] **David Rees:** I've got Alun, Lindsay and then Lynne.

[303] **Alun Davies:** Can I say, I'm somewhat surprised, and I think probably a little disappointed in your response to that last question? It appears to me that you don't have much faith in the management of the national health service in Wales doing anything, unless you use the pretty big stick of legislation. You know, Dr Wheatley said there's nothing in place; it, clearly, cannot be put in place very easily. A set of guidelines can be put in place without going through the process of legislation. But the three of you, in different ways, don't appear to believe that anything short of that great big stick of changing the law will actually have the impact that I think everybody would like to see. Is that really your position?

[304] **Dr Banfield:** It's been described to me by members of both medicine and nursing that there is a vacuum in capacity planning and workforce planning in Wales. We've been flagging up the problems with shortages of nurses for three years. In those three years, you could've had a cohort of nurses through that would've solved the problem. Scotland, for example, has a commitment that, when it trains its nurses, it will employ them. Now, we're training nurses and midwives in Wales, and they're going to work in England straight away.

So, I'm afraid, for us, the evidence, given the Andrews report and other reports, says, no, we don't have confidence in the health boards to deliver what they are mandated to deliver.

[305] **Alun Davies:** Okay, I accept that, but the earlier points, of course, about workforce planning and training are not relevant to this, because, you know, where someone is trained or qualified, assuming that they're able to practice here, is—I think it is important, by the way; I wouldn't describe it as not being important—not relevant to the question of whether we legislate or not, because what we're talking about is the number of staff of a relevant description on a ward at any one time, and while I've heard your evidence this morning, I am surprised that you don't believe it can be achieved without legislation. But, I'll leave it at that.

[306] **David Rees:** We'll just leave it at that point. Lindsay?

[307] **Lindsay Whittle:** I just wondered if you think there are any financial—. As keepers of the public purse, are there any financial benefits in this Bill? And, perhaps the most important question, what are the benefits to the patient? Because the patient is sacrosanct in all this, surely.

[308] **Dr Dowdle:** I think there are financial benefits in this Bill, because, if we can mimic what's happened in other countries, where they have implemented this legislation, and get returning nurses, fully trained and experienced, coming back into our fold, we won't need to employ the expensive bank nurses, who can be paid six-figure sums over a year. I mean, it's a vast amount of money. We can save money by getting returnees coming in at normal salaries. And is it good for the patient? Yes. These returnees are locally trained, locally experienced nurses. They know the patch; they know the way we work. So, I think there are benefits financially, potentially, and there are benefits for the patient, potentially.

[309] **Lindsay Whittle:** That's good, thank you.

[310] **David Rees:** Okay. Lynne?

[311] **Lynne Neagle:** I don't know whether you were able to listen to the evidence of the previous set of witnesses from the health boards, but they were quite worried that the requirements of implementing this Bill would take nurses away from their caring duties. They were describing nurses being sort of bogged down with the administration of making sure that they'd met these ratios. Do you share those concerns?

[312] **Dr Wheatley:** We're rolling out e-rostering across Wales, and, if the health boards are worried that they're going to have difficulty getting the data, then that indicates that e-rostering isn't going to provide the data, but what needs to happen is that an electronic—. If you've got e-rostering, you should be able to tweak it, and press a button, and the data should come out, and if it's happening in Salford, you know—.

[313] **Lynne Neagle:** So, you're not worried about that, then?

[314] **Dr Wheatley:** I think if there is any aspect of this that takes nursing colleagues away from looking after patients, I think that's a concern, but the way to resolve that is not to say, 'Well, then we're not going to legislate'; it's to fix the issue—fix the burden of collecting the data.

[315] **Lynne Neagle:** Thanks.

[316] **David Rees:** Any other Members? Well, if there are no other questions, can I thank you for your evidence this morning? You will receive a copy of the transcript; if there are any factual inaccuracies that you may wish to identify, please let us know if there are. Once again,

thank you very much.

[317] **Dr Wheatley:** Diolch yn fawr. Thank you.

[318] **David Rees:** We'll be moving on to our next panel of this morning's session.

11:27

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 5 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 5

[319] **David Rees:** Good morning. We're a little bit earlier than scheduled, but thank you for coming a bit earlier. Just to remind you, the microphones will come on automatically, and translation is available on the headphones on channel 1. They should be set up for you.

[320] **Ms Ford:** Could I just ask people to speak loudly, because I'm deaf? Thank you.

[321] **David Rees:** Can I welcome, therefore, the next panel? We have Dr Gosling from the Chartered Society of Physiotherapy; we have Pip Ford, from the Chartered Society of Physiotherapy; and Dr Stroud, from the Royal College of Speech and Language Therapists. Good morning. Can I thank you for your written evidence, which we have received? Clearly, there will be some questions based upon the evidence, and your views on this particular Bill. We will go straight into the questions, if that's okay with yourselves. Gwyn?

[322] **Gwyn R. Price:** Thank you, Chair. Could you tell me whether you support the minimum staffing ratios for health professionals other than nurses?

[323] **Ms Ford:** Thank you very much for your question. If I could perhaps just very quickly start by saying that our concern is to ensure the highest standards of patient care are achieved; so, care that is safe, effective and delivered with compassion and sensitivity to individual needs. We don't see patient-staff ratios as the way to achieve safe, effective and good-quality care, but we do fully appreciate that that's the rationale behind the Bill. We don't support patient-staff ratios as a way forward, really. We think that it's too rigid and too simplistic an approach, and we don't really think that it will be effective for nursing staff, or indeed for any other professions.

[324] **David Rees:** Dr Stroud, is that your view as well?

[325] **Dr Stroud:** It is. The Royal College of Speech and Language Therapists has looked at speech and language therapy ratios over the years and found that it's more complex than just a minimum level. It's an analogy; it's not exactly the same as acute ward work, but we had many years, over eight years, of high complaint levels about speech and language therapy services in Wales. Many of you—I've missed all your letters; thank you. But instead of doing minimum staff levels, we actually worked on more of a prudent healthcare-type model, looking at co-production, looking at doing only what you can do, and we worked in a very multidisciplinary, multi-agency way on building capacity in the community around children with speech, language and communication needs. The measure we've got for the success of that is that I no longer get letters from you all. So, I believe, from the patient experience end, we've improved services that way, rather than going for the knee-jerk, minimum staff levels to patients.

[326] **David Rees:** Gwyn.

[327] **Gwyn R. Price:** I'm sorry; thank you, Chair.

[328] **David Rees:** Elin.

[329] 11:30

[330] **Elin Jones:** So, what you're saying, then, in your response there, is that your preference would be to work on the supply side, rather than the demand side, which, really, legislation is about. We've heard similar views, really, from others this morning about the need to increase the numbers of nurses out there to be employed, as one way of addressing the issues around safe nurse staffing ratios. But, part of the reason this legislation has been brought forward is that safe staffing isn't being achieved in many aspects of the NHS, and legislation is one means of trying to redress that. Do you want to, sort of, expand, maybe, on what you've already touched on? What methods do you think Welsh Government could look at to provide that safe staffing context and improve, specifically the nursing issues, at this point, without legislation?

[331] **Dr Stroud:** Without legislation. I think it's such a complex system, and we all know it's so complex that touching just one bit of it with legislation may have the unintended consequences of knocking other things out that we can't predict now. I believe we've got other means in Wales currently that we're exploring, such as prudent health care principles, that may achieve the safe and effective care that we all want for patients, rather than just hitting one small bit of it with legislation.

[332] **Dr Gosling:** To add to what Alison said, I think we are very keen, in response to your initial point, to respond to demand need, so patient need, and to ensure that the focus is on the outcomes of care for patients, and quality of experience for patients, as opposed to focusing on workforce supply in a narrow, input-focused way. I think, as Alison said, we are keen that the approach looks at the huge variety of factors that will impact on the quality of care received and those, crucially, are patient need in terms of dependency, acuity and complexity, and there are the issues of the environment in which care is delivered. Even in the setting we are focused on here, obviously there's a huge variety in terms of design, ward layout and the mix of how a service is delivered, and how it fits with other delivery of care, before and after. Then, obviously, there are much broader issues of staffing and, crucially, issues of skill mix across multidisciplinary teams and within the professions themselves. So, I think we're keen that the approach starts with achieving, as Pip said, good-quality, safe patient care and then looks at how you address the complexity of issues that'll inform that, rather than looking at staffing levels and nurse staffing levels in isolation in one setting. I think that those are our primary concerns and the risks of the approach.

[333] **Ms Ford:** Thanks, Sally. I'd also say that staffing needs to be looked at in the whole, so you need to be looking at staffing levels across all the professions, whether that's looking at workforce planning, looking at skill mix or looking at service redesign. So, this legislation would lead us to be looking at and focusing on one profession, to the exclusion of other professions, and that can skew how we look at service design—quite rigid and quite inflexible.

[334] **Elin Jones:** The reason we've been given all morning, really, that nurses, in particular, are the focus of this legislation is that the evidence base is around the improvement to service from safe staffing of patient to nurse ratios. Do you know of any evidence in any other health professions where safe staffing could apply—where the same principle could apply—because we've been told it doesn't exist for other health professions?

[335] **Dr Gosling:** I think we certainly have some concerns about use of the available evidence around nursing, as well, and, obviously, from an England perspective, looking at the NICE work and the research that was commissioned to underpin that. Certainly, most of the

evidence that is available is from outside the UK. I think only one UK study was included in the research evaluation that was done on behalf of NICE last year. So, I think there are issues around making inferences from the evidence base internationally. I think also what that evaluation did again highlight was the multiplicity of factors that add to how safe and effective care is assured, and nurse staffing levels are only one element of that, and the correlation between nurse staffing levels and positive patient outcomes isn't necessarily made. Again, all the causal factors are much more varied. So, I think there are risks of adopting that evidence and translating or transposing it to the NHS in the UK—in Wales in this instance. I think we are aware there isn't a solid evidence base for staffing levels for any area, and we're keen to explore those issues, but we acknowledge it's an issue and it adds to the challenge of ensuring safe, quality care for patients.

[336] **David Rees:** Peter.

[337] **Peter Black:** Yes, you referred a couple of times to minimum levels, but the Bill is not about minimum levels; it's about safe staffing levels and actually takes account of the complexities that you also referred to. Do you not accept that—

[338] **Elin Jones:** The version we've been given refers to minimum levels.

[339] **Peter Black:** Well, the Bill—

[340] **Elin Jones:** The content of the Bill is around minimum staffing—

[341] **Peter Black:** It's about safe staffing, isn't it?

[342] **Elin Jones:** Well, no, it actually says 'minimum'.

[343] **Peter Black:** It's about safe staffing. It's about making sure we actually have proper assessment of acuity and stuff like that.

[344] **Elin Jones:** The Bill says 'minimum'.

[345] **Peter Black:** Do you not accept that it gives tools to the Government Minister to actually issue guidance in terms of what is safe staffing, taking account of those complexities and the various acuity tools? Do you not accept that is going to make a difference?

[346] **Dr Stroud:** There is other evidence, recently. The NHS benchmarking UK network—and I think all seven health boards are members of that network in the UK—have very recently reported on their latest audit. Admittedly, it's in community hospitals rather than in acute adult wards or intermediate services, but their key message from the audit last year was that, if we're talking about safety as being positive outcomes for patients, their evidence showed a strong positive link between outcomes for the patients and the diversity of professions around the patient. So, actually, their evidence strongly was saying that safer outcomes positively correlate to the diversity of professions around the patient.

[347] **Peter Black:** I represent Swansea, Neath Port Talbot and Bridgend and, as you know, the Andrews report has highlighted a number of problems with those hospitals there. Some of the issues that came out of that very clearly relate to inadequate nursing levels in those hospitals. I find it difficult to believe that you're saying that that isn't relevant in terms of this Bill.

[348] **Ms Ford:** I think the wording is very important, and I think that 'minimum' and 'safe' and 'appropriate' are different words that are used in different contexts. 'Minimum' is used within the legislation, and 'minimum' doesn't necessarily mean 'safe'. I think there

needs to be really strong clarity about what we're meaning. The Bill has changed to become the Safe Nurse Staffing Levels (Wales) Bill, but, actually, the wording still relates to minimum staffing levels. So, we do have an issue about that, and if I could just say as well—

[349] **Peter Black:** It says 'ratios' not 'levels'.

[350] **Ms Ford:** 'Ratios', yes, but even so, 'ratios' are still meaning that you're looking at minimum numbers and—

[351] **Peter Black:** It also talks about healthcare support worker ratios, as well.

[352] **Ms Ford:** Indeed, indeed—

[353] **Peter Black:** So it's not just about nurses.

[354] **Ms Ford:** But I think there's a problem when you think that the word 'minimum' is automatically going to mean 'safe'.

[355] **Peter Black:** Do you not think there should be a minimum? I mean, do you think a ward can manage on one nurse? What's the minimum in a ward?

[356] **Dr Gosling:** I think the issues that we're concerned about are the risks of attaching and defining a minimum, whether it's around registered nurses or, obviously, the valuable role that care assistants and support workers play as well. The complexity is around defining a minimum that has actual meaning, given the variability in patient need, dependency, acuity, patient turnover, complexity of case mix. So, the risk is that a minimum level doesn't have meaning; it's potentially not in patients' interests to ensure their safety. So, the minimum would be variable according to the context: the patient need, the skill mix, the broader staff team. I think it's a risk that the minimum could become what becomes the norm, and that clearly is, you know, putting patients' interests at risk.

[357] **Peter Black:** A substantial part of this Bill—sections 4, 5, 6 and 7—actually set out in some detail the sort of considerations that need to be taken into account. Doesn't that satisfy you?

[358] **Dr Gosling:** I think the exercise of professional judgment, the use of acuity tools—that mix of things—is hugely important. I think we have a concern that the focus on patient-staff ratios can be a distraction from looking at the evaluation of needs that need to inform how staffing levels are calculated and monitored on an ongoing basis.

[359] **Peter Black:** Isn't the truth, though, that you're actually concerned that you'll have a Bill about professions allied to medicine as opposed to nurses? Are you just jealous of what's happening here?

[360] **Dr Stroud:** Not at all.

[361] **David Rees:** I don't expect you to answer that question.

[362] **Peter Black:** I think it's a relevant question, frankly.

[363] **Dr Stroud:** It's entirely not that. It's that it could have unintended consequences. It's a very blunt tool. I think what the NHS Confederation evidence is talking about is that it's not just a minimum but that we need values-based recruitment, passionate workforces et cetera. You could go outside to the pay and conditions of a mainly female profession, except for welfare, housing—it could go really broad. I know you can't legislate for all those things, but

it is a complex business.

[364] I was privileged to hear Professor Andrews speak recently in Wales, back in the autumn, at the AcademiWales clinical leadership conference in SWALEC. She'd come down within about five to seven days of her mother dying in a hospital in the north. I hope she won't mind. She was publicly speaking about her personal experience, and she said they were on the ward and the nursing staff came to her and said, 'We are incredibly stretched today—we've got two or three very highly acute patients. We will not likely have the time to care in the way we would like, in terms of washing, feeding and giving drinks to your mother. If you as a family are able to support that, we'd be pleased'. So there was early communication about the particular stresses that day on the ward. Her family said, 'We were particularly delighted to be able to support our mother in these final days—actually caring for her ourselves in those ways that we could'. That, to me, is about individual-level co-production, which is what prudent healthcare is trying to develop. These principles need time to embed. It's more complex than just safe staffing levels.

[365] **Peter Black:** Can I just raise one more question? When we asked the RCN about your particular concerns, they said that if you have a safe staffing level in terms of nurses, they will identify problems earlier, they will be able to carry out assessments earlier, and they'll be able to refer them more appropriately to professions such as yourselves and they'd make your job easier—well, not easier, but make your job better able to be delivered because of that thing. Do you not recognise there's a benefit there in having that?

[366] **Ms Ford:** But as a result of having an effect on the allied health professions, in terms of only focusing in on nursing, the actual outcomes for patients—. I mean, nurses may be able to refer, but if you haven't got the allied health professions there, then, actually, the outcomes for patients are going to be worse.

