Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

15/03/2017

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Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Dawn Bowden Bywgraffiad|Biography	Llafur Labour
Jayne Bryant Bywgraffiad|Biography	Llafur Labour
Angela Burns Bywgraffiad|Biography	Ceidwadwyr Cymreig Welsh Conservatives
Bethan Jenkins Bywgraffiad|Biography	Plaid Cymru (yn dirprwyo ar ran Rhun ap Iorwerth) The Party of Wales (substitute for Rhun ap Iorwerth)
Caroline Jones Bywgraffiad|Biography	UKIP Cymru UKIP Wales
Dai Lloyd Bywgraffiad|Biography	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Julie Morgan Bywgraffiad|Biography	Llafur Labour
Lynne Neagle Bywgraffiad|Biography	Llafur Labour

Eraill yn bresennol
Others in attendance

Dr Frank Atherton	Prif Swyddog Meddygol Chief Medical Officer
Vaughan Gething Bywgraffiad|Biography	Aelod Cynulliad, Llafur (Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon) Assembly Member, Labour (The Cabinet Secretary for Health, Well-being and Sport)
Julie Rogers	Cyfarwyddwr y Gweithlu a Datblygu Sefydliadol Director of Workforce a Organisation Development

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

Zoe Kelland	Dirprwy Glerc Deputy Clerk
Claire Morris	Ail Glerc Second Clerk
Sian Thomas	Clerc Clerk
Dr Paul Worthington	Y Gwasanaeth Ymchwil Research Service

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

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

[1] **Dai Lloyd**: Croeso i bawb i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. O dan eitem 1—cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiant—gallaf gyhoeddi nad yw Rhun ap Iorwerth yn gallu bod efo ni heddiw, ond mae Bethan Jenkins yma fel dirprwy. Felly, croeso, Bethan, am y tro cyntaf i'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon—croeso i chi'n wir. Gallaf i ymhellach egluro, er bod pawb, yn amlwg, yn ymwybodol bod y cyfarfod yma'n ddwyieithog—gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu i glywed cyfraniadau yn yr iaith wreiddiol yn

Dai Lloyd: Welcome, everyone, to the latest meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. Under item 1—introductions, apologies, substitutions and declarations of interest—I'd like to announce that Rhun ap Iorwerth cannot be with us today, but Bethan Jenkins is here in his stead. So, Bethan, welcome, for the first time, to the Health, Social Care and Sport Committee. Can I further explain, although everyone is obviously aware that this is a bilingual meeting, you can use the headphones to hear simultaneous translation from Welsh to English on channel 1, or amplification on channel 2? Could I remind people to switch off their

well ar sianel 2. A allaf i hefyd atgoffa pobl i ddiffodd eu ffonau symudol ac unrhyw offer electronig arall, neu eu tawelu, o leiaf? Nid ydym yn disgwyl tân y bore yma, felly os bydd larwm yn canu, dylem ni ddilyn cyfarwyddiadau'r tywyswyr.

mobile phones and any other electronic equipment, or switch them to silent, at least? We don't expect a fire this morning, so if you hear the alarm, then please follow the instructions of the ushers.

09:31

Ymchwiliad i Recriwtio Meddygol: Sesiwn Dystiolaeth 11—Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Inquiry into Medical Recruitment: Evidence Session 11—Cabinet Secretary for Health, Wellbeing and Sport

[2] **Dai Lloyd:** Felly, gyda chymaint â hynny o ragymadrodd, awn ymlaen i eitem 2: ymchwiliad i recriwtio meddygol. Hon ydy sesiwn dystiolaeth 11, a heddiw, y bore yma, rydym yn croesawu Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon. Dyma'r sesiwn olaf, yn wir, yn yr ymchwiliad yma, ac felly, a allaf groesawu Vaughan Gething, Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon, yn ogystal â Julie Rogers, cyfarwyddwr y gweithlu a datblygu sefydliadol, a hefyd Dr Frank Atherton, y prif swyddog meddygol? Diolch yn fawr iawn i chi'ch tri am eich presenoldeb.