[367] **Peter Black:** There's no proposal to reduce the number of allied health professionals, is there?

[368] **Ms Ford:** But there's a focus purely on one profession, which then means that your holistic planning, your holistic service delivery—

[369] **David Rees:** We've had that debate.

[370] **Ms Ford:** —is not being looked at.

[371] **David Rees:** John.

[372] **John Griffiths:** I think the committee is aware of the possibility of unintended consequences in looking at this legislation and it's always an issue for legislation. One of the matters we have to turn our minds to, I think, is what legislation would achieve compared with what guidance can achieve, and what maybe better and stronger guidance might achieve. The committee's been interested in what's going on elsewhere in the UK, for example in terms of England and Northern Ireland, where they tend to have better nurse ratios, with guidance, perhaps, as the major driving force, and certainly not legislation.

[373] I just wondered, you know, in terms of that team approach that is very, very important, because it is a team effort, in terms of delivering healthcare in our hospitals and on our acute wards, is the current guidance that exists strong enough in terms of that team approach that's necessary, or does that guidance itself, in your view, concentrate too much on nursing ratios, rather than the team approach? You know, would you like to see guidance changed to get this team approach stronger than is currently the case, given that you don't think that legislation is going to do that and could undermine it?

11:45

[374] **Ms Ford:** Shall I start? The guidance that's out there at the moment is the guidance from the chief nursing officer, and I understand that that, and then future acuity tools, will be used. The guidance has been used to compare nursing staffing levels with the rest of the UK, but it is purely about nursing, so it doesn't encompass the whole of the rest of the multidisciplinary team. I think if it demonstrated that there are requirements for nursing in Wales, then rather than resorting to legislation, perhaps looking at the reasons behind the current nursing staffing levels is something for Welsh Government to look at. In terms of developing staffing ratios or guidance along that line for all the professions, that's not something that we would be looking for, because looking at safe, effective staffing levels and outcomes for patients is so much wider than just the staffing element. It's about the patient needs and the complexity of patients. It is about staffing, but that's the skill mix and the skill sets that you've got and that you might need, and it's about the locality, the location and the environment that you're providing your services in as well. So, guidance, I think, would have to look at the whole of the workforce, but at the moment the guidance that's out there is purely on nursing.

[375] **David Rees:** On that point, are you uncomfortable with the guidance that currently exists from the CNO?

[376] **Ms Ford:** Uncomfortable for the whole of the professions, or uncomfortable with it purely for nursing?

[377] **David Rees:** Well, uncomfortable with it in delivering better outcomes.

[378] **Ms Ford:** Better outcomes for patients?

[379] **David Rees:** Yes.

[380] **Dr Gosling:** I think, as Pip said, it would be helpful, possibly, to look at the underlining reasons why the existence of the guidance isn't achieving the staffing levels that are producing safe and effective care. So, I think it's taking that broader approach to explore the reasons while also, I think, looking at the necessarily dynamic nature of health and social care delivery rather than focusing on needs now. The acute sector is looking at how patient needs can be met through, as Alison said, co-production, promoting self-management, and I think looking at the context in which healthcare needs to change rather than looking at it at a relatively static point for one professional group. So, I think evaluating and looking critically at the reasons and, I think, the value of professional judgment and the use of acuity tools are all really important for how the real issues underpinning the needs can be explored more fully.

[381] **Dr Stroud:** From my experience in the Royal College of Speech and Language Therapists, when we had problems with safe outcomes for patients needing speech and language therapy, we never asked for ratios of staff; we looked at the whole system and built up capacity in others around the child in a co-production type way. We stuck to doing only what we can do. We are all understanding of pressures on the very acute end of the system, but if we could solve pressures the other end, in the community, then those pressures could go. We found that, by building capacity in the community around the child, the demand didn't escalate at the acute end of speech and language therapy. So it's about reducing the flow as well not just about solving the current unique issue.

[382] **David Rees:** Okay. I've got Lynne and then Darren.

[383] **Ms Ford:** I'd also say that ratios and guidance around specific ratios lead you to think about numbers, and the danger there, then, is that the organisations will be thinking about numbers, inputs and tasks rather than thinking about the outputs for the patient, for the safe care and the optimum patient outcomes, which is the outputs part of it. So, for us, I think, guidance around ratios would not be acceptable.

[384] **David Rees:** Lynne?

[385] **Lynne Neagle:** Yeah. I mean, your concerns about this legislation are based mainly on the fact that you think it doesn't take a whole-team approach. Nobody on the committee would want to see a reduction in physiotherapy services or the other related professions, but do you not accept that nurses have a pretty unique role in that they are probably the only professionals—nurses and healthcare assistants—who are there all the time? You know, physiotherapists come onto the ward, and speech therapists come onto the ward, but nurses are there providing around-the-clock care. Do you not think that makes a case for looking at the staffing needs of nurses in a different way to other professions?

[386] **Dr Stroud:** I think, if you look at them in isolation, it's not clever enough, really. So, if we're short of speech therapists, the pressure goes on nurses. So, I think we need a bigger approach than just solving the current problem with legislation.

[387] **Ms Ford:** My answer would be that patients are not with nurses 24/7, because they will be going off to have tests and diagnostics and therapies like physio and—

[388] **Lynne Neagle:** But the vast majority of the care for patients is provided by nurses and nursing assistants, isn't it? The vast majority of time somebody spends in a hospital is going to be with those particular professionals.

[389] **Ms Ford:** I agree with you to a point. I think that there's a point to be made about levels of dependence, as well. I think there are times when patients are going to be wanting more nursing care, but there are also times when you're thinking towards hospital discharge and them actually making their way out of hospitals—out of the hospital environment—when they're going to need more therapy time and other treatments and interventions, which will mean that they are getting home faster, that their outcomes are better. So, the danger of focusing in only on nursing is that you're then not focusing on the rest of the team.

[390] **Dr Stroud:** Can I come in, Chair?

[391] **David Rees:** Yes.

[392] **Dr Stroud:** There was a review of the literature done in 2013 by Smith et al, which again, supports the NHS benchmarking evidence that stronger positive outcomes for patients correlate with a diversity of professions around the patient. So, I haven't got the evidence—. You know, I don't want to sound against nurses, because I'm entirely not, but it may be that the solution isn't just about nurses, but it has to be about a diversity of professions around the patient. So, it isn't just the nurse all the time that's the only person on the ward.

[393] **Lynne Neagle:** I didn't say that, but, if you were to measure the amount of time patients spend with particular professionals, then more of the time, significantly more, would be with nurses and nursing healthcare assistants.

[394] **Dr Gosling:** I think, to add to what colleagues have said, I think we absolutely respect the essential role of nursing staff. Obviously, the value and the importance of that within the setting, which the legislation is focused on, is obviously there and something to be addressed. I think our reservations are in part, as well, the fact that it is simply, for

understandable reasons, focused on acute in-patient wards, when, obviously, there's lots of other factors within a patient's pathway before and after their hospital stay. So, I think the risk of focusing on nurse-to-patient ratios within that setting are not only to other professions—ultimately, what we're concerned about is the quality of patient care—it could also have an impact on availability of the nursing workforce for other settings as well. So, I think it's, again, focusing on patient quality of care, safety and effectiveness of care, across the spectrum, and I think there is a risk that the focus on nurse ratios in one setting could actually work against the quality of care that patients receive and, ultimately, their outcomes. So, it's not a protectionist or defensive approach, it is focused on quality of care for patients and the whole patient journey, respecting that, obviously, how services are delivered across different sectors is quite rapidly evolving and that needs to, perhaps, be considered in how the complex issues are addressed.

[395] **David Rees:** Is it right to say that, actually, we're not talking about mutually exclusive things, anyway, we are actually talking about the ability for an appropriate number of nurses to be able to deliver the quality of care so that other professions can also be part of that team? So, it's a whole-team approach, but, in one sense, there's also an important aspect that, if there is a lower number of nurses, then the whole team can actually have difficulties, because nurses aren't in a position for you or other professions to actually work with those patients. I think there's a collective. Is that a fair point?

[396] **Ms Ford:** Yes. It's the multi-disciplinary team working. I mean, I think all professions are interdependent upon each other. You know, the nurses work very closely with their medical and allied health professional colleagues. So, if you have a lack of therapists, that will impact on nursing staff. Equally, if there's a lack of nurses, that will impact on therapist staff.

[397] **David Rees:** Darren.

[398] **Darren Millar:** Yes, thank you, Chair. I'm just a little perplexed by some of the arguments you're using here. You seem to be suggesting that, actually, there ought not to be any minimum nurse staffing ratios at all in Wales, either in guidance or in legislation, because they are unhelpful and don't necessarily focus on what's best in terms of patient outcomes. But we do have guidance. For whatever reason, it doesn't appear to have been successful yet in being implemented fully by the health boards. The evidence that the committee has received from all witnesses so far, apart from you—your organisations—is pretty clear that there is a correlation between safe nurse staffing levels and good staffing ratios and outcomes for patients. We know also, because of the work of Professor Andrews, which you mentioned earlier on, Dr Stroud, in terms of the Princess of Wales Hospital, that some of the issues there and some of the failures in that hospital related to insufficient numbers of nurses, and the same in Mid Staffs as well. So, there seems to be a whole host of evidence that suggests that we need better ratios. But I do accept also that patient outcomes are also impacted in terms of making sure there's sufficient availability of therapists and other allied health professionals for patients. So, isn't the bigger problem, and you've sort of hinted at this, but perhaps not emphasised it sufficiently—. Isn't the bigger problem that patients' acuities change all of the time? From one shift to the next, from one hour to the next, from one admission to the next, it's pretty difficult, actually, to establish what is the perfect staffing ratio or the safe staffing ratio on a ward. If that is the case, if you do accept that, how can we secure an appropriate measurement, and how regularly would that measurement need to be adjusted to ensure that we do have safe nurse staffing ratios? There is obviously a lot left to regulation in the Bill, and to ministerial guidance. So, it's insufficiently detailed for us as a committee to be able to identify the sorts of tools that might be available. Do you think it's practicable to expect those tools to come forward or not?

[399] **Dr Gosling:** I think you've summarised it: is the complexities of the issues, it is the

patient need and the different ways that can be measured and defined, and, as you say, it rapidly changes. It is to do with the service and it is to do with the staff factors. I think there is a huge challenge in how those tools can be developed to support decision making at a local level. But I think our feeling is that the tools need to enable the exercising of professional judgment—the use of tools, the taking account of patient need, and the service factors, in order to make local decisions that are responsive to that changing dynamic of patient need. Certainly, work that we're undertaking at the moment as the CSP is to seek to develop materials that support our members to actively review, and services and teams to actively review, safe and effective staffing for physiotherapy, but in a way that takes account of all the variables that we are highlighting. So, I think the question is whether you could develop a tool or guidance that, in its own right, can meet and respond to the need. I think it's more putting the onus and the accountability on services to go through that process of decision making and responsiveness to change. It's complex, but I think it needs to be at that level.

[400] **Darren Millar:** Obviously, the guidance that exists at the moment is around minimum nurse staffing levels, rather than safe nurse staffing levels. So, there are the bare minimum that always ought to be on a ward during the day and during the night. In terms of the mix between registered nursing staff and healthcare support workers, you've talked about the dangers of perhaps that minimum becoming the norm, rather than a safe nurse staffing level becoming the norm. I'm just not fully persuaded by the argument that you make that that is not a sensible approach, at least on which to start, in terms of agreeing that there must be something, somewhere, that says, 'This is what is safe beyond which you ought not to—'. This is a red line that you ought not to cross'. For some reason, you—

12:00

[401] **Ms Ford:** I think the nursing profession are developing the acuity tools and professional judgment. These are key things. Some of the evidence we've looked at in reviewing America has shown that actually having ratios hampers professional judgment and that the nursing profession, and our own professions, need to have acuity tools—tools that look at complexity, co-morbidities and other factors to be able to then help to give that evidence as to what is safe, because you will be able to look at all of the factors, put it all together and provide information. And I think that the development of the acuity tool that the chief nursing officer's office has been looking at, combined with professional judgment, will go a long way to being able to provide the nurses with the evidence that they need on a shift-by-shift basis. If you've got hard-and-fast ratios and then you have changes to the patients on your ward, how do you manage that? If you suddenly have a change of complexity, do you rush a few nurses in from another ward and have to shut that ward in order to be able to a) meet your legislative requirement, but b) make sure your patients are safe and that they are going to be able to get the right outcomes? So, I think the actual practicalities will be quite difficult and the guidance that's going to have to be created, as part of the legislation, is going to have to be very detailed, particularly around 'minimum', 'safe', all of those different words. 'Reasonable steps'—you know, what are 'reasonable steps'? There's quite a lot in there that would have to be looked at very carefully in terms of how that guidance then will help the service to be able to deliver on the legislation.

[402] **Darren Millar:** Do you think too much is being left to guidance and ministerial regulation rather than on the face of the Bill?

[403] **Ms Ford:** I think it's a concern that a lot is being left to guidance, yes.

[404] **David Rees:** Do any other Members have questions? Alun.

[405] **Alun Davies:** I'm not convinced you've made your case this morning, quite frankly. I thought my colleague, Lynne Neagle, asked an absolutely key question and I wasn't

convinced by your answers to that. Is there not a sense here that, actually, whilst it is true that managing a large, complex organisation is difficult—. But that's what we pay people an awful lot of money to do, right, and so they should get on with it. Is there not a sense that, you know—. And I am disappointed by earlier sessions that the only way to achieve this is via legislation; I'm not necessarily of the belief that that is always the case or is the case here, in fact. But is it not the case that a development of a very straightforward set of guidelines, based on the acuity tool that the Welsh Government has already provided, would provide both the structure for the team approach and would also meet the needs of patients within a less complex and a more streamlined system? Because I am concerned that, you know, politicians believe that you can legislate to change the world sometimes; I'm not entirely convinced of that either. But I feel that we need to do something to deliver this on the ward level, whereas I'm not convinced I know what you think yet, I'm sorry.

[406] **Ms Ford:** I don't think you need legislation to do this; I think there are other ways of looking at how you deliver on your safe, effective staffing levels. For example, where we have got guidance already—guidance has been developed by the chief nursing officer—there are ways, for example, using your tier 1 performance management processes, for Government to hold organisations to account and, when they don't meet those requirements, then there's escalation and, you know, organisations look into the reasons behind why these things are not being met. So, there are other ways of looking at this; it doesn't necessarily need to be legislation that is used to deliver on the safe, effective staffing levels and, most importantly, the outcomes for patients.

[407] **David Rees:** Okay. No other Members have any questions. Can I thank you very much for your evidence this morning? It would be remiss of me not to congratulate you on behalf of the committee on your award of MBE in the new year honours list for the work you do for your profession. You will receive a copy of the transcript for any factual inaccuracies. Please let us know if there are. Thank you very much.

[408] **Ms Ford:** Okay. Thank you very much everyone.

12:04

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r
Cyfarfod**

**Motion under Standing Order 17.42 to Resolve to Exclude the Public from the
Meeting**

[409] **David Rees:** I now propose that, in accordance with Standing Order 17.42(vi), the committee resolves to meet in private for the remainder of this morning's session, and we will come back into public session after lunch.

Cynnig:

Motion:

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

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

*Cynigiwyd y cynnig.
Motion moved.*

[410] Members are content? Okay. Thank you.

Derbyniwyd y cynnig.

Motion agreed.

*Daeth rhan gyhoeddus y cyfarfod i ben am 12:05.
The public part of the meeting ended at 12:05.*

*Ailymgynullodd y pwyllgor yn gyhoeddus am 13:30
The committee reconvened in public at 13:30*

Ymchwiliad i'r Gweithlu Meddygon Teulu yng Nghymru: Sesiwn Dystiolaeth 1 Inquiry into the GP workforce in Wales: Evidence Session 1

[411] **David Rees:** Good afternoon. Can I welcome Members back to this afternoon's session of the Health and Social Care Committee? This afternoon, we'll be looking at GP workforce recruitment and retention issues, and we have three sessions with witnesses. Before I start, can I also now pass on the apologies of Janet Finch-Saunders for this afternoon's session? No substitute has been allocated for that.