Dai Lloyd: So, we now go on to item 2: the inquiry into medical recruitment. This is evidence session 11, and today, this morning, we welcome the Cabinet Secretary for Health, Well-being and Sport. This is the last session in this inquiry, indeed, so I would like to welcome Vaughan Gethin, the Cabinet Secretary for Health, Well-being and Sport, as well as Julie Rogers, director of workforce and organisation development, and also Dr Frank Atherton, the Chief Medical Officer for Wales. Thank you to all three of you for being here.

[3] Rydym wedi derbyn eich datganiad ysgrifenedig, a gyda'ch caniatâd, awn yn syth i mewn i'r cwestiynau. Mae gennym ni nifer helaeth o gwestiynau a fydd yn cael eu gofyn mewn modd byr, bratiog, gan ddisgwyl atebion yn yr un modd oherwydd pwysau amser. Lynne

We have received your written statement, and with your permission, we'll go straight into the questions. We have a number of questions that will be asked in a succinct way, with the expectation of succinct answers, because of the time available. Lynne Neagle to start.

Neagle i ddechrau.

[4] **Lynne Neagle**: Thank you, Chair. Good morning. Can you tell us what the impact of the new single body, Health Education Wales, is likely to be on the funding and structure of medical education in Wales?

[5] **The Cabinet Secretary for Health, Wellbeing and Sport (Vaughan Gething)**: I think it will actually allow us to use our ability to plan our whole workforce in a different way, in a more joined-up way, rather than having different streams looking at things separately, and that's been part of our challenge. Actually, what I've been encouraged about is the buy-in that people have had. So, I think, structurally, it will help us to have a more joined-up structure that will make a lot more sense.

[6] On the funding question, though, I don't think you could honestly say that changing the structure will change some of the challenges around funding. We still have difficult investment decisions to make and everyone here is aware of the reality that we have less money available to us in the Welsh Government. Even though health has done well out of the last budget settlement compared to every other area of Government, that doesn't mean that we're awash with money. So, I wouldn't want to try and pretend to you that Health Education Wales means there will be more money, but I think we'll be able to make smarter and better use of it in the way that we plan our whole workforce, not just the medical part of it.

[7] **Lynne Neagle**: And where are we in terms of actually getting it approved and established?

[8] **Vaughan Gething**: I've made a statement on this already. I still expect it to be up and running by April 2018, although we expect to have some form of shadow body in place before then. So, it isn't simply about asking them to start work from day 1 on 1 April. So, yes, I think it's all on track. We'll have options about how we establish it, and, obviously, I expect to provide further statements to Members over the rest of this year to confirm that we're on track, and what the actual structure of the organisation will be.

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

[10] **Dai Lloyd**: Diolch yn fawr. Caroline Jones sydd nesaf.

Dai Lloyd: Thank you very much. Caroline Jones is next.

[11] **Caroline Jones**: Diolch, Chair. Good morning. One of the main purposes of medical schools is to provide the future NHS workforce in Wales. Could you tell me if they're delivering on this responsibility? Also, given that medical schools are competing in the higher education sector, with the emphasis on recruiting the brightest and best from around the world, is this in conflict with this responsibility to recruit those most likely to serve in the Welsh NHS?

[12] **Vaughan Gething**: I think they're two distinct questions. I'd start off by saying that it hasn't always been the mission of the two medical schools that we have to simply recruit the future NHS workforce for Wales. Swansea is different to Cardiff, of course, because it was created after devolution, but Cardiff's history hasn't always been that they are there to provide doctors for a Welsh medical workforce. There are challenges there about how medical schools see themselves as well. They want the brightest and the best and we should want very high-quality applicants, but there is a challenge, I think, about ensuring that we do get more Welsh-domiciled students to be offered places in our two medical schools, without compromising on quality, because I don't accept that you have to compromise on quality to do that.

[13] I think it's fair to say that, previously, we haven't had as much return as we would have wanted. I also think it's helpful to say that I think both medical schools recognise that. I met them not long after I'd been appointed—I met both deans together, and I think they're very clear about the message from Government and the expectation. That's within their current envelope—we expect them to do better. I know Cardiff have recent figures showing they've done better this year than last year, but I'm really clear that I think there's more they could and should do within their current envelope, let alone any potential for expansion, because this Government would expect that any further investment into those two medical schools, to expand the numbers of training places, would have to be on the basis that there would be more Welsh-domiciled students taking up those places.