[412] In our first session, can I welcome Dr Charlotte Jones, Dr Phil White and Dr Peter Horvath-Howard, all from the British Medical Association? Congratulations and welcome.

[413] **Dr Jones:** Thank you.

[414] **David Rees:** Thank you for the written evidence that we have received in relation to this. I know it was a very short timescale that we had. I appreciate very much the response, but clearly there are some questions that we'd like to pursue further if possible, and we'll start those questions off with Gwyn Price.

[415] **Gwyn R. Price:** Thank you, Chair. Good afternoon, everybody.

[416] **Dr Jones:** Hi.

[417] **Gwyn R. Price:** How do you see the key aspects of the role of the GP in the future delivery of healthcare?

[418] **Dr Jones:** Certainly, I see GPs as being the specialists in managing the complexity of care of patients within the community—so, managing teams of allied healthcare professionals, including practice and district nursing teams, wider community nurse specialists, and working with them to meet the patient's needs and having more of a consultative role with some of those aspects of patient care, but still being available to make sure that patients can access care, whether it's an acute problem that they've got or whether it's a more complex problem, and, of course, ensuring that we have wider access to end-of-life care as well, which is certainly a passion of mine.

[419] **David Rees:** Anybody else?

[420] **Dr White:** Certainly. I've been doing the job for almost 40 years now, practising medicine certainly, and I feel that the work that I do as a general practitioner now is what the old general consultant physicians used to do when I first started—certainly the complexity of the work. We are chronic disease managers, and not only that, because many patients have more than one chronic disease, of course, we are often the sort of referee between cardiologists and chest physicians and renal physicians, and, in the end, we try to steer a course that is safest for our patients.

[421] **Dr Jones:** Yes. We manage the complex patients with more than one condition to

make sure that, instead of looking at the individual condition, we manage a variety of conditions within that one patient to make sure that their holistic needs are met. I see that continuing in the future and, hopefully, working with our wider community partners as well—with our pharmacists, working more collaboratively; working with our community nurse specialists and having outreach specialists from the hospital. But, again, with us maintaining the overall co-ordination of the care to the patients.

[422] **Gwyn R. Price:** Do you think you could delegate more duties down to different parts of the organisation?

[423] **Dr Jones:** I think we're already delegating as much as we certainly can. We're certainly seeing practice nurses taking on a lot more of the chronic disease management role of specific entities. In turn, they then delegate down to healthcare specialist workers as well. We also delegate to our district nursing partners appropriately, where we can. The problem is that the capacity within the system is such that, actually, everybody is working to virtually full capacity—if not beyond, actually, in some areas.

[424] **Gwyn R. Price:** Thank you, Chair.

[425] **David Rees:** Lynne.

[426] **Lynne Neagle:** Thanks. I've got a couple of questions. The first is on the partnership model that is so prevalent in lots of our communities. You have said that the partnership model is unattractive to some younger doctors and I wondered if you could expand on that, and also whether you could say how effectively alternative models, such as salaried GPs, are being used in different parts of Wales.

[427] **Dr Jones:** I think it's fair to say that the partnership model of practice offers great value to the NHS generally. You know, for a relatively small amount per head, you get unfettered access to the GP and their teams. What has happened though, over years, is that the demands on GP partners have increased exponentially. There's ever-increasing bureaucracy and I'm not talking about the contract; I'm talking about wider aspects where we're increasingly scrutinised; we have multiple inspections; we have paperwork coming at us from all angles, all, for some reason, wanting a GP signature on them. A lot of work is going on and the stress of managing the practice business is very high. The premises—you've got to take on control of the business at the side of the premises, and the uncertainty over financial flows can also be quite worrying to new GPs. So, I can understand why for younger GPs, looking at the strains of managing the workload demands of every day, coupled with business concerns, it means that it may not be what they want to do, at the moment. That's to say, though, when you look at the wants of the newer generation, that they may want to have flexible careers available to them throughout the time of their careers within the NHS in Wales. Actually, most of them still want to enter partnership, but not at the current time with the current pressures that we're facing. So, we need to address that and actually make partnership more attractive, because that is the best for the pivotal provision of service for the NHS with respect to general practice.

[428] Salaried models are very good in terms of supporting that model, but I would urge the Welsh Government to think very carefully before it would consider going down a salaried model, for the reasons we've outlined in our strategy document, 'General Practice: a Prescription for a Healthy Future', which clearly highlights where they can support the partnership model, but should not replace it.

[429] We need to think about flexible, innovative career options. For example, some of my colleagues very much enjoy working in certain hospital specialties, so we need to offer hybrid roles to them, as well.

[430] **Dr White:** Can I make a point there? In north Wales, we've had to have some managed practices because of a failure to recruit general practitioners to posts. I did have a discussion with our director of primary care finance and, on average, she'd worked out that, over two years, three different practices had cost £30 per patient per year extra, which is a lot of money. We find when we employ locum doctors that they do actually cost more than the partners. So, it's not something to be jumped at as an ideal solution.

[431] **Dr Jones:** Certainly, there are partners that we can work with in order to, you know, have a wider skill mix available to us. Our experience is that when we have spoken to nurse practitioners, advanced nurse practitioners, pharmacists who have autonomy and work with the practice teams, what they like is working within the practice team, within the ethos, again, with a GP overseeing them. But we need to look at, you know, smarter ways of working; we need to look at the provision of care that we can provide and we've got to be realistic, really, given the strains that are within the service at the moment. Do you want to talk about Powys?

[432] **Dr Horvath-Howard:** Yes, I mean, I think the two questions that you've asked subsequently tie in, really, because, I think the future model should primarily be the independent contractor status, because I think that's what affords GPs the passion and commitment to develop the service. It's been shown many times over that, you know, we're good at that, and the other models can tie into that, but I think losing that essential model in Wales would be one of the biggest mistakes that the NHS has ever made. As you say, there is this differential change now, and approach, in that young GPs are looking at partnership and thinking, 'Why would we want all that extra responsibility?' There are fiscal elements to it: a salaried doctor can pretty much earn as much as a partner would bring into a practice now.

[433] The whole nuances of running a business have become really complex now. There's a lot of health and safety to deal with and there's a lot of regulation. General practice is becoming hyper-inspected, in my view—over-inspected—particularly compared to secondary care, and a lot of those kinds of issues can be avoided by going into a salaried role, where, basically, you spend more time seeing patients, which is, after all, what we're trained to do. So, there's an imbalance creeping up, which is not favouring the model that—. The other big thing is the gatekeeping role we were talking about. I think general practice, and particularly independent contractor status general practice, performs a gatekeeping role without which the problems in casualty and secondary care would be many times worse.

[434] **Dr Jones:** That's not to say that we don't recognise that the current traditional model of individual single practices and lots of single-handed practices is probably not sustainable for the future. What we want to do is to address the pressure, as I've said, but also, get practices starting to look at how they can work more closely together to enable a wider range of opportunities, so the newer GPs coming in can then build up confidence in the partnership model and hopefully, then, continue providing GP care to patients in Wales in the best way for NHS Wales, which is primarily through the independent contractor model.

[435] **Lynne Neagle:** Okay. Both of you, in your answers, referred to GPs being over-inspected, which surprised me a bit because I don't really think of GPs as being like that, but maybe that's just a lack of information on my part. Could you explain a little bit more about that and what exactly you are being subjected to by way of inspection that you feel might be putting people off?

[436] **Dr White:** To begin with, you have Healthcare Inspectorate Wales inspections that are being set up; the equivalent of—is it CQC in England? Then you have community health council inspections. Then you have the health board doing their standard contract inspections. Then you have the inspection for the post-payment verification.

[437] **Dr Jones:** Then you've got multiple layers of bureaucracy to complete, lots and lots and lots of form filling, often replicating information that is already available in other avenues, and we have highlighted this. For example, I believe that HIW are going to try to marry up their visits with the community health councils, because it makes sense to me that you should all go in together. It's less disruptive to the running of a practice. To be honest, a lot of the information they are looking at is very much similar across the board. So, it's a bit like when you see a utilities company working on the road; you've got the water company finished, then the electrical company comes, the road opens up, and then you've got the gas people on top. It's just not done in a very co-ordinated or streamlined way, and it's extremely disruptive to the running of a practice if you're having these visits, because they take the practice manager away, at least two or three reception staff, and the clinicians. Rightly so, they need to be available for the inspections, but equally, that has a knock on onto the running of the practice.

[438] **Lynne Neagle:** But, HIW and CHCs can equally go into secondary care settings. What is it about your setting that you feel makes you less worthy of such levels of inspection?

[439] **Dr Jones:** It's because we are small entities as it is. So, when you go in, essentially, we have to stop all our work. Also, when they are doing the same sorts of things, why can't they co-ordinate and have a set system to do it? We've highlighted the disruption to patients and let's not forget that, obviously, when you're in a hospital setting, you've got myriads of managers and additional clinical staff who can be removed from front-line duty to do that in a day because you always have emergency on-call teams. It's very much different in a smaller organisation there, and we would say they may be not subject to exactly the same levels of scrutiny appropriate for a small business.

[440] **David Rees:** Okay, Lynne?

[441] **Lynne Neagle:** Yeah.

[442] **David Rees:** I've got Elin next, but Alun wants to come back specifically on salaried GPs, unless you are also salaried GPs?

[443] **Elin Jones:** No.

[444] **David Rees:** Salaried GPs, Alun.

[445] **Alun Davies:** I'm not convinced by your argument that the best way of managing general practice is by way of the independent GP practice. I'm not convinced that delivers for my constituents in Blaenau Gwent. I wasn't convinced by it in Mid and West Wales when I represented that area, either. There were always problems with the retention of doctors and recruiting doctors for those areas, and I'm not convinced by it now. I'm not convinced by your answers, I'm sorry. I don't understand why doctors, and GPs specifically, are not a salaried profession within the national health service. I understand the history, by the way.

[446] **Dr Jones:** Yes, I appreciate that. If you look at where they have utilised salaried doctors—for example, in RCT—or if you look at where there are salaried professions across the NHS in Wales, what you will find is that sickness rates are higher, for a start. They are significantly higher, whereas practices and partners have a sense of obligation to the patients they serve, so, sometimes to their own health's detriment—I'm not saying that's good—they will often come into work when maybe they shouldn't be. For example, I am here today and I probably shouldn't be. It's not just that; the productivity goes down, so if you look at those practices that are actually directly managed by health boards—so, they are essentially using salaried-type staff—if you look at their QOF figures, which is the quality and outcome framework, their achievements are much lower. Continuity of care to patients, which is a key

tenet of the doctor-patient relationship, is extremely important when you're managing patients from the cradle to the grave, and managing quite complex problems, and is far better served by GPs and teams who know their patients. Continuity of care can be a problem. Raising the issue of a salaried profession has been something that has been looked at, has been considered in the past, and there is an awful lot of additional bureaucracy for Government and health boards in terms of administering that, for a start. Also, you're not necessarily going to get it at the cheaper level, which is what a lot of people want, and I'm not sure that the patient care outcomes will be any better.

[447] **Alun Davies:** I'm not sure that some of those assertions can be sustained in argument. You've used the term 'bureaucracy' on a number of occasions to answer your questions now, but that can be a very, very broad brush and, actually, I'm not convinced that the BMA could actually sustain all of that. But I mean, let me—

13:45

[448] **Dr Jones:** Can I refer you to our 'General Practice: Prescription for a Health Future' strategy document? It actually evidences and references why—we looked at all these options—we came down in favour of promoting the value of the independent contractor status with support from salaried GPs and also looking at flexible career schemes. We fully referenced and evidenced it.

[449] **Alun Davies:** I understand that. In terms of why an independent contractor is so much better than a salaried—. Of course, you could make a similar argument in lots of different professions, but you don't, and we don't because we've found, as a society, that the employment of people to deliver services is the best way of delivering those services over a long period of time. I'm not convinced that GPs are so different to the delivery of other services. I understand the points that you make about sickness levels and the rest of it and productivity, but I have to say that I haven't seen any numbers that would actually sustain that. Do you have numbers to sustain that argument?

[450] **Dr Jones:** As referenced in our document. The other key areas that you need to look at are the importance of the doctor/patient relationship within general practice, particularly at partnership level—we're the only independent advocate for that patient within the NHS. That is an extremely important role for the patients who are registered with that practice. I don't think that I'm going to convince you, but I would refer you back to our strategy document.

[451] **Dr White:** Have you counted the number of managers involved in managing primary care over the years and compared it to the number of managers involved in managing secondary care? And a previous director of the NHS in Wales was quoted as saying that the only cost-efficient part of the NHS was general practice, because you only paid it for what it did.

[452] **Dr Jones:** I would also refer you—

[453] **David Rees:** We've got to that point. I'm conscious of time and I want to move on a little bit because the point's been made there. Elin.

[454] **Elin Jones:** I want to ask you in particular about the problems that are caused by unfilled training places and, also, your paper makes reference to the fact that Wales has the lowest number of foundation level 2 posts in GP practice. The figures are quite staggering, actually: 24% in Wales and 55% is the average across the UK. So, I want to then take you to what some of your suggestions are for improving this, and you do mention golden handcuffs and incentives. I prefer 'golden hellos' myself, to 'golden handcuffs', but they actually mean the same thing. The UK Government for England announced this week that they were going

to introduce golden hellos for newly qualified doctors to become GPs, so we have an issue in Wales where we don't have such an incentive either for areas of Wales—geographical areas that are hard to recruit to or to get people to train to become GPs—but also, generally, for people to become GPs. It is not a significant part of your report, but it is in there. How important do you think it is now for Welsh Government and/or the associated partners to consider financial incentivisation to GP training and then to serving as GPs?

[455] **Dr Jones:** Absolutely critical. We have to look at all the solutions available to us to attract GPs to train in Wales. We also have to look at ways of trying to keep them within Wales. I actually had a golden hello—you used to have a golden hello in Wales; I had one.

[456] **Elin Jones:** Did you?

[457] **Dr Jones:** Yes, I did have one, and I deserved every penny of it, because I'm still in Wales and I'm still sat here doing this. However, that is to say that we should have them, but it's not just that, because different GP trainees will have different needs and different wants. Money always talks—market forces always do—but I do think that the proposals around the single lead employer will actually also help attract trainees, if they're thinking of general practice, to maybe consider Wales, because of all the benefits of having a single employer for three years. But, I think, certainly, we need to make sure that we look at all the solutions that are financial. But, also, we need to look at other things that are important, particularly to lady GPs if they are married, such as spousal opportunities and if they've got children—school care, for example; we need to make sure that we've got really good schools for them and maybe look at childcare vouchers. All of these sorts of things that actually are very well taken up in the private sector. Actually, as I say, it's not as simple as just money; I have absolutely no problems with money, if it is a reasonable amount, being tied to a duration of service and I would point you to learning from the highlands and lowlands of Scotland, where they have given financial incentives there. You tend to find that, if you keep somebody in an area for two or three years, they tend to establish things and don't want to move, and why would you? You've got to get them into gorgeous rural Wales for them to experience it, and I think, once they're there, they'd probably want to stay. For some time, I've also thought that Welsh Government needs to maybe think a little bit more smartly about how it supports students wanting to enter medicine, because it's very hard for students to get into medicine. If they're lucky enough to get a medical school place anywhere in the UK, then—a bit like how the army gives support there—you could tie that to a level of service in Wales, and again, introduce them to parts of Wales that maybe they haven't considered before.

[458] We certainly need to look at foundation year placements, because foundation placements are usually the year where people make decisions. It's changed from the days when I trained where you could move specialities relatively easily. Now you go down a path and you're sort of stuck there. So, I do think that we need to increase exposure to general practice and actually look at schemes whereby we mentor medical students and whereby we mentor foundation doctors, because they value it. When they come to the practices, the feedback from practice education is extremely high and very positive. We all stay in touch, but we need to develop those links further to make it more attractive for people to think about general practice.

[459] **Elin Jones:** Would you support something that's in the Wales Deanery paper later on this afternoon, where they talk about medical school placements? They suggest that there should be significant quotas for appointees to Welsh medical schools, with proof of Welsh residence, so that the medical schools in Wales have a set quota for giving places to young Welsh people then, I guess, from Welsh schools, and that that would help retain those young people in Wales to become doctors.

[460] **Dr Jones:** I'll let Pete answer that formally, but yes, I would support the deanery's

comments there, but also, I know of students who come to me who want to do medicine as a career, so they want to come to me for work experience, and I know the challenges they face in even getting as far as an interview, are huge. So, I mean if we've got Welsh students who can get a place anywhere, I think we should support them, with a tieback to Wales. It's my personal view, but I will let Pete give a view on this.

[461] **Dr Horvath-Howard:** I wanted to say, just going back to the beginning of your question on the handcuff—

[462] **Elin Jones:** Hello.

[463] **Dr Horvath-Howard:** Hello. I think you need to be very clear that you do have a retention problem, which is going to hit you a lot more quickly as this graph I have here evidences. So, the recruitment issue is important, but that's going to take years to have any effect on what we're talking about. So, there does need to be an urgent addressing of why people, very much in mine and Phil's age group, would stay in general practice, bearing in mind all the issues that have been outlined in this paper, because that's going to come first. And if that predicates efforts to improve on recruitment, it could be too late. So, I think the handcuff/hello things are similar, but very different, in the sense that there has to be a very quick assessment of how we keep GPs in their middle 50s in the job.

[464] **Elin Jones:** So, you handcuff the older ones and you hello the younger ones.

[465] **Dr Horvath-Howard:** You handcuff the older ones and you hello the younger ones, yeah.

[466] **Dr Jones:** And the handcuffs would incentivise the older generation, because it will not be about finances, in the main. What is staggering though, and I don't know if the committee is aware of this, is that at no point does an exit discussion or interview happen with those GPs who indicate a want to retire. To my mind, they may not have thought of alternatives as to what they could offer the NHS in Wales. Sometimes, they want to be removed of the partnership burden and they solely want to see patients, which is actually what most of us want to do most of the time. I think we need to really start making sure that health boards have those discussions with the older GPs at the time when they indicate that they're thinking of retiring, to find out if there is anything that they could do to help them stay within the NHS in Wales, even if it's for one morning a week. The expertise that we lose year-on-year with retirement is enormous and, as Pete says, it takes time to train up the younger generation to be as experienced as before.

[467] I think there are some elements for the older doctor, which maybe Phil would like to touch on, because we've had some thoughts subsequent to our paper—

[468] **Dr White:** You're calling me old now, are you? *[Laughter.]*

[469] **Dr Jones:** Well, you're retired, darling; I think it's fair to say.

[470] **Dr White:** Semi-retired.

[471] **Dr Jones:** There are things that sometimes do push GPs to think, 'Well, the indemnity fees for me to carry on in practice don't make it financially sensible', or actually, 'Oh goodness me, I'm going through a revalidation next year; do I really want to go through the hurdle of that?' It can just be something fairly minor, but it could be just enough to tip the balance of a decision. But Phil is probably better to speak about this.

[472] **Dr White:** Nobody actually asked, and when I took my pension and then came back

half- time, three of my contemporaries in the Bangor area—they were the same age as me—just gave up, and I don't think anybody asked them, particularly, why. They told me they were just sort of fed up of all the hassle and that was it, and they were going to enjoy retirement, but—

[473] **Dr Jones:** And if you look at pandemic flu, for example, we could have utilised an enormous swathe of people who were quite happy to come in and help, but we couldn't because of the challenges of reintroducing them to the workforce. So, there are things that Welsh Government needs to look at about retaining our current expert GPs while we look at the more innovative models, which are not just about GPs; it's about the wider practice and community teams.

[474] **David Rees:** We've got a few more questions. Just one quick point. [*Inaudible.*]—because of the golden hello. Do you have any figures as to what percentage of people have stayed as a consequence—those who took the golden hello?

[475] **Dr Jones:** I wouldn't know, because I didn't actually administer it. I was just luckily one of the ones in receipt, but there should be figures from the health boards. They should have those figures as to who they were given to, and then you can follow the career progression of them. I absolutely think, though, that if Welsh Government is making a significant investment in somebody financially that it is not unreasonable that you have some tie-in to service provision with it. As I say, that's a personal view, but I would be surprised if that would not be the view of the GPC in Wales.

[476] **David Rees:** Okay. John.

[477] **John Griffiths:** On that point, I think a lot of people would say that it does obviously take a lot of time and a lot of money to train GPs, and I think most people would think that an expectation or a requirement that a certain minimum period is spent in the national health service is not an unreasonable stipulation, but there are obviously all sorts of ways of trying to achieve that, which, perhaps, we need to think about. Sorry, I just think, in passing as well, that what you say about retired and retiring GPs has a lot of strength, Chair, and I think that's something we would want to give quite a bit of consideration and thought to, because the ability to work on with flexibility and to be part-time rather than full-time, I think, is something that appeals across the piece in terms of occupations and, obviously, there's great strength in that for GPs as well. I'm sure that could be quite attractive. There must be very considerable numbers in Wales of GPs who, you know, are fairly newly retired and, indeed, are coming to the stage where they might think about retirement. So, I think that's going to be an area that this committee will want to give considerable thought to.

[478] **Dr Jones:** And, certainly, it's like a lot of things—. When doctors take career breaks, wherever they are, they're not often aware of how they can keep in touch without having to go through the hurdles then of returning to the workforce. I certainly think that a lot of GPs just aren't aware, maybe, of the options available to them to, you know, enable them to continue contributing to the NHS. I know that a lot of my colleagues have exactly those problems, and when I hear that a partnership is under strain I often give the doctors a ring and have a chat to them about options. It's surprising the lack of knowledge of what is available out there, and I think that's a real shame. I think that's something we certainly need to develop, and also using our older GPs to mentor the younger generation coming through. I think that's a really important fundamental role that our older GPs have to get them to embrace the wider NHS in Wales, really.

[479] There are huge opportunities here in Wales—enormous opportunities—we just need to grab them and, maybe, move steadily away from the traditional model, but offer a variety of options so that people are excited about coming to Wales, giving them opportunities to go

through the geography of Wales and just keep them in the workforce, perhaps starting as salaried and moving into a hybrid role, doing a bit of ENT or casualty, and then moving them into the partnership model as they feel that they're able and willing to do that. And I think we need to think about how we can move away from individual small practices, which can be very off-putting to a younger GP, who may not want to work, you know, in that sort of isolated way. I think, you know, sometimes we've got to grasp the opportunity to say, 'You need to start thinking about maybe looking at a slightly different way of providing care and working with, you know, other local practices, thinking about using other allied healthcare professionals', and it would be a far more satisfying job, I think, for them. And it might, just might, be an opportunity here in Wales to drive that forward. It a little bit disparate in England at the moment and in other parts.

[480] **Dr White:** Part of the problem isn't that we're training them up and they're disappearing. We're short on numbers applying to train. What you're talking about—the younger doctors going abroad—they've perhaps got £60,000 or £70,000 of debt, and if you've got the Australian Government or the New Zealand Government offering you so much per year you stay over there to pay off your student loan, what are you going to do? That's it, you know; you can't turn around and tell them, 'Oh you've got a debt; stay in this country—we've educated you'. You tell somebody with that amount of debt that they owe the country something.

14:00

[481] **Dr Jones:** One of my colleagues, my counterpart in Northern Ireland, told me about Emirates airline coming over to Northern Ireland to recruit GPs to look after their staff, and they lost about five or six just recently trained GPs to there, because some of them were ladies with children, but they were offering private education, they were offering free first-class flights back, a nice holiday, and a significant amount of money tax free. You know, there is a package there, isn't there? It's quite difficult. Maybe we could do the same for Wales. [*Laughter.*] Dragon air.

[482] **John Griffiths:** There are obviously lots of issues around all of that and different ways of dealing with it, but I just wanted to ask a further question about the more deprived areas in Wales and what you would say to the committee, really, about the particular issues in terms of recruitment and retention, and an adequate level of service in those more deprived areas.

[483] **Dr Horvath-Howard:** I think the word 'deprived' gets used a lot, but, you know, there are lots of different kinds of deprivation. The one that tends to spring up on the news is the inner-city deprivation. I work in a very rural area. You know, I go up to a lot of hill farms where there's a very different kind of deprivation, but it's real nonetheless. I think the issue in a nutshell, really, is, again: how do you attract professionals with a choice? As Phil says, you're looking at now, due probably to 10 years of concerted bad publicity from the press and, possibly, lack of support on our behalfs, youngsters who are not even considering general practice as an option. So, you can't really even tie them in if they're not considering it as an option. How do you, on top of that, encourage them to go to work in areas where, let's face it, there are challenges, in terms of, you know, the workload, the environment? And, with those young people come spouses, who will also be looking for jobs, will be looking for schools. So, from the rural perspective, if you accept the fact that there's an entity called rural deprivation as well, which might have different challenges, but are real nonetheless, the difficulty is: how do we make it attractive? And it's an ever-changing ball game, really. When I first came to general practice, everybody had to do out of hours, so you may as well go to a rural area where you had the beauty of the area and you had the hobbies and the pastimes and whatever. When out of hours started changing in the urban areas, suddenly we became a bad choice, because it took us many further years to get out of hours sorted out in the rural areas.

It had to be a change of legislation for us to do that. So, there are lots of external factors, including socioeconomic factors, that affect that. So, in a nutshell, it's: how do you attract professionals? You know, where's the premium for a professional to take on those additional challenges, when they've got the choice?

[484] **Dr Jones:** I think we also need to increase exposure to rural health programmes, and I think, across all healthcare providers, actually—students as well—to the beauties of working in rural practice, and to the difference in rural practice, as well. I know that they've had rural practice programmes in various places, and some have been successful, some haven't, and maybe that's something for Welsh Government to look at, to utilise the learning from what has worked well and what hasn't, and why not. In the Scottish highlands and lowlands, although they've managed to maintain a GP workforce, I would argue they rotate around very, very quickly—there's a churn there every two or three years—and that sadly came down to purely money and for as long as the person could stay in such a remote area. It's not like that in rural Wales, but there are certainly ways that we could improve exposure to rural medicine, and I don't think the medical schools do enough of it, and I don't think we do enough to promote either.

[485] **David Rees:** Okay. Thank you. Before I ask Kirsty to come in here, I'm just going to make a point that I want to make. Obviously, I also look at the inverse care law. Dr Julian Tudor Hart clearly put that together 40 years ago—in my Afan valley, as it happens. To quote my predecessor, I've worked alongside him, so, when I look at some of the issues, I do look at where the inverse care law applies in that sense. So, I think it's also attracting people into those areas where we're seeing that happen.

[486] **Dr Jones:** And I think, to be fair to Welsh Government, we're very grateful for the recent announcements of the investment, particularly for primary and community care and how some of that has been allocated to looking at some of the inverse healthcare issues and inequalities, and looking at new models of care, and it would be really interesting working through the detail of that.

[487] **David Rees:** Kirsty.

[488] **Kirsty Williams:** Can I ask you about the opportunities and potentials for GP clusters? In your paper, you say that there are real differences across Wales as to how the GP clusters are developing—some not at all, others forging ahead. But you said they will only work if they're given adequate resources and real decision-making power. Well, I understand the resourcing issue, but could you outline what you would regard as real decision-making power that will ensure that the GP clusters achieve their potential?

[489] **Dr Jones:** That is whereby, if a cluster makes a decision that a particular service is needed, they're given the resource whether it be staffing, finance, premises—whatever it is—to deliver that service. All too often, what happens is that a need is identified, a suggestion is given and it is blocked somewhere within the health board. So, we need to have delegation of decision-making powers and to have the resource available for that. So, we need to make them into bodies whereby they can manage community staff under them—maybe not employ them. We need to have them working more closely with their partners, but actually becoming delegated bodies with proper management support to them, rather than what we've got at the minute, which is a bit of a hotch-potch around Wales. In actual fact, one of our discussions this afternoon when we get back to committee is around the clusters—what's working well and what isn't, what support they need and how we can support them to enable them to actually take forward a vision of general practice to meet their local needs, because that's what they're there to do, isn't it? They're there to identify what their local population needs, which isn't necessarily what the health board has determined, because often it's a view centred around a secondary care service, and sometimes primary care is forgotten.

[490] The new announcement of the £6 million for the clusters, it'll be interesting to see how that is taken forward, because I think there are real opportunities in the clusters to have a wider workforce, and actually start patients being aware of how access healthcare services when they need them, and also maybe do more of the prevention agenda as well. But, at the moment, very little actual real decision-making power is given to them, because it seems, as I said, they come up with an idea, they come up with a plan and it is not progressed for whatever reason—it is either inertia or actually maybe it doesn't fit with the plan. That's all very interesting, but the clusters need that feedback.

[491] I think what will be interesting for you as a committee will be to look at the reports when they come out from this year's first year of the contract, with respect to the cluster development domain, which is the first year of the three-year programme. And from that, I think you will see where it's worked very well, because I think you will see real innovation out there, particularly around the virtual ward in Powys and how that's really energised the GP community. But I think you'll also see areas, even within one health board area, where they're not having the support they need. And I think we need to drill into the detail of that, because, obviously, Welsh Government want to move forward and it's where we see the future of general practice sustainability being as well.

[492] **Kirsty Williams:** It seems to me we're almost reinventing the wheel. It's not that long ago, as I can just about remember GP fundholding, and what that did was that go-ahead practices really invested, provided excellent extended care to their lists, and other GPs didn't take up those opportunities. And one of the criticisms of the GP fundholding and one of the excuses why it was got rid of was because, 'Oh, well, it's not an equitable service and we have to have an equitable service'. How can we prevent that from happening again, and therefore ensure that everybody is participating, so that those that are successful and are forging ahead don't lose that opportunity, not because of what they've done, because then we'd get into an argument about services not being equitable?

[493] **Dr Jones:** When we developed our strategy document, we looked at fundholding and the impact of it. What we found was that even among those that weren't engaging, there was a drive-up of general quality and development of services. What I would say is that, for this year, subject to the contract negotiations being agreed, we have actually put it in as a contractual requirement that practices engage in the cluster work. That means that contractually they will have to do it. That's not dependent on them engaging with QOF or the actual domain itself; they have to do it.

[494] We feel that GPs see the potential of it; they're starting to realise that there is a potential of working together collaboratively and what they could do with it. And I think what we're going to need to do is to start those clusters that are further ahead having additional, whether it's additional bodies or workforce, et cetera, so that they can do more. I think once two or three other areas see this is working really well, and the impact that has on patient care, the delivery of service and the demand on them, I think they'll all want it. Certainly, I look to Northern Ireland that have got federations of practices—some of them have got a pharmacist now attached to the practices—and the impact that's having. That's starting to drive other federations getting involved.

[495] So, I think we need to make sure that all clusters have investment and support, but where those clusters are ready to make the next step, maybe into managing community teams, maybe into having proper budgets, that they actually are given it and told to get on with it.

[496] **Kirsty Williams:** Thank you.

[497] **David Rees:** Lindsay.

[498] **Lindsay Whittle:** Thanks for that. I wanted to concentrate on investment and partnership. I was at the northern resource centre at the top of the Rhymney valley on Monday, which has two large practices with a pharmacy, a dental surgery and optometrists; on the ground floor, a day centre and eight hospital beds; and on the first floor were the council's social services and child protection teams. So, it's all singing, all dancing. No issue with attracting GPs there at all. You would never have said that just three years ago, let alone in the past. My own surgery—I'm an Abertridwr guy—is the old Co-op. The butcher's is now the doctor's office, and the fruit and veg is where you see the nurse. So, it wouldn't attract a soul. It wouldn't attract a soul. I think that investment in buildings is equally as important as well—you know, accessible buildings. I wonder what you're doing to encourage that, really.

[499] **Kirsty Williams:** Perhaps it's not the building, perhaps it's you.