[14] **Caroline Jones**: So, are you content with the number of Welsh-domiciled students applying to these schools? What are we doing to offer encouragement?

[15] **Vaughan Gething**: I think it'd be wrong to say I'm content with the current position, because I think it needs to improve. We have numbers applying. There's a challenge about making sure people continue to apply—but, actually, we want to see people offered places and we want to see those

places taken up. Equally, in terms of the point at which people make choices about their careers, we need to be both better at retaining people, wherever they come from, within the Welsh system, once they've completed their graduate or postgraduate training.

[16] Also, we need to be better at understanding where people from Wales go if they don't study in Cardiff or Swansea. We do need to be much better at attracting back Welsh students who have undertaken medical training in England or in Scotland—in England in particular, because you'd understand why a lot of people—say, if you live in north Wales, you might decide, actually, Liverpool or Manchester sound like great places to be a student, far enough away from home to not be at home and, equally, not so great a difficulty to come back. We know lots of people go to London, Birmingham and other places as well, but I don't think we really do well enough at attracting those people back.

[17] **Caroline Jones:** We have received evidence to suggest that, perhaps, we should use positive discrimination to attract more Welsh-domiciled students. Can I ask your opinion on this?

[18] **Vaughan Gething:** I used to be an employment lawyer, as you'll know, and positive discrimination itself is a loaded phrase, and it's a phrase that gets lawyers very excited. We need to have a system where we can encourage Welsh students to apply and be clear about our expectations for Welsh public funding and what that will deliver for the Welsh NHS. I expect there to be both more applicants and more students offered places without compromising on quality, and I think the way that our current medical schools look at their applications processes is important within that. I wouldn't use the phrase 'positive discrimination', but I certainly expect there to be positive forms of action, which is a more legally sound phrase to use, and looking at the context in which admissions are undertaken.

[19] To be fair, I know that Cardiff and Swansea have already made some changes. The challenge will be a proper review on what that's delivering. So, not just to say they've made changes, so it's all okay, but to look at whether they're actually making the sort of difference that they say they expect and that we certainly expect in terms of the numbers of people who are offered places, as I say, without compromising on quality. So, I think, in the past, there's been this idea that we're asking them to compromise on the quality of their applicants; that absolutely isn't what we want, and I don't accept that that's the real reason why we haven't done better at recruiting Welsh-

domiciled students into Welsh medical schools.

[20] **Caroline Jones:** Finally, studying medicine hasn't always attracted people from deprived backgrounds or harder-to-reach communities, and I wonder if you could tell me: do you have any plans to address this?

[21] **Vaughan Gething:** Yes, the previous health Minister, you may remember him, started a programme on widening access, and, again, working with medical schools to look at how you actually provide an experience to people from non-traditional backgrounds before they get to university. So, there's been a pilot programme and that one's carrying on, and I'd like to see how much scale we could add to that as well. So, we already recognise that it's a challenge about getting people into a medical career from broadly poorer backgrounds. I'm not saying there isn't talent—there's lots of talent still available, and that's part of the frustration. We know it's part of the mission, both of the Government, but also of the whole service, and, indeed, the two medical schools need to take on board their part of the responsibility, because if you don't think that a career in the health service is for you and it's never offered as an opportunity, we shouldn't be surprised if we essentially self-select the same sort of people coming through.

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

[23] **Dai Lloyd:** Bethan nesaf, wedyn Julie.

Dai Lloyd: Bethan next, then Julie.

[24] **Bethan Jenkins:** Rwyf jest eisiau gofyn cwestiwn clou ynglŷn â sut rydych chi'n gweithredu fel Llywodraeth ynglŷn â recriwtio myfyrwyr cyfrwng Cymraeg. Rwy'n deall bod rhai staff yng Nghaerdydd yn meddwl bod hynny yn rhywbeth positif, ond bod rhai eraill efallai yn gwthio yn erbyn hynny. A allwch chi esbonio sut ydych chi'n gweithio gyda'r Coleg Cymraeg Cenedlaethol i ennyn mwy o fyfyrwyr cyfrwng Cymraeg i fynd i mewn i'r sector yma yn benodol?