[500] **Lindsay Whittle:** No, it's not me; I'm a model patient.

[501] **Dr Jones:** What we're doing is that we're actually trying to ensure that Welsh Government has a premises strategy for primary care, which is sadly lacking. Part of that has been around approving applications for where there are improvement grants to existing buildings or new projects. It used to sit within Welsh Government, both approving it and then appealing, and there was a problem there. There's also some work going on in the legal premises directions, which is going forward. England and Wales tend to mirror each other with that. We have been lobbying and asking, as RCGP have, for true premises investment, not necessarily for new builds, for improving existing structures where it's appropriate to do so, but actually making sure that we can use our community resources to the best—again, thinking of the clusters—for the local population needs. We've been pushing for it. We would love to see significant investment in premises, which has been lacking. We want patients to be able to be seen in premises that are fit for purpose, and, actually, where our patients should be seen in the twenty-first century. We want them to have good-quality premises. I don't want to consult out of poor premises. Actually, I'm lucky enough that I don't, but I think that should be a given, really, for patients in Wales. I don't know whether you want to say more.

[502] **Dr White:** You also need decent accommodation for training. One of the big problems that we highlighted when we went to visit Powys was that most practices wanted to be training practices, but did not have the physical space for extra room for a trainee. Trainees become partners in practices where they train. If you're not training trainees, you will not get the partners.

[503] **Lindsay Whittle:** It's interesting because you don't need golden hellos and golden handcuffs if you can offer them these fantastic facilities. They are coming to Rhymney. They're just volunteering. They're buying into Rhymney. They're not buying in to my surgery.

[504] **Dr Jones:** I don't think that all GPs necessarily want the same thing either, but I think that we should have proper premises to see patients wherever it is.

[505] **David Rees:** Darren. I am conscious of the time.

[506] **Dr Jones:** I'm sorry.

[507] **Darren Millar:** So, from listening to you, you're suggesting that the current models aren't sustainable in terms of the number of people that are being trained, and you suggest that there is a need for 200 training places per year rather than 136, which is currently on the table; that we need a combination of retainers to handcuff people in who might be close to retirement, and perhaps to handcuff those people who are training in Wales in, so that they

stay with us for a period of time; and golden hellos to entice people into Wales or entice people back into the GP workforce, but that's all to meet current demand, isn't it?

[508] **Dr Jones:** Aha.

[509] **Darren Millar:** Yes?

[510] **Dr Jones:** And for the—

[511] **Dr White:** The 200 will be for the future.

[512] **Darren Millar:** The question is: is that going to futureproof the GP workforce to ensure that it is sustainable in the future, given the fact that a lot is moving from secondary into primary care?

[513] **Dr Jones:** That would sustain the general practice element of it, but we need to look wider at the practice nursing and, of course, how we best utilise and work with our other partners, such as pharmacists, for example, and also optometrists, et cetera. Certainly increasing the numbers to 200, provided that you can find the trainees for that, would futureproof the future requirements for general practice to be able to do the complexity of care that we do, but you've still got to look at the wider workforce needs because, with an ageing population, increasing chronic diseases and increasing complexity of care, we are going to need more of everybody if we are truly going to move the care closer to the patient at home.

[514] **Dr White:** Don't forget the out-of-hours service. That depends on GPs, and that's been sadly neglected. A lot of the problems in secondary care arise from that neglect.

[515] **Darren Millar:** So, it appears that we've had complete failure in workforce planning, over a number of years, which has led to this retirement bulge, which is about to manifest itself upon the Welsh NHS.

[516] **Dr Jones:** Absolutely.

[517] **Darren Millar:** Is that essentially your analysis?

[518] **David Rees:** Short answer.

[519] **Dr Jones:** I think that that's exactly what we've said in our 'General Practice: a Prescription for a Healthy Future' strategy document: that there has been a complete failure of adequate, robust workforce planning.

[520] **Darren Millar:** So, how can we make sure that the workforce planning arrangements for the Welsh NHS in the future are right, so there doesn't have to be a crisis on the horizon before we tackle it?

14:15

[521] **Dr Jones:** Well, what you'll find from the proposals for the cluster development next year is that we're going to get actual proper workforce data within each individual practice, and indications of what the nurses and doctors within that practice currently are thinking of. Then you need to look at the health board's intermediate care plans and the requirements for primary care staff within that, and then you need to model it up. Welsh Government needs to look to—. I would argue that the National Leadership and Innovation Agency for Healthcare possibly needs to utilise some of the resource and intelligence from the Centre for Workforce

Intelligence and other parts of the world that have got more robust workforce governance than we have, and then they utilise all of that to come up with a proper workforce plan for Wales.

[522] So, it's something we've been pushing for, repeatedly; we've been saying that general practice tends to get forgotten about and actually, I don't think it's forgotten, I think it's in the 'too difficult' box a lot of the time.

[523] **Darren Millar:** Do you think that part of the problem is that everybody knows that we need these 200 training posts, but we can't fund them? You know, there's insufficient resource available.

[524] **Dr Jones:** That would have to be something to discuss with the deanery, because that's not something that—. We get told that we're not going to find the bodies for those 200 places, and I say, 'Well if you could fund them and you could find them, would that be a problem?' and nobody ever gives you a straight answer on that.

[525] **David Rees:** We'll ask the deanery when they come in.

[526] **Dr Jones:** Yes. To be fair, it might be that it's a question for the wider Welsh Government, 'Would you fund it if we could get them?'

[527] **Darren Millar:** Are there some health boards that are better than others at forecasting their workforce needs?

[528] **Dr Jones:** I'd say it's pretty—

[529] **Dr White:** I don't think it's a matter of forecasting. I mean, ideally, you'd replace people who are due to retire with youngsters, but the youngsters aren't there and it isn't so much a sort of Valleys problem; it was a Valleys problem in the 1960s, but it isn't so much a Valleys problem now. The worst areas are actually parts of rural Wales.

[530] **Darren Millar:** But it's actually false to assume that everybody who has trained in Wales will stay in Wales.

[531] **Dr Jones:** Yes.

[532] **Darren Millar:** Because we recruit from over the border as well, don't we?

[533] **Dr Jones:** Yes.

[534] **Darren Millar:** So, there's got to be a discussion on a UK basis too, yes?

[535] **Dr White:** Well, there've been problems with recruiting from across the border until recently, because of restrictions on performers lists, which has been a deterrent.

[536] **Darren Millar:** Yes, and I understand they're being tackled, aren't they?

[537] **Dr Jones:** And the returner scheme in Wales is being tackled, as well, in order to make it more appropriate to the needs. There's also been—without wanting to labour the point—the differential in the pay between England and Wales. That is slowly changing, and, as I said, if we can address some of the other pressures, I think that that would only help to encourage more doctors to train and work in Wales.

[538] **David Rees:** Okay, I'm going to call it a point there, because we have come to the end of the session. So, thank you very much for your evidence.

[539] **Dr Jones:** Thank you very much for inviting us.

[540] **David Rees:** You will receive a transcript for any factual inaccuracies. Please let us know if there are any. Thank you very much.

14:17

Ymchwiliad i'r Gweithlu Meddygon Teulu yng Nghymru: Sesiwn Dystiolaeth 2 Inquiry into the GP Workforce in Wales: Evidence Session 2

[541] **David Rees:** We'll move on to the next session, as we swap witnesses.

[542] Good afternoon and welcome. We have Dr Paul Myres and Dr Rebecca Payne, both from the Royal College of General Practitioners. Thank you very much for your written evidence. I appreciate the short timescale we had for the turnaround. Obviously, we have some questions, because we're on a very tight schedule, I'd be grateful if we could keep to succinct answers and I've asked Members to be succinct in their questions, as well. Okay, does anybody want to kick off? Gwyn.

[543] **Gwyn R. Price:** Thank you, Chair. Good afternoon, both. How do you see the key aspects of the role of the GP in the future delivery of healthcare?

[544] **Dr Myres:** I think the GP will still remain a very core part of the delivery of primary care. I think the strengths of the GP coming out in GP training are to be able to provide a very holistic approach to the care of individuals and families, having an understanding of how health relates to work, the environment, family conditions, being able to make an assessment from what often comes out in a fairly incoherent and uncoordinated way from patients who, at times, may be distressed, help them to try to formulate the core of their problem, and then work with them on some sort of plan to help them either to get over their condition or live with their condition. I think that those are very unique skills of GPs. I think that GPs will increasingly work with others in healthcare and social care in the future. I think that they will be working much more as part of teams, with practice nurses, pharmacists, social workers, chiropodists, or whoever might come into the team. I think, given the workforce situation, which I'm sure we'll be discussing, we may need to let go of some of the things that we do and concentrate on the things that we do uniquely well, which, as I say, is making that assessment and management of complexity.

[545] **Gwyn R. Price:** Right. Good answer. Similar? Do you agree?

[546] **Dr Payne:** Yes, similar, and I guess, our role as a team leader. So, we have lots of different professionals in the general practice family, and we see people like pharmacists and practice nurses expanding the role that they play within general practice. It's about having a GP there at the centre that they can come back to for that holistic role and bringing other aspects of care in.

[547] **Gwyn R. Price:** Thank you very much.

[548] **David Rees:** You've mentioned that you see diversification, in one sense, within the whole practice. We are seeing an allocation of funding for that particular purpose. Do you see that that's the way of travel that we actually are taking now in that the GP practice is going to change in terms of what we've been used to, which is basically just a GP and a practice nurse, to far more a combination of professions in one sense?

[549] **Dr Myres:** Absolutely. I think that we have to change. We have to hang on to what

patients value and found useful, which is the personal service, the person-centred service and the continuity. We really have to hang onto those, but I think that we need to realise that there are plenty of other people—other professionals—who can contribute to caring for patients and embrace them and have them with us and try not to be working in lots of separate areas.

[550] **David Rees:** Elin.

[551] **Elin Jones:** Yes, I want to talk about training and new medical students going into GP training. There are unfilled training places. That's an issue. Do you think that part of the answer to that is that we've reached a time where some of the NHS budget should be allocated to incentivising financially young medics to go and train the GPs and then work in the NHS as GPs for a time? There's been an announcement in England this week on golden hellos for new GPs. Do you think that we have reached the stage in Wales where that's going to become necessary?

[552] **Dr Myres:** I will say 'yes' quickly, but then with a big 'but', because I actually don't think it's about money. It's about making the job attractive again. I think, because of the high workload and the high stress among colleagues, it's no longer considered an attractive career. I think that we have to reverse that trend—

[553] **Elin Jones:** In comparison to acute hospital doctors?

[554] **Dr Myres:** Yes.

[555] **Dr Payne:** Can I come in on that? When I did my GP training, actually, if you wanted a work-life balance, general practice was one of the few options that you had, but, with the changes to working conditions for hospital doctors, you actually have a lot more options now. So, I think that that is a big issue. People are looking for lifestyle factors as well as money, and, in common with many rural areas across the UK, it can be difficult to get people to the more rural areas. Looking at where we have our gaps in Wales, it is the more rural—the further west that you go, it appears the harder it is to fill training schemes. We need to look at other factors too. Jobs for spouses is a massive one, because, if you're a GP married to a hospital consultant and there isn't a vacancy for a hospital consultant, you're not going to go to that area. So, it's part of the whole package. I don't think that just money is the answer. We need to look at everything else that people are looking for.

[556] **David Rees:** Okay, Elin?

[557] **Elin Jones:** Even to training places—unfilled GP training places—say, in Bronglais hospital, for example, I think that there are six, apparently, training places and they frequently don't fill that quota every year. So, even in areas where you can't fill the training places, where some of those lifestyle decisions maybe aren't as prevalent in—

[558] **Dr Payne:** I disagree with that, because, if you look at the age of group of people taking up training places, it is often the 27 to 35-year-old age group, and they're people who are starting to have children, often married to other medics, or teachers or social workers, or a lot of scientists as well, and so, even at that stage, they're looking for somewhere to settle for the next three years where their partner can have opportunities too.

[559] **Dr Myres:** In fact, I've spoken to trainees and asked them where they want to go, and they say that, just after they train, most of them still like the excitement of the city life, where their university has been, and, actually, they like that lifestyle and they don't want to change. In many ways, we're never going to persuade these people to come to Wales because they just want to work in cities. They'll come to Cardiff, but they won't come to the areas where the gaps are. It's once they're starting to bring up their children that they're beginning to start

looking as to, 'Where do I want to bring my children up?' So, I think we need to look at the educational provision, because that's clearly what young medical parents are looking at—'What are the opportunities for my kids' education?' That will often make them choose. So, if we can provide good educational opportunities, paradoxically, that's going to help our health service.

[560] **Dr Payne:** Doctors are absolutely obsessed with education. My husband's registrar has crammed his entire family into a tiny flat in Cyncoed just to get his children into Cardiff High School. You can't overestimate how much doctors obsess about their children's schools.

[561] **Elin Jones:** Some fabulous green category schools in Aberystwyth were announced today, so—. [*Laughter.*]

[562] **Dr Payne:** That's what we need to promote.

[563] **David Rees:** John.

[564] **John Griffiths:** We know that one of the issues for us in Wales is the fact that those with greatest health need often receive less adequate healthcare than people in other communities. So, making sure that people in our Communities First areas and other areas of relative deprivation receive a good service in terms of primary care and from their GPs is very important to us. Is there anything that you would say to the committee about how we can ensure that we get the message across through recruitment and retention in those particular areas?

[565] **Dr Myres:** I think incentives work, but I think the incentives are not just financial, as I said before. I think some of the frustration that GPs find is the lack of support services. So, whilst they can make a good assessment of the needs of the people with them, they can't always find the organisations to meet those needs. That's often particularly true in areas that are relatively deprived.

[566] I think, perhaps, among the exciting things on the horizon is this idea of moving towards sort of a social model of care where we actually start using some of the facilities that are already there in the communities, and that's where, I think, it does need the support of local authorities and Government to make sure that the communities have the facilities, so that, when we are aware that there are issues, we know that these needs can be provided. It becomes very frustrating, both for the patient and for the doctor, that, once you've made a needs assessment, the facilities aren't there to help these individuals. So, I think if doctors knew that the communities they were going to were actually going to be well supported, that it was going to be a satisfying job and they would see their patients benefit, that would be an incentive. We do need to encourage people to go back and work in these deprived areas, definitely.

[567] **Dr Payne:** I've worked in some of these areas and it can be so frustrating as a GP, because you see people again and again and you can't fix the things they need. They need the housing, they need work and they're coming back to you for a sick note or back to you for letters for housing. Actually, that joint partnership working with the local authority that could move things forward would make the GPs happier, as well as improve things for the patients, because you'd come home thinking, 'I did something today to improve the lives of my patients', rather than, 'I'm just going round and round in the same circle and nothing's changing for the people I'm interacting with.'

[568] **Alun Davies:** I'm glad you're taking a more holistic approach to this. The BMA seem to have a fixation on money and virtually nothing else and so it's a refreshing conversation. In terms of this wider holistic approach, which you've described very well, I'm

interested to know whether you believe that changing the structures within which the GPs, doctors, will actually work would actually have an impact on this as well. Now, the BMA seemed to be saying earlier that, obviously, they were not happy with a salaried service, but then talked about the stress of running a practice. I'm not sure—. I think what you said would justify that, but, do you believe that the current structures within which GPs are employed is actually going to be fit for purpose in the future?

14:30

[569] **Dr Myres:** The college believes in a multiple approach. It would not sort of say that, across the board, there needs to be any change, but I think we would recognise that, in some areas, the current system may not be the best one. Therefore, we believe there probably needs to be a plurality of choice; the independent contractor status might work very well in some areas and in other areas it won't. You know, we are well aware that, in terms of the health inequalities that are, perhaps, more marked in parts of Wales than in England, the current system of providing primary care in general practice has not addressed those inequalities. That's something that the college would recognise, and therefore we need to look as to whether alternative models might. We need to look for evidence and there is evidence from other countries that alternative models work in some areas.