Bethan Jenkins: I just want to ask a quick question on how you operate as a Government in terms of recruiting students who are Welsh-speaking. I understand that some members of staff in Cardiff think that this is something positive, but others perhaps are pushing against that. Can you explain how you work with the Coleg Cymraeg Cenedlaethol to attract more Welsh-speaking students to enter this sector specifically?

[25] **Vaughan Gething**: We recognise that the ability to speak Welsh is a real care need in both health and care, so we will need more doctors who have the ability to speak Welsh. It's also partly why I said that we need to attract people back into Wales, because a number of those will be Welsh speakers. They are specific skills that we would obviously want to make use of here that aren't necessarily going to be utilised if you have a medical career in Manchester or in Newcastle.

[26] Part of our challenge always is: how do we ensure that the attitude that I think you put your finger on in medical schools and in medical training recognises that skill, and recognises that, actually, from a Welsh point of view, we need to have Welsh speakers within our medical cohort? Again, it's part of the area where I think we need to recognise that we haven't done as well as we could have done. So, it isn't an area of complacency—for example, in Swansea, they'll guarantee you can have an interview through the medium of Welsh if that's what you want. But, actually, it isn't just about the interview process—it is about the teaching and the learning. Going back to the point about access, it's about how we make sure that people see that there is a career for them.

[27] I don't think it's just about the Coleg Cymraeg—I think it's through the whole education system and what people expect for themselves as they go through, and whether they feel that their ability to speak Welsh is a positive advantage, which I think it should be seen as. Again, being perfectly honest, we would have to say that we don't think that we've made as much of an advantage of that, so that students themselves recognise that that is a positive advantage for them as well as for the whole service to attract and retain those people.

[28] **Bethan Jenkins**: Felly, a oes yna weithredu positif yr ydych yn gallu ei wneud yn yr adran yma? Beth ydych chi fel Llywodraeth yn gallu ei wneud i newid hyn, os ydych chi'n cydnabod ei fod yn broblem nid yn unig ar gyfer y Coleg Cymraeg ond ar gyfer y system ynddi ei hun?

Bethan Jenkins: Therefore, is there positive action that you can take in this area? What can you as a Government do to change this, if you recognise that it is a problem not just for the Coleg Cymraeg but for the system in itself?

[29] **Vaughan Gething**: That goes back to the point about our recruitment process to undertake medical training and at what point people make career choices, because everyone around this table knows that you don't just make

a career choice when you're filling out your UCAS forms—in my day; I'm not sure what they're called now. When you're making your choices at the age of 17 or 18, lots of people have already made choices, or the illusion of choice is no longer there, because we know that, actually, lots of people's aspirations change before they leave primary school. So, the idea that we can resolve all of this just by concentrating on one point in someone's life journey I don't think is right.

[30] There's still something about making sure that people understand, despite some of the publicity—. This is a concern that the BMA and royal colleges have, that the way the NHS has been talked about, not just in Wales but broadly, will put talented people off wanting a career in medicine. So, actually, there's something about the conversation that a career in the health service will be demanding, but also really rewarding—earning money and actually a much greater reward—and how we make clear, actually, if you think that this might be something for you at a young age, how you maintain that level of aspiration.

[31] There's something here about not just about this part of Government as well. It is about, through education, through the new curriculum, what we expect people to see from themselves and how they place value on themselves as well. You and I both know from our time in student politics that, when we're talking about access, we're talking about that the reality of access is that, if you don't get it right up to the age of 12, you're unlikely to get those people back—it's possible, but it's much more difficult. So, what do we do through primary school and into high school, and then, in terms of whether people are making choices and saying, 'I want to study in Wales, or I want to come back to Wales afterwards', how easy do we make it for them? I anticipate that we're going to on to attracting people who are part-way through their training or postgraduate training later on, but this is all part of the same point. So, at each point, we have to understand what we are doing, how effective it is and what we can do better, and that obviously involves me, the Cabinet Secretary for Education and our officials as well.

[32] **Dai Lloyd**: Ocê. Diolch yn fawr. Julie.