[570] **Alun Davies:** Sorry, would you mind if I just came back on that? So, the current model is broke, essentially—

[571] **Dr Myres:** No, I didn't say that. Those are your words.

[572] **Alun Davies:** Yes, but I'm interpreting what you're saying, because if it isn't addressing health inequalities for people like those I represent in Blaenau Gwent, then it doesn't work, because it should work for everyone.

[573] **Dr Myres:** I think, as I said, the model works very well and I think there's plenty of good evidence from the reports we get from patients that the current service provided by general practices is very effective. A 90% satisfaction level, you know, is the sort of level that many industries would absolutely die to get. So, we have to accept that patients—

[574] **Kirsty Williams:** Politicians would like those kinds of satisfaction levels.

[575] **Dr Myres:** Exactly. We're quite happy that our satisfaction levels are slightly higher than yours, but that's not being smug. That's just an observation. [*Laughter.*] But, we do accept that there are certain areas of Wales where, actually, you're right—the type of care that patients should now be expecting to get, they're not necessarily getting. Therefore, we should look at whether there are alternative ways of doing it. I don't think we should make assumptions that the model necessarily is broke. It might be the way that we're applying it.

[576] **Dr Payne:** I would add as well that patients in different communities are different and, actually, what doctors are looking for—there's a whole diverse range of that. So, although the independent contractor model works very well for some patients, some doctors, some areas, in other areas, something else would work, just like if you had high blood pressure, one pill would work for you and another pill would work for Paul. Everybody's different. So, we can have more than one model. It doesn't need to just be one way or the other way. We should have that diversity, and that will build in more resilience as well.

[577] **Alun Davies:** But what is the key determining factor? It has to be what is best for the patient and what is best for the community.

[578] **Dr Payne:** That is true, but if we can't get people to work there, then we need to look

wider than just that.

[579] **Alun Davies:** And we're not getting people to work in these places at the moment, as you've just said.

[580] **Dr Payne:** So, they'd be areas to explore other models, but that doesn't mean we need to throw out the baby with the bathwater across Wales as a whole.

[581] **David Rees:** Kirsty, do you want to come in on this?

[582] **Kirsty Williams:** Yes. I'm just interested in other models and what we can do to really, perhaps, enhance what GPs and GP practices can do for their patients and their communities. I'm interested in your views about the potential for GP clusters in terms of delivering better services for patients, but also in your aim to make general practice a more attractive proposition for a young medical student to think, 'That's the kind of place I want to practice my medicine, because it's not just going to be run-of-the-mill GP work. Actually, I'm going to be extending my practice. I'm going to have links into a multidisciplinary team that I call on.' So, is making a success of GP clusters going to deliver better services for patients, but also make general practice a more attractive proposition for younger medical students?

[583] **Dr Myres:** I think GP clusters have a huge potential to deliver a better service for patients, and based more on need, rather than just reacting to what comes through the door, certainly. The college has long been in favour of federations, which is where practices come together to share resources, and if one practice has a particular expertise, that expertise is made available to more. GP clusters are the model that we're going with in Wales. It's not quite the same as federations, because it isn't actually, yet, a business arrangement. So, I think there are huge opportunities. I'm aware that also what we're seeing now is collaboration with local public health teams and general practitioners, which was something quite unheard of in the past. So, the people who are leading GP clusters are beginning to understand and learn about population health and instead of, as I said, dealing with a person who's coming through the door, they are actually looking outside, thinking about the person who doesn't come to the door at all and what is best for the whole population as well as individuals. So, it's a journey. It's quite a long way to go.

[584] Just in terms of the last discussion, I was lucky enough to go with the patient partnership group of the RCGP in London to Bromley-by-Bow. They have a fantastic set-up there of two GP surgeries associated with a sort of community centre, whereby there are things like therapeutic gardens, poetry classes, drawing classes and computer classes. GPs prescribe some sort of social activity, but they don't specify what that social activity is. Then, there is a specialist who then speaks to that person and identifies what their interests are. That person might get pointed to an art class or something. What I was really interested in is that they have actually retained the independent contractor model status within that system. It's not a social enterprise, although the whole thing as a whole is a community enterprise. That seems to be showing huge success in a very disadvantaged ethnic community. So, it was really interesting that the community model, almost a social enterprise model, can fit with the independent contractor status. It can work. I'm not saying it would work in Wales, but it could do.

[585] **David Rees:** It was interesting, in that example, you highlighted the diversity available within the practice as well.

[586] **Dr Myres:** Yes.

[587] **Kirsty Williams:** I'm aware of at least one GP cluster that is looking to set up a social enterprise with their own resources and resources from the LHB to try and meet

community need. I'm just wondering: the BMA said that to make clusters really work you need resources, but you also need the devolution of decision-making power out of local health boards into practices. I guess that would have to come with some kind of devolution of financial resources as well. Do you have a view on whether the powers that GP clusters have are sufficient, or do you think there needs to be a greater devolution of decision making down to those clusters?

[588] **Dr Myres:** I don't think GP clusters have any power at the current status, but they have potential by identifying the needs of their communities to start thinking as to how the needs of those communities should be met and to be able to put pressure on health boards to provide those services to those communities. It is only when they have that influence and that ability to make those decisions that it will make any difference, and of course they will need resources to do that. Currently, the GP cluster leads—they are not all GPs, some of them are nurses and other professions, some are from social care—are given two sessions a week to run a really new and totally different model and it's not adequate. As you're probably aware, in some parts of Wales, they're steaming ahead, and, in others, they're really struggling to get engagement. The potential is there, but unless they're backed by LHBs and given a degree of autonomy by LHBs so they really feel they can make a difference, they ain't going to go anywhere.

[589] **Kirsty Williams:** Thank you very much.

[590] **David Rees:** Obviously, we are talking about recruitment and retention, therefore the question around that is: is the cluster approach you talk about going to be something that would attract individuals into the area? I wonder if it can be something where we say, 'Actually, we've got this, so it's well worth coming here because of these facilities and this cluster approach'.

[591] **Dr Payne:** I don't think cluster working per se is going to be what attracts people. What attracts people is having a satisfying job to go to. Actually, addressing some of the things that are being done in general practice that perhaps could be done by other people can help. Looking at the whole package, so, not just work but the rest of life as well, will help. I think the clusters do give opportunities for special interest to develop, but GPs have always taken opportunities of work with hospitals and developing special interests anyway. So, I think it depends how they develop. If they become more than a talking shop, great. But, we need to see significant development to get to that stage.

[592] **Dr Myres:** I think if clusters begin to support the back-room functions, then practices will begin to be an attraction. I've spoken to GPs and said, 'How much of your time do you think is something that somebody else can do?' It varies from 15% to 50% when you ask people. We think it's probably around about 20%. So, some of the work that GPs are currently doing could be given to other people. GPs could hand over a lot of the management tasks to practice managers, a slightly unrecognised group who do a huge amount for the health service but are not more skilled up. We can pass work down to practice nurses and practice nurses can pass down work to healthcare assistants. We can start involving chiropodists, physiotherapists and pharmacists in particular. If we can use the GP cluster model to shift work off GPs to other people who can do it, then I think we will provide attraction. The days of the single-handed practitioner, wonderful people though they were—and I've utmost admiration for the care that they used to deliver to their population and the dedication that they give—. Actually, it's a very isolating job being a single-handed practitioner, and, probably, it's becoming increasingly unsafe not to have regular contact with your colleague. Again, clusters actually will allow that model to survive, because you'll be able to have relationships with other GPs and colleagues in your area.

[593] **David Rees:** Thank you. Darren.

[594] **Daren Millar:** We heard from the BMA that there's this retirement bulge on its way, and that the problem is perhaps more acute than just sorting the training provision out at the start, and you've talked about the need to look at working practices to make them more attractive, and also focus on the lifestyle that GPs might want to enjoy. But, you also refer in your paper to the Work for Wales medical recruitment campaign, and I just wonder whether you could just expand on your comments and tell us whether you think that was a success, and do you think that more needs to be done to sort this immediate problem out in terms of attracting people into Wales from elsewhere, whether that's over the border in England or further afield in the EU or elsewhere overseas?

[595] **Dr Payne:** I definitely think we need to do more to attract younger GPs, but actually I think we do need to address the issue of retiring GPs. And the changes through revalidation have meant that a lot of GPs are handing back their licence to practice and can no longer pick up the odd session. So, what we're implementing in BCU is, when a GP says that they're going to come off the performers list, we're writing to them to say, 'Please do some out-of-hours sessions; we'll make it easy and we'll help you with your revalidation', because, there are so many boxes to tick and hoops to jump through to stay registered, it's a real issue. So, I think we need to look at the people leaving as well to see if there's anything that can be done to encourage them to keep their licences, even if they're just doing a couple of out-of-hours sessions a month, that still helps out the workforce. But, yes, in terms of reaching out to more people, I think we do need to do more to reach out to people who are qualifying as GPs elsewhere in the UK and bring them to Wales.

[596] I was thinking about this the other day and wondering whether, when people check into hotels or cottages for their holidays, we should have a little leaflet in there saying, 'You enjoyed your holiday—now come and stay; work as a GP in Wales'. But, yes, we definitely need to do more.

[597] **Darren Millar:** But the problems do seem to be more acute in Wales than perhaps elsewhere. Do you think we've had a delayed reaction to the looming sort of balloon in retirement that's appearing? The BMA presented this picture of very, very poor workforce planning, basically, that was leading to this crisis on the horizon that we've got an opportunity now—but it's a short opportunity, a very brief opportunity—to put right. You would agree with that analysis?

[598] **Dr Myres:** We are aware that there has been a crisis on its way for some time. I've been trying to get rid of my retirement bulge—thank you for that term. But, I know that people in my age are choosing to retire early. You know, we are seeing people leave at the age of 58, 59, 60 whereas, previously, GPs would go to 65, 70. I do think that's a workload issue. I know there are issues about pensions and 40% taxation and everything, but I think the real issue is about workload. We're worn out. And I know plenty of colleagues around my age, many of whom are retired, and they all say, 'Why aren't you retired? Why do you carry on working?'. You know, I think we've still got quite a lot to offer. And certainly in north Wales, there is a real problem that the number of people over the age of 45, as Phil White may have told you, is not matched by the younger people.

[599] So, we actually have to attack both ends. The top end is definitely about working conditions and allowing people to wind down and yet retain their really useful important skills, and the other is about attracting people into general practice. The RCGP has just released a video encouraging people into GP, saying what a great life it is. We need to work with our secondary colleagues. I'm afraid there are still secondary—this is the only insult I'll throw out; our secondary colleagues still do tend to diss us in general practice and think, 'You're far too clever to go into general practice'. You may have heard Rebecca talking on the BBC at the weekend, saying that it's a very intellectually satisfying job being a GP; it's

actually more difficult in many ways—the opportunity to share with people over a period of time their life journey through their health, through their ups and downs, is just wonderful, and we need to shout about it. And, with respect, we need you to shout about it as well, because I think we find it very hard when politicians look to be very critical of GPs. We don't get it right; we're not perfect—nobody is, but, actually, it is the best job in the world, when it goes well—no doubt about it.

14:45

[600] **Darren Millar:** Can I just ask you one more thing, and that is about the pressures in secondary care and tertiary care and the extent to which they may contribute to the pressures in primary care and make it a less attractive place to perhaps work? There was a report out by the Wales Audit Office this week. It suggested that some of the problems in our hospitals, and in GP practices, in terms of appointments, are as a result of the very long waiting times that we have for secondary care procedures, elective procedures, at the moment. Is that something that makes it a bit grimmer, perhaps, to be a GP in Wales than elsewhere?

[601] **Dr Payne:** It is not just the waiting list; it is what happens when a patient phones up and says, 'Oh, I'm still waiting', and then, very often, by the secretaries, they're told, 'Go back to your GP and they'll write a letter to expedite it'.

[602] **Darren Millar:** Yes, absolutely.

[603] **Dr Payne:** So, that's the challenge, and, actually, if we could train consultants' secretaries to say, 'Well, you know, it's going as fast as it can; you've got about this much longer to wait', maybe people would feel a bit more in control, and they wouldn't need to come back to us so much. So, that is something. Also, if somebody is on the waiting list, they still need the medication—perhaps pain medication—that's keeping them going in the meantime, and they do keep coming back. So, it does come back into primary care.

[604] The other thing is we get e-mails out saying, 'Please don't admit anybody'. And so, you can feel anxious: 'Oh, am I taking more risk, because I'm trying to protect the hospital?' So, yes, it has an impact, but I don't think the answer is just spending more money in secondary care. Obviously, there are efficiencies that can be made throughout the process, but we know that we can do more in primary care. And so, yes.

[605] **Darren Millar:** I know you've got a campaign, obviously, and—

[606] **Dr Myres:** It's connected to what I've been—

[607] **Darren Millar:** I can see your badges, you know.

[608] **Dr Myres:** Thank you for mentioning the campaign. We've recently had some work done for us in the RCGP UK by Deloitte, and they've been looking at where the money should be. Particularly if you look at the recent crisis in A&E, we would argue that some of that was avoidable. If more resource had gone into primary care, we would be handling a lot of these people better in primary care. We would like to spend more time with the patients that need it. There are some patients that need half an hour, 45 minutes sometimes, you know, and we would like to be able to give them that time and come up with clear care plans, helping them with how they could manage themselves, and also trying to predict crises, when they occur, so there is not so much demand on secondary care. I think our disappointment, as you will all be aware, in terms of our campaign—. You know, it's great that we're getting this money beginning to shift now, but it would have been nice if it had happened two years ago so we perhaps wouldn't be in quite the position where we are. We can't solve all secondary care problems; we need secondary care, but we do support the shift from secondary care to

primary care. We do believe that, by handling things well in primary care, we can take some of the load off hospitals and make them more efficient, but we do need to see that percentage resource shift.

[609] **Dr Payne:** And a big area for that is the out-of-hours side of things, which is predominantly where I work, and it has been traditionally under resourced, and there are times when, if we could respond quicker, people wouldn't give up and dial 999 and end up in the secondary care system. So, more resource into out-of-hours would have, I think, a disproportionate effect on the knock-on into secondary care.

[610] **Darren Millar:** Really? So, in terms of the focus immediately of some resources, just a simple switch into GP out-of-hours service would definitely help to alleviate that?

[611] **Dr Payne:** Definitely, yes.

[612] **Dr Myres:** We don't do simple in the health service—a switch, but not necessarily a simple switch.

[613] **Darren Millar:** But a rapid decision would immediately alleviate some of the problems.

[614] **Dr Payne:** It would, yes.

[615] **Darren Millar:** Okay, thank you.

[616] **David Rees:** Elin, and then I'll ask the last question.

[617] **Elin Jones:** Just to ask you something the BMA suggested, in terms of trying to help the retention and return of the older GP, that every GP that's considering, or is, retiring has a kind of formal exit interview, so that the options that a health board might have for them, or other options for support for trying to retain part of their service to the NHS, are explored fully, rather than just sort of retiring and disappearing out of the NHS completely. Do you think that that idea has some credibility to it, or usefulness?

[618] **Dr Myres:** I think it's worth trying. Let's ask these individuals why they're leaving and what would keep them working for little bit longer.

[619] **Dr Payne:** And put in place administrative support to help them through some of the challenges, because, to stay on the list, you have to go through an annual appraisal, and it can be quite a lot of work collecting the bits of paper. Not all older GP's are terribly computer literate. The vast majority are—I can see Paul shooting daggers at me—but some of our colleagues do find that side of things harder and it might be that, if LHBs put in some admin support for them to do that, they might consider going through the process just a few more times.

[620] **Dr Myres:** I think there's one other area that could make a big difference and which several of us have been advocating for some time, and that's the idea of care co-ordinators. I think one of the most frustrating things, and you may have heard from others, is that we can spend, sometimes, half an hour or an hour planning to get a social care arrangement, trying to get somebody into hospital or trying to insist why this person could be seen quicker. This is not good. We are expensive people, obviously, we are value for money, but we are expensive items, so, you know, it's not good that we should be spending that amount of time. If we could have care co-ordinators, probably based in our practices, who, actually, once you decide you need an endoscopy, you need meals on wheels, you perhaps need to go to an art therapy class or you need to see the community psychiatric nurse—. Somebody else then does all that

organising, focused—with the patient there, so it's done in a patient-centred way. But, we should be focusing on devising those plans, not seeing that they're actioned.