Dai Lloyd: Okay. Thank you very much. Julie.

[33] **Julie Morgan**: Thank you. We've had quite a bit of anecdotal evidence saying that very talented Welsh students have been unable to get into Cardiff, for example, and have got places at other, prestigious English medical schools, although, in fact, when Cardiff University came and gave

evidence to us, the percentage of Welsh students getting an offer was much higher than I certainly knew, so that was slightly reassuring. But I just wondered if you had any comments about that.

09:45

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

[35] So, I recognise that that's a real feature in the story, and it's really about ensuring that medical schools respond properly to that, in looking at their own admissions procedures, and understand that we expect them to do better. As I say, you could not expect this Government to invest further public funds in expanding medical places if we are not certain that we're going to see Welsh domiciled students have a much better prospect of receiving an offer to study medicine in Cardiff or Swansea. When I say 'Cardiff or Swansea,' I mean those medical schools; of course, undertaking their studies will take them into different parts of Wales as well. But I welcome the progress they've made—to be fair, they have made some, but more to come.

[36] **Dai Lloyd:** Symud ymlaen— **Dai Lloyd:** Moving on—Dawn Bowden. Dawn Bowden.

[37] **Dawn Bowden:** Thank you, Chair. We heard quite a lot in evidence about medical school places and the rise in the numbers of places available in England, and whether we were going to do something similar in Wales. I notice in the evidence that you submitted—your written evidence—that you talk about this is part of your 10-year strategy, really, around workforce planning. But it was the particular concern about whether we would lose

more students to England, which has already declared that it will have more medical places—have you got any views and comments on that?

[38] **Vaughan Gething:** The English and the Scottish systems are looking to expand their numbers of places. The challenge will be whether they can actually fill those places in medical schools and whether they can fill those places in training as well. So, it isn't just the point at which people make their choices to study—it's then where they're carrying on their postgraduate training as well. As I've said, on the medical places for study, I think I've been clear that, if we're going to have any expansion, we've got to be clear about what the return is, in terms of people who we can expect to stay, or to be from Wales, ever taking those places.

[39] When it comes to doctors in training, and the number of training places we have—for example, on general practitioner training—we need to fill our places first. The English system has a big, bold plan to have 5,000 extra GPs. Nobody believes they're going to do that unless they recruit them from overseas, which, given the mood music, is unlikely. In Wales, we know there's been a consistent campaign, and you'd expect it from both the Royal College of General Practitioners and the BMA, to say, 'We need more GP training places and we want more GPs to be training within the system'. The honest challenge I've always given back to them is: I won't say that we're going to expand our number of GP training places unless, and until, we fill our current places—we have 136 available this year. But if we get close to—once we do fill those, we can have a different conversation in the future.

[40] **Dawn Bowden:** So, can I just be clear about that—the current level of school places that we have, we're not filling at the moment?

[41] **Vaughan Gething:** No, in medical school, we fill medical school places, but the training that takes place after that, we don't fill all of those. We had a fill rate of—was it 75 or 79 per cent last year?

[42] **Ms Rogers:** It was 75.

[43] **Vaughan Gething:** Seventy-five per cent last year; it compares well with other UK nations. So, they're not filling all of their training places after they've undertaken medical school. The challenge there, of course, is: well, if you can't fill all of those places, why would you then expand that part of the numbers? There's a different conversation to be had about places at medical school, because I think, if you expand medical school numbers, you almost

certainly will get people who want to go—. But, like I said, that has to be a conversation. If we're going to put that resource in, what does that ultimately produce? Are we training doctors who we think are going to stay in the Welsh system, or do we think we're potentially just training doctors for the rest of the UK system? So, we have to think about the whole package of it—not just the places at a medical school, but what happens in training after medical school and where those doctors will ultimately end up.

[44] **Dawn Bowden**: Okay. I guess that'll come back to the recruitment and retention questions that somebody else is going to ask you later. Can I just ask you briefly, then, about the support within Welsh Government for the development of a north Wales medical school?