[621] **David Rees:** Okay. The final question from me: in your paper, you mentioned a four-year training speciality. Obviously, that increases the time at the moment. Could that, actually, first of all, be a hindrance to attracting people, because people will want to get trained and perhaps get, you know, into the workforce as soon as possible? Is that an issue that you think is something that the deanery is accepting of, in that direction? How do we manage that?

[622] **Dr Myres:** We very firmly believe that the GPs of tomorrow need to have a longer training programme to meet the needs of the patients and the expectations of the service from them and that, currently, three years to be a highly trained professional is inadequate. If you speak to GPs who have just come off the training scheme and they've got their certificate, they still feel not fully prepared to go out and work as a single-handed or professional in their own right. We need to spend more time looking at mental health, we need to spend more time looking at child health, we need to spend more time looking at safe prescribing and we also need to spend more time understanding quality improvement methodology, how to improve. So, we very much do believe in the four years. The person in their fourth year would be contributing to the service, so this idea that that's another year lost to the service is not true. They would contribute. They would be primarily learning, but they would be contributing to the service. There will be a shortfall for that period of time when we switch from three to four, so, obviously, that has to be carefully managed. But the fact remains that, unless we ensure that our GPs of the future have those additional skills and competencies, we're actually going to struggle.

[623] **David Rees:** That's fair enough. In previous inquiries, we actually had the need to enhance the GP awareness of many conditions. Are there any other questions? Can I thank you very much for your evidence? You will receive a transcript of the session, and, if there are any factual inaccuracies, please let us know. Thank you very much. We'll have a—the witnesses are here—10-minute break, starting back at 3.05 p.m. We'll start at about 3.05 p.m.

*Gohiriwyd y cyfarfod rhwng 14:53 ac 15:06.
The meeting adjourned between 14:53 and 15:06.*

Ymchwiliad i'r Gweithlu Meddygon Teulu yng Nghymru: Sesiwn Dystiolaeth 3 Inquiry into the GP Workforce in Wales: Evidence Session 3

[624] **David Rees:** Can I welcome Members back to this afternoon's session? We'll be continuing our evidence collection for the inquiry into the GP workforce, particularly focusing upon retention and recruitment. Can I welcome, this afternoon, representatives of the Wales Deanery? We have Ms Mary Beech, who is actually, if I'm right, organisational lead, GP speciality, prescribed training.

[625] **Ms Beech:** That's right.

[626] **David Rees:** And Dr Martin Sullivan, general practice associate dean for the deanery. Thank you very much for coming this afternoon. Can I thank the deanery for the evidence it has provided as well? I appreciate that it was short notice and we are very much appreciative of the turnaround on that. Obviously, as every time we receive evidence, we want to ask some further questions on it, so we'll go straight to questions, if that's okay. Gwyn.

[627] **Gwyn R. Price:** Thank you, Chair. Good afternoon to you both. I was reading in your notes that Wales has a much lower recruitment target for GP training than other parts of the

UK. Have you got a view on why this is and what we can do about it?

[628] **Dr Sullivan:** Yes, I'll take that one. As I understand it, the figure, and our annual figure for recruitment, which is 136, was set approximately 10 years ago, with discussion between the deanery and the National Assembly at the time, and that number hasn't changed over the last 10 years or so, despite various initiatives across the board in England recently increasing their number of GP trainees that they intend to recruit. So, we'd very much like to make some suggestions with regard to increasing that number. Of course, it cannot come just as an increase, as we'll go on to tell you. We're not currently filling 136 places, so we'd like to talk about different ways of incentivising trainees, young trainees, to come to Wales to train in general practice. So, we can't do one without the other, but we would like to increase it by making, perhaps, the training experience more attractive in Wales.

[629] **Gwyn R. Price:** This goes back 10 years, when this was first—

[630] **Dr Sullivan:** As far as I understand it, yes.

[631] **David Rees:** Can I ask you a question on that? Obviously, you say the number was given to you by the Welsh Government 10 years ago. Has the deanery had discussions with the Welsh Government to look at whether it should increase that number in that 10-year period?

[632] **Dr Sullivan:** As far as I understand it—. First of all, I'd like to convey the apologies of Professor Malcolm Lewis and Dr Phil Matthews, who are both my bosses and who had already pre-arranged a holiday before the date of this hearing. But they attend regular liaison meetings with the Welsh Government, and I'm reliably informed that they persistently raise this as an issue of concern and have done so for some time, Chair.

[633] **Ms Beech:** I would just add that Professor Lewis and Dr Matthews made Welsh Government officials aware of the increasing numbers in England and the increase in training places in England and highlighted that. They've done that, you know, several times over the years.

[634] **David Rees:** Okay. Thank you. Elin.

[635] **Elin Jones:** Yes, we had a figure from the BMA that they thought there should be 200 GP speciality training places in Wales. Would that be a figure that you would think is realistic? Then, on the issue that you're struggling to fill the 136 that you have, and that may be in particular areas—I don't know; I'll leave you to say whether that's the case. Then there is the role of incentivisation, possibly financial incentivisation, to getting young people—usually young people—to go to those places to train. You've alluded to that. Do you want to, sort of, expand on whether you think that could play an important part in filling those training places that aren't currently being filled?

[636] **Dr Sullivan:** On the first part, the ballpark figures, yeah, I think it's in that ballpark of 200. To bring us up to numbers per head of population that Scotland are training, we'd probably need about an extra 50 or so GP trainees recruited per year, and that still puts us a little bit below England. But that would put us in the sort of ballpark. Of course then, the big challenge is: how do you get them when you can't attract the 136? So, we've made some reference towards the end of our paper about possibly incentivising trainee places financially in certain parts of Wales. Now, historically, we've not had a problem appointing to the, sort of, main part of the M4, with our training schemes along the M4 and the A55, but we've often had a problem recruiting to Carmarthen and west of Carmarthen and north-west, including Aberystwyth and Bangor. Whilst we are very clear that we want to maintain a presence in those areas, and we want to make sure that training thrives in those areas, we are struggling to

attract people away from the urban centres to the more rural parts of Wales.

[637] We'd like to think that, if we can attract them there and they start to put some roots down—. I am the associate dean for Pembrokeshire, so I know what a pleasant place it is, particularly in the summer—maybe less so, as everywhere, in the winter. But I think once people can put some roots down, they may well retain doctors in that area.

[638] **Elin Jones:** Would you go as far as to say that that incentivisation could have, as part of its payback, that people would serve the NHS in that area for the first three years once they've completed their foundation training?

[639] **Dr Sullivan:** I think that's a perfectly reasonable suggestion and, as you may know, NHS England came out with a plan on Monday that suggested that in hard-to-recruit areas. I think that's perfectly reasonable, that if we give a little, they should give a little. And I think that increases your chances of people putting roots down.

[640] **Elin Jones:** Yeah. Can I just ask about one other issue that I found quite interesting and, possibly, unexpected in your paper? That's the issue of medical schools, and medical schools being given a quota of Welsh-domiciled students for entry. You suggest that there's evidence in other countries that, where this kind of proactive policy is operational, it leads to better numbers of doctors staying within country or within locality. Are you able to tell us about any of that evidence?

[641] **Dr Sullivan:** I've done all the talking so far, so—

[642] **Ms Beech:** Yeah, we know that, in Australia, they run a rural residence programme to encourage medical students from rural Australia to go to medical school. And then, the thinking is, and the evidence is, that they go and practice in rural parts of Australia.

[643] **Elin Jones:** It's certainly my experience that some young people, 18-year-olds, have found it extremely difficult to get anywhere near Cardiff medical school even for an interview and they have ended up in medical schools in England—I even know of one in Ireland—and they have ended up then working in the NHS in those areas.

[644] **Ms Beech:** Yes, and I think we do see some of the trainees who apply to train in Wales who have actually done their medical degrees outside, in English medical schools, and they do want to come back to Wales. So, I think if there's a link to the area, it's important.

[645] **Elin Jones:** Good. I was pleased to see it; it's a good idea.

[646] **David Rees:** Darren.

[647] **Darren Millar:** Yeah. We heard evidence, particularly strongly from the BMA, which suggested that the workforce planning arrangements in Wales were what had given rise to what is now on the horizon as a potential crisis if we don't immediately deal with it. As Elin has said, they suggested this number of 200 training places per annum, rather than the 136 that is currently the case. Given that you're working off 10-year old plans, how often are these relooked at? I appreciate that you said that your colleagues were raising this regularly with Ministers. When did they first realise that, you know, potentially, there may be a problem emerging, and that these places were insufficient to meet the demands?

15:15

[648] **Dr Sullivan:** I can't give you an exact number, but I would suggest that, over the last four to five years, they've been raising it with increasing frequency. We were involved in

producing a paper—and I don't quite know where it was submitted, but I think it was somewhere within Welsh Government—commissioned with the National Leadership and Innovation Agency for Healthcare in 2012; Rhydian Owen drafted a paper on workforce planning and suggested then that if the current workforce issues continued, there may well be a deficit at some point in the future. Part of the problem is that we're seeing older GPs, who have worked full-time or almost full-time, throughout their careers being replaced by younger GPs who simply don't wish to work that level. You almost need to train more to compensate, because you're not replacing one doctor for one doctor; you may be replacing one for maybe three-quarters in terms of the time spent seeing patients.

[649] **Darren Millar:** We're also told that GPs—. There's a trend towards them retiring earlier as well, because of their perception of the workplace perhaps not being as they would like it. Can I just ask then? So there's no programme to revisit these numbers on a regular basis. There's not a sort of, 'Let's review it every three years and have a discussion and a formal decision every three years'. It's just, 'There's the plan—I know it's 10 years old, but that's what we're working to, unless somebody tells us we've got to do any different'.

[650] **Ms Beech:** Our funding, you know, from Welsh Government is on the basis of 136 training places per year. We haven't had any indication that we'd be getting more funding to increase the number of places, so—

[651] **Darren Millar:** But you help to inform the Welsh Government's workforce planning, don't you?

[652] **Ms Beech:** Yes.

[653] **Darren Millar:** And your advice has been that that's been an insufficient number for a number of years now and there's been no change in terms of the policy and the cash that's been awarded to be able to put that right. So, what's the formal mechanism that the Welsh Government uses to review its workforce planning arrangements and how—? Or isn't there one?

[654] **Dr Sullivan:** I'm not privy to the discussions that my colleagues have had, unfortunately, so I don't know what the formal mechanism is or should be, but—

[655] **Darren Millar:** Or if there is one.

[656] **Dr Sullivan:** Or if there is one. But, I'm informed that they raise this. This has been on the sort of front line of our agenda for some time. We commissioned a capacity survey, probably two or three years ago, amongst our practices to see if we had the capacity to take more trainees, and it appears that we do. So, we've already, you know, tried to scope that. But I don't know what formal process there is for making a change to that number.

[657] **Darren Millar:** So, just in terms of that capacity programme then, that capacity seems to demonstrate that an additional 50 trainee places, for example, to get us on a par with Scotland, would be easy to accommodate.

[658] **Dr Sullivan:** Easy in terms of we may have the rooms and the buildings to put them in and the number of trainers. There may be some infrastructure investment that's needed. Of course, there is the additional investment of the 50 trainees and, obviously, we wouldn't, at this point in time, wish to destabilise our hospital colleagues, but we may well be able to accommodate that without too much destabilisation of the hospital workforce—if any.

[659] **Darren Millar:** I mean, you've mentioned the fact that more people are wanting to work part-time after they've qualified rather than perhaps full-time. The Royal College of

General Practitioners said in their paper that, of the 136 trained in Wales last year—or perhaps slightly lower than that if it wasn't fully taken up—45 of those went out of Wales after they'd completed their training. You refer, as well, to not monitoring where people go after they've been training, in paragraph 2.6 of your paper. I would have thought that was something essential for you to do, actually. Is there a reason you don't monitor what happens to them once they've finished their training?¹

[660] **Ms Beech:** It's quite difficult to, because once they're out of the—. You know, they've no longer got a national training number and we don't have a mechanism where we can track them, so unless they're remaining on the medical performers list in Wales—you know, that's one way we could possibly—

[661] **Darren Millar:** Couldn't you just speak to the Royal College of GPs? They know where their GPs have gone.

[662] **Dr Sullivan:** It's possible, but some will have gone overseas and so on; some will have left medicine, but it's certainly something that we would be keen to do. The difficulty is trying to catch them all—

[663] **Darren Millar:** Why can't you speak to the Royal College of GPs? Is that not feasible?

[664] **Dr Sullivan:** It's feasible, yeah. It's something we can look in to. We've had difficulties with our returner programme and with doctors returning to practise, which we've managed. We've had a policy of emailing them all over the years to see where they're still working and whether the investment that's been in them to return to practise in Wales has meant that they've stayed in Wales. So, we've done that, but that's a smaller number and they're easier to retain, but even then, the difficulty is trying to make sure that they all respond. They may have dropped off.

[665] **Elin Jones:** But, an interesting start to this would be those on the Wales practice list, or—. You'd be able to access that information to know how many are practising in Wales, percentage wise.

[666] **Ms Beech:** Yes.

[667] **Elin Jones:** Do you have any idea, of the 136—if there are 136—what percentage does it look like work in Wales? Is it 50%, 70%?

[668] **Dr Sullivan:** No, we don't, but we could find that out and we could report back to you on that.

[669] **Darren Millar:** So, there's a possibility of being more sophisticated in tracking those individuals in order to better inform the work planning processes, if there is a formal regime that can be established for revisiting those numbers in the future.

[670] **Dr Sullivan:** Sure, yes.

[671] **Darren Millar:** Okay.

¹ For clarification, the Royal College of General Practitioners would like to assert that: the figure of 45 referred to in the question relates to medical graduates in general rather than specifically to medical graduates specialising in general practice.

[672] **David Rees:** You've surprised me a little bit, because most education institutions are actually required now to actually put down where graduates go—destination surveys—and they actually have to be on the websites for people applying. So, you've surprised me a little bit that that actually isn't achieved.

[673] **Lindsay Whittle:** Just a small question on that: I can't understand why we're told that so many students training in Wales want to return back to their country of origin, but Welsh students training in England don't want to return back to Wales. Or so it seems.

[674] **Darren Millar:** Well, I suppose you don't know the extent of that, either.

[675] **David Rees:** Well, it's not fair to ask the Wales Deanery what's happening in England with people going back—

[676] **Lindsay Whittle:** It doesn't seem right.

[677] **Dr Sullivan:** I'd just like to say I did. [*Laughter.*]

[678] **David Rees:** John.

[679] **John Griffiths:** We heard earlier in taking evidence today that there might be quite some benefit in terms of retaining GPs longer in practise, rather than them retiring, and that there is a tendency now to retire earlier than was previously the case. In your evidence, you say that it would be beneficial to have schemes that could, effectively, retain GPs for longer. We know that greater flexibility and part-time working might be quite appealing to GPs in that context. Have you given any thought to what sort of schemes might be most effective in terms of greater retention of GPs longer into their working lives?

[680] **Dr Sullivan:** That's a good question. I can give you an answer as a GP. It's not specifically, I guess, our remit in terms of the deanery and in terms of training GPs. I think, perhaps giving them the opportunity to consider continuing to practise without having to deal with a lot of the bureaucracy that partnership brings and a lot of the form filling and targets, and so on, that they've had to adapt to in the last 10 to 20 years, and actually get back, probably, to the job that they saw themselves entering into, which was seeing patients in the first instance.

[681] I can't really give you any sort of specific answers as to what would really retain somebody in the profession, because they're probably making a lifestyle choice, really, with regard to reducing the, sort of, high stress days that we all experience, for better days, really. What would retain them? I don't know. I think, if you're talking about terms and conditions, it would probably take a significant investment to retain doctors at that stage of their career when they've actually already worked for, say, 20 or 30 years and made that decision to reduce, anyway. Maybe reducing the bureaucracy, maybe enabling them just to get on and see patients, possibly in, I guess, a salaried model, or something like that, which would reduce the bureaucracy that they'd have to put up with as partners.

[682] **John Griffiths:** Okay. Can I just ask, as well—you've touched on it in your paper—about particular geographical areas where there are particular shortages? I'm particularly interested in Communities First areas and areas of greater relative deprivation. I think we all know that there's the inverse care law, which often results in those communities receiving a lesser standard of service rather than a greater standard, which you would expect in terms of the health needs in those areas. So, you know, it does make recruitment and retention all the more important, I think, in those particular places. Is there anything that you could tell us today in terms of how the health service might be more effective in terms of recruitment and retention in those particular places?

- [683] **Dr Sullivan:** Okay. I don't know which particular area you represent.
- [684] **John Griffiths:** Newport East.
- [685] **Dr Sullivan:** Okay. Well, I know that it's not Newport East, but we just approved a practice in Blaenau Gwent, a training practice, this morning, which is a step in the right direction.
- [686] **Alun Davies:** I represent Blaenau Gwent.
- [687] **Dr Sullivan:** I didn't know that. In fairness to me, I didn't know that.
- [688] **Alun Davies:** Where in Blaenau Gwent?
- [689] **Dr Sullivan:** Blaenavon.
- [690] **Alun Davies:** Blaenavon?
- [691] **Dr Sullivan:** Yes.
- [692] **Alun Davies:** That's in Torfaen.
- [693] **Dr Sullivan:** Oh, I beg your pardon. [*Laughter.*] Mary will have to inform me, but I know that Phil Matthews, the head of school, submitted a paper. I don't know who he submitted it to.
- [694] **Ms Beech:** It would have been to whoever was the health Minister at the time.
- [695] **Dr Sullivan:** Okay. You'll probably get the RCGP talking about a four-year plan of training and expanding training because a lot of trainees feel that they're not ready to enter independent practice after three years. We thought of an idea of, I guess, a hub-and-spoke model of those fourth-year trainees with a good degree of experience practising with a degree of autonomy where the hub could be their training practice and then the spoke could be an area that is deprived or under-recruited in terms of general practice, and they would spend the majority of their week there with still the umbilical cord, which is their practice. We think that that's quite an attractive model and also quite good experience for them because they realise that sometimes the protected world of their training practices is not always a real world.
- [696] **David Rees:** Kirsty.
- [697] **Kirsty Williams:** Could I ask you about paragraph 4.3 of your paper, which talks about Wales as having the lowest exposure at foundation level to GPs? So, they're doing their training and we've got fewer medical students experiencing some general practice as part of their foundation training than anywhere else in the UK. When you say, 'Fund a significant and permanent increase', what kind of ballpark figure are we talking about, resource-wise, that would be needed to get us up to the UK average of 55%? I mean, how much money would we have to spend to do that?
- [698] **Ms Beech:** Off the top of my head, I couldn't supply the exact figure, but—
- [699] **Kirsty Williams:** A note would be fine.
- [700] **Ms Beech:** I think that, apart from the funding, the issue in terms of creating new

foundation rotations with a general practice element in is it would mean decommissioning a hospital post that's currently in a three-year rotation. That's where some of the problems occur, because those foundation doctors are contributing to the on-call rota in the hospital, and that's where we struggle sometimes to try and create a new rotation. Having said that, we have got a couple places where the F2 in general practice continues to stay on the on-call rota and so is providing the service in the hospital but still getting a general practice experience. In terms of the cost of it, I mean, the additional cost to having people in hospital posts is the trainer's grant, which is about £8,000 per year that they receive. So, if we were increasing, that would—. I can't work it out in my head, but going up to 55%—

[701] **Kirsty Williams:** Do you think that the reason why we've had only a small uplift for academic years 2014 and 2015 is a problem relating to money, or is it a problem relating to not wanting to make a difficult situation with rotas for paediatrics and other specialties even more difficult?

[702] **Ms Beech:** It's a combination of the two, and those extra posts—to bring it up to 30% for this year—are being funded out of our underspend in our GP registrar budget for this year. So, it's not sustainable going forward because it presupposes we'll never reach our target of 136 registrars.

[703] **Kirsty Williams:** Okay. It's a bit like chicken and egg, isn't it? Because, if we don't expose students to a general practice, we're never going to fill our 136 places.

[704] Can I ask about, then, funding to move from 136 places up to a more realistic proposition for what we need to be training? What kind of costs are associated with that? What kind of level of investment would you have to see to add those 50 or 60 places?

[705] **Dr Sullivan:** I wouldn't want to give you—

[706] **Kirsty Williams:** Could you write to us?

[707] **Dr Sullivan:** Yes, if you want.

[708] **David Rees:** That would be helpful.

[709] **Dr Sullivan:** Absolutely.

[710] **Kirsty Williams:** That would be really helpful. Finally—

[711] **David Rees:** Can I ask a question? If you're going to write, could you write very quickly to us because we've got a very tight timescale?

[712] **Dr Sullivan:** Yes, sure.

15:30

[713] **Kirsty Williams:** Finally, on paragraph 4.5, you talk about postgraduate qualifications. I remember coming to see Professor Gallen to talk about the possibility of creating a postgraduate qualification for GPs practising in rural areas, because often they are practicing really at the, you know, far end of competency; they're doing a lot more than, perhaps, a GP in a more urban setting would do. I received—I think I can say the words—'short shrift' that such a thing was helpful or necessary. I'm just wondering, could you talk about why you think it's important to have put postgraduate qualifications in your paper as a way of incentivising people to look at general practice? Because I, personally, can see the value in it.

[714] **Dr Sullivan:** I think this is something we'd seek to expand into a fourth year of training, rather than fill an already compacted three years, with all the assessments they have to do. But, yeah, we could look at whether it's some form of accreditation or qualification for rural healthcare, appreciating that it is quite difficult, compared, for instance, to me in the centre of Swansea, and also for those who want to embark on some form of clinical leadership, or become a GP with special interests, et cetera, et cetera. So, there would be opportunities, but I have to say that the current three-year programme is pretty tight, just in getting them through the number of assessments and getting them up to speed in terms of practicing independently.

[715] **Kirsty Williams:** Sure. So, paragraph 4.5 is realistic only if we move to a different model of training GPs in the first place.

[716] **Dr Sullivan:** I think so, yes.

[717] **Kirsty Williams:** Okay.

[718] **David Rees:** Can I expand upon that, before I bring Elin in? Obviously, the RCGP have talked about a four-year training programme for GPs. Is that postgraduate qualification that you're talking about in addition, if they wanted a four-year course, and on top of that again? Because they identified four years to actually develop the skills and knowledge on a wider range of subjects for GPs. So, is this going to be in addition to that, or would it form the four years?

[719] **Dr Sullivan:** Theoretically—and I am being theoretical—I would say that that would be part of the four years. For instance, we currently offer four-year training programmes for our small number of academic trainees. So, for instance, there's one in my practice who's pursuing an MSc in medical education, and there would be a variety of others across Wales—a small number. We've created a little bit of extra time for them to do something with that that's relevant to the service. So, I wouldn't say it's four years plus, I'd say it's four years within.

[720] **David Rees:** And are there any examples of this actually happening elsewhere in the UK?

[721] **Dr Sullivan:** I'm not aware of any. I'm certain that there are in terms of four-year training. We piloted some four-year training programmes two or three years ago—

[722] **Ms Beech:** Yes, about three ago.

[723] **Dr Sullivan:** Yeah, and there was a sort of mixed response, really, amongst trainees. Some thought it was extremely useful, and others less so. So, I wonder whether the case for it being made to all trainees is a case that the college have made and they believe in it. I think it's probably more useful to spend a significant amount of that time getting trainees up to a certain level of speed and proficiency and independence as well as letting the, let's call them 'high fliers', if you like, develop extra qualifications and so on, if they deem fit.

[724] **David Rees:** Okay. Elin.

[725] **Elin Jones:** You know this note you're now sending us, I wonder if you could include in that information on where the unfilled places are, say over the last three years—

[726] **Dr Sullivan:** Yes.

[727] **Elin Jones:** —the number of unfilled places and where they are. You've already alluded to the places, but I'd just like to see the actual stats on it. Then I wanted to ask you about paragraph 4.4, where you talk about the salary supplement for GP trainees and the fact that that was reduced, and you think it should be restored. Am I right in thinking, then, that what that means is that, if you're a GP trainee, you're actually getting less than if you were a hospital specialty trainee? So, there's almost a financial incentive to take people towards the hospital training, rather than the GP training. Who would need to take the decision to restore that? Who's the decision-making authority there? Is it the health Minister, is it the individual health boards, or is it you?

[728] **Ms Beech:** It's not the deanery. [*Laughter.*]

[729] **Dr Sullivan:** If I could do that—. [*Laughter.*] I think the first thing to say is: yes, you're right. We looked at this on Tuesday. It depends upon the banding of the hospital job and the intensity of work of the hospital job. So, I don't know the bandings of all the hospital jobs in Wales, but suffice to say, somewhere like accident and emergency departments, for instance, would be highly banded because of the intensity and would attract a greater sum of money. But, yes, there is the obvious disincentive of taking a pay cut if you wanted to enter general practice training, rather than hospital training. So, yes, we could explore that, but we suspect that that is a factor in making that decision.

[730] **Elin Jones:** Then the authority to restore this supplement, where would that lie?

[731] **Dr Sullivan:** I would suspect it would lie with Welsh Government.

[732] **Ms Beech:** Yes, I mean, I think it's part of the national negotiations done by the doctors and dentists review board, but I don't know how much scope there is for Wales to do something different to the rest of the UK.

[733] **Darren Millar:** So, that's the same in other parts of the UK?

[734] **Ms Beech:** Yes, it's across the UK. Yes.

[735] **Darren Millar:** So, it's not as though they're disadvantaged in Wales.

[736] **Ms Beech:** No, no.

[737] **Kirsty Williams:** So, it's like a pay review body?

[738] **Ms Beech:** Yes.

[739] **David Rees:** Okay. That's important. Darren.

[740] **Darren Millar:** Yes, I just wanted to ask—. You made reference in paragraph 2.10 to GP out-of-hours services and that, you know, some GPs choose to earn their living that way. Is that something that perhaps could be further developed in terms of training, so that that is the niche, as it were? Are we missing a trick in trying to sell, you know, the sort of more old-fashioned GP practice approach when people, actually—some will want to be salaried GPs, but some may actually just want to be out-of-hours GPs and do three 12-hour shifts or whatever it is each week and then that's it? Is there a particular way that that could be developed into a special training scheme? I don't know.

[741] **Dr Sullivan:** Well, all our trainees get experience of out of hours. It's mandatory that they have to do a certain amount of out of hours, and part of that supplement is historically to recognise that, although the number of hours has reduced over the years. I guess that,

naturally, what happens is that, when a trainee comes to the end of their post, they'll do some locum work in a variety of practices, possibly a part-time salaried post and then some out of hours. I know that's what I did and I know that's what my trainees do now when they leave my practice, so it kind of naturally happens. Some doctors are appointed to work full time in out of hours, and I remember when I helped to set up the existing Swansea out-of-hours service 10 years ago that we employed one or two young doctors to work exclusively in out of hours. It's part of the gap that needs to be filled by GPs finishing their training. Some do it because they like it—they like the flexibility it gives them.

[742] **Darren Millar:** The variety, and—.

[743] **Dr Sullivan:** Yes. And most units are working alongside casualty, and, you know, that may be a draw for them, but then others choose not to do it for personal reasons, for family reasons and so on.

[744] **Darren Millar:** I mean, there have been big pressures, haven't there, trying to recruit into out of hours in some parts of Wales? I mean, particularly in my area in the north there, there have been all sorts of issues with ensuring that there is sufficient cover for rotas. I just wonder whether the opportunity to sell out of hours specifically as something that you don't do just a little bit of and dabble in in addition to your practice work but something that you choose as your career path, whether that is being properly exploited or not.

[745] **Dr Sullivan:** We did a survey last year or the year before—

[746] **Ms Beech:** Yes, last year.

[747] **Dr Sullivan:** —on GP trainees' out of hours experience, and, lo and behold, most wanted to work in out of hours where they had a positive experience in out of hours. Now, I appreciate that it's a vicious circle. If the experience isn't good, they don't want to work in it, but that was quite clear. At least we've got 43% wanting to work in out of hours—not full-time but for a significant part of their time—but it's relating to the experience they get in the first place.

[748] **David Rees:** Okay. Anyone have any further questions? Okay. Thank you very much, therefore, for your evidence this afternoon. I've just got one final point. Obviously, the deanery offers all postgraduate qualifications in Wales, all specialities. When people choose other specialities perhaps and do not pick being a GP, do you actually discuss with them their reasoning and their thinking so you have an idea actually why they're not going into GP training?

[749] **Dr Sullivan:** We don't formally discuss it with them, because they don't become part of our world. I can give you anecdotes as to why they don't. My godson's currently choosing—he's an F1 and he's choosing where he wants to go. There is still a feeling and a perception within medical school that general practice is second-best, that it's a second choice if you can't get to where you want to go. It doesn't have the bells and noises and atmosphere of an A&E department, but then it doesn't have the unsociable hours of an A&E department either. So, there's definitely a perception in medical school and amongst medical students that it is not the desired first choice for a variety of reasons.

[750] **David Rees:** So, in a sense, exposure, as Kirsty pointed out, could be a critical element to actually make them realise the differences between the different pathways.

[751] **Dr Sullivan:** Well, if I may, in the North Western Deanery, which was Manchester but has just merged with Liverpool as well, they had 95% exposure to general practice in the second year of the foundation programme and, lo and behold, they haven't had a recruitment

problem for general practice.

[752] **David Rees:** Okay, that's interesting. Thank you very much. You will receive a copy of the transcript for any factual inaccuracies, and if there are any, please let us know, and we can correct it. Thank you very much for your evidence this afternoon.

[753] **Ms Beech:** Thank you. In terms of the information we'll submit, do we send that—

[754] **David Rees:** Send it to the clerk.

[755] **Ms Beech:** To the clerk. Okay.

[756] **David Rees:** Yes, please.

[757] **Ms Beech:** Thank you.

[758] **David Rees:** And as soon as possible because of our turnaround time.

[759] **Dr Sullivan:** Sure. Thank you.

[760] **David Rees:** Thank you very much.

15:40

Papurau i'w Nodi Papers to Note

[761] **David Rees:** If I can invite Members, therefore, to come on to next item of the agenda, we have some papers to note: the minutes of the meeting of 15 January 2015; correspondence from the Minister for Health and Social Services regarding the legislative consent motion in relation to the Medical Innovation Bill; and correspondence from the Petitions Committee regarding P-04-600, Petition to Save General Practice Wales, and, as such, obviously there's—

[762] **Darren Millar:** Noted.

[763] **David Rees:** Can we note all those?

[764] **Darren Millar:** Yes. [*Laughter.*]

[765] **David Rees:** I have written back to, or I will be writing back to the Petitions Committee, basically to inform them that we've done this afternoon's session and we will be writing to the Minister and that, obviously, we'll wait for the Minister's response on the workforce plan.

15:41

Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod ac o Eitem 1 y Cyfarfod ar 4 Chwefror 2015 Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from the Remainder of the Meeting and for Item 1 of the Meeting on 4 February 2015

[766] **David Rees:** Therefore, in that case, in accordance with Standing Order 17.42(vi), we agree to meet in private for the remainder of this meeting and for item 1 of the meeting of 4

February 2015.

Cynnig:

Motion:

y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac o eitem 1 y cyfarfod ar 4 Chwefror 2015 yn unol â Rheol Sefydlog 17.42(vi).

the committee resolves to exclude the public from the remainder of the meeting and for item 1 of the meeting on 4 February 2015 in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.

Motion moved.

[767] Are all Members content? Then we will go into private session.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 15:41.

The public part of the meeting ended at 15:41.