[45] **Vaughan Gething**: Obviously, I've had several questions on this in the Chamber and I remain consistent—we're looking at the evidence. There have been a range of meetings that have already taken place with stakeholders across north Wales—those who want to see a medical school built as well as those who are already involved in medical training. That does involve conversations with both Cardiff and Swansea, because I've got an open mind about what we should do. I'm interested in what we would do in terms of having more medical school places available and what that would look like. I'm interested in whether that is likely to result in more people staying within the Welsh NHS and does that mean that a new medical school is the answer, or does it mean that looking at alternative arrangements is the answer. I'm certainly interested in more people undertaking their training in north Wales, or certainly a decent chunk of their training, because we know that actually that is part of what has an impact on where people then apply to undertake jobs afterwards.

[46] So, I've got an open mind, but we're still looking at the evidence and the views of stakeholders. It's taken a bit longer than I thought, actually, so I'm not expecting to have a recommendation to me until after the Easter recess, so we'll be into summer. But, certainly, when I get evidence and a recommendation, I expect that this committee will be interested, as well as Members across north Wales. So, it's still on the agenda, but still the same answer.

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

[48] **Dai Lloyd**: Turning to trainee doctor places, Angela, you have the floor.

[49] **Angela Burns**: Thank you very much indeed and thanks for your paper. You referred, and, in fact, Dawn's just referred, to the 10-year plan for the medical workforce. Can I just start off by asking: what is the process for deciding how many trainee doctor places there should be throughout the NHS in Wales?

[50] **Vaughan Gething**: Do you want to take this? Do you want to give the technical answer?

[51] **Ms Rogers**: Yes, certainly. So, we introduced a new process last year, because what we'd uncovered was that traditionally what the deanery had been doing on our behalf was rolling forward similar numbers for speciality training in particular. So, what we did was we brought together quite an inclusive group of key interests to actually look at better matching the number of speciality training places to the needs of the service and particularly the shortage professions across Wales. We brought that together last year—that produced a set of recommendations for the Cabinet Secretary and then he took decisions around the priority areas.

[52] So, building on that process for last year, we're into that process again this year and we should get a set of recommendations before the summer. But it is trying very much to target those areas where we know we've got shortage specialties, and also looking at how we might actually get a better match between training places and the needs of the service in Wales.

[53] **Angela Burns**: So, just to make sure I'm completely clear, if we were to take accident and emergency as a speciality subject, what you're talking about here is that you're matching the number of posts that you think will become vacant in the next three, five, 10 years with the kind of training places that you could put in there, because we're basing this on the assumption that where people might do their medical training and their postgraduate training is where they will perhaps settle and stay.

[54] **Ms Rogers**: Yes, absolutely.

[55] **Angela Burns**: That's a decision of Welsh Government, or is that a decision of the deanery?

[56] **Ms Rogers**: That's the decision of Welsh Government. It's the Cabinet Secretary's call, based on recommendations from a group that includes the deanery, NHS employers and Welsh Government.

[57] **Angela Burns:** Okay. I'll tell you what I'm trying to be really clear that I understand: the tensions between ensuring that you have junior doctor training that is well-supported in a hospital that does enough of whatever that person is training in—psychiatry—for them to be able to get the training that they need—the tension between that and filling gaps in junior doctors in rural environments, and then also tying that in with the fact that we're trying to slightly—. I got the impression from your paper that, in the long term, we're trying to just slightly pull away from just total specialisms all the time and trying to build some more general practice back in, and I don't mean GPs, I'm talking about general surgery, so that, when we get people going into hospitals, there's a slightly more holistic view of them and not simply a specialist who looks at their small finger or something, because that's been the driver for the last x years, hasn't it? I wanted to understand how much influence you have, and how much it's about the deanery saying, 'This is the way we need to do it' and how much it's about the royal colleges saying—the classic one is—'If you're going to be a paediatrician, you must be in a place of 2,500 births.' So, I'm just trying to kind of understand that in order to understand how we get to where we need our medical training places.

[58] **Vaughan Gething:** Yes, there are always tensions, and it might be helpful to have Frank's comments on a more generalist approach to training, because a number of the royal colleges have been very supportive of that approach. And you're right, there are always going to be tensions, and that's why, for example, we've developed a point about having a proper education and training contract as part of our offer to doctors in training, so there's some certainty about what is expected of them and what they can then expect in return in terms of that protected time for learning, and that's actually been very popular. We're the only part of the UK to have something like that; we think that other parts of the UK are looking at what we're doing and actually recognising that it's positive. So there are a range of things where we're already taking steps forward where the rest of the UK is looking to follow us. But there are always going to be tensions about your training and your taking part in providing direct patient care and what that looks like, and any decisions that the deanery make at present on where training takes place and its impact on service provision.

[59] It isn't just the rural question; there are a range of different questions in how we provide the right sort of doctors and provide the right sort of service all across the country, whether that's in a specialist centre or whether it's actually a more generalist point as well. But, you know, the drive not to

have super-specialism as being the only game in town has been very clear, and we've got a number of things we're expecting over the course of this year—you know, the Shape of Training review and others as well. It might helpful if Frank tells you where we are now and what we can expect over the summer.

[60] **Angela Burns:** But also, Cabinet Secretary, you haven't exactly answered my question, which is about who has that ultimate decision making. That's what I want to understand. Is this driven by the Government's desire to know where the gaps are and fill them? Is it the royal colleges saying, 'This is clinical excellence; it overrides everything else'? Or is it the deanery saying, 'This is how we need to move the people about the system'?

[61] **Vaughan Gething:** Well, we bring people together to make a judgment call, because you have to try and balance those competing demands and interests, because, sadly, Angela, we don't get unanimity on what the right thing to do is for the service.

[62] **Angela Burns:** No, but the buck stops somewhere, Cabinet Secretary. Somebody has to make those final decisions, and I want to drill down to who that is.

[63] **Vaughan Gething:** Well, ultimately, I made the choice.

[64] **Angela Burns:** So, it is a Government decision.

[65] **Vaughan Gething:** So, ultimately, the recommendations come and then, ultimately, I have made a choice about what we're going to fund and where that's going to be funded. But that comes through the funnel of a process where you do have stakeholders having proper engagement and involvement. But, ultimately, you know, as in most things, it will end up on my desk at some point.

[66] **Angela Burns:** So, how then would you cope the tension when a royal college turns around to you and says, 'Clinical excellence dictates this', but you don't feel that that actually serves the needs of the people? So, if I take for example the Royal College of General Practitioners, if you press them a little bit on the length of time that you might give to a patient who wants to come and see you—it's the 10-minute window—you know, they're quite soft on what that clinical excellence should be, on what that standard should be. You know, they're prepared to accept that could move a bit, whereas you get

other colleges that are absolutely rigid and say, 'Nope, if a junior doctor or trainee doctor does not go into this kind of environment and do this type of thing, then they won't pass muster.' So, I'm just trying to see if there's any way or what kind of negotiations are done with the royal colleges to ensure that we have a correct balance between clinical excellence and necessity of the population, or the needs of the population.

[67] **Vaughan Gething:** Well, they're part of the conversation. So, it isn't like they're excluded; they are part of that broad conversation that takes place.

[68] **Dr Atherton:** So, it's a really important dynamic. You know, as the Cabinet Secretary says, there is a training and a service delivery aspect to doctors in training, and they have to provide both of those, and the educational contract helps that.

[69] You're absolutely right: the standards that are set by the various colleges do impact on the training process, because the deanery has a responsibility for making sure that training placements are robust and meet criteria, and one of those criteria is to take into account what the various colleges are saying. So, that certainly has an impact, and we need to be mindful that, really, the whole training programme has to be geared to the population and the population needs of the future, really. So, you know, we know that the population is ageing, that multimorbidity is increasingly common, and so, that shift—to some of your earliest points—from super-specialisation to more generalist training is one that we recognise very clearly in Wales and we need to move on, and we think that the 'Shape of Training' report is the right way to move.

10:00

[70] So, we have to make sure that the doctors of the future are aligned with what the population is going to need. But you're right: the various colleges do have an impact on the training programme through the standards that they set. One of the discussions that we have had with those colleges, and continue to have, is the extent to which some of those quality standards apply in urban versus rural areas, because that has a really big implication for us in areas like mid Wales and north Wales of course.

[71] **Angela Burns:** My final question on junior doctor training is: how well are we doing on that journey of trying to encourage some more generalism

within the specialties, if that makes sense? Because, again, you were quite clear in your paper, and it was also a point that was brought out by the previous committee's report into recruitment and training—it was one of the things that were brought out—so I just wondered how well we are doing with getting that, so that we get the orthopaedic surgeon who has a good sense of the holistic needs of an individual. In fact, the orthogeriatrician is perhaps an example of a specialism that has that holistic bit added on, because their job is to send the patient out completely well, not just with a fixed hip or whatever, isn't it?

[72] **Vaughan Gething:** Again, to go back to the different parts of doctors' training, both their time at medical school and what that looks like, what experience they get during that time, I would expect that Cardiff and Swansea medical schools both talked about changes that they have made to provide that sort of experience. Also, when you think about the way that doctors are trained, so that it will be consistent with what they can expect in practice, so that you're not training for a model that no longer exists, so that you're trained alongside other healthcare professionals and that's part of what you expect, rather than, you get out, you finish your training, and you think, 'Oh, I've got to work with these people that I've never met before but I've only read about.' So, that's part of the training.

[73] It is also then about understanding when you actually go out and undertake that postgrad training where people want to go, and about making sure that those opportunities exist, because of course some people want to be generalists and they recognise that that's the move, and some people want to work in rural healthcare. It's about how we ensure that we positively promote that. Again, you'll see that some of the successful recruitment activity is about positively promoting what is different about that place to get people interested in working there. So, that is part of our conversation with doctors in training about what they think works and what they think we can do better.

[74] For example, we had recent awards for the first time for doctors in training—a very inspiring and very interesting evening. The deanery made it clear that they want to talk to those people again about why they felt that they were doing particularly well and what they felt worked, and equally what they felt didn't work so well. So, there's still something about understanding and listening to doctors in training as well as us having a view. I think we've got a clear enough view. I don't think people would misunderstand where we want to go, but we need to actually listen to the current and the future

workforce to say, 'What does it look like to you and how can we improve on it?' That's being properly self-critical.

[75] **Angela Burns:** But you think that that journey's quite successfully started now, the journey to the—

[76] **Vaughan Gething:** We've started, but we're certainly not complete.

[77] **Dr Atherton:** Just a couple of examples, I suppose. Foundation years 1 and 2 training, when people come out of medical school, are a really important time, because that's when people are starting to firm up on their career choices. So, building more general practice into that has been a positive thing, I would say. Core medical training, so that people develop general medical skills as well as their specialty interest, is really important as well. Again, you're right to point out that it's the geriatricians and the GPs who have that broad range of skills and they are a good model as to how we align the medical workforce with the future needs of the population.

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

[79] **Dai Lloyd:** Ar gefn hynny, achos fe gawsom ni dystiolaeth yn rhai o'n sesiynau tystiolaeth blaenorol. Er enghraifft, yn y cynllun hyfforddiant meddygon teulu yn Wrecsam, mae mwy o feddygon yn ceisio am lefydd nag sydd o lefydd ar gael. Nid oes llefydd gwag ar gael ym mhob man, wrth gwrs; mae yna effeithiau lleol, yn amlwg. Nid wyf yn gwybod pa rôl sydd gennych chi fel Llywodraeth i nid jest cymryd y syniad bod wastad llefydd gwag mewn hyfforddiant meddygaeth teuluol achos, yn amlwg, mewn o leiaf un cynllun, mae yna ormod o feddygon yn ceisio am y llefydd. Ar ben hynny hefyd, pa ddylanwad sydd gennych chi fel Llywodraeth, o gofio bod 40 y cant o swyddi arbenigwyr mewn ysbytai yn wag? Pa rôl sydd

Dai Lloyd: On the back of that, because we had evidence in some of our previous evidence sessions. For example, in the GP training scheme in Wrexham, there are more people applying than there are places available. There aren't vacancies available everywhere, of course; there are local impacts, of course. I don't know what role you have as a Government to not just take this idea that there are always vacancies in GP training, because clearly, in at least one scheme, there are too many applicants. Also, what influence do you have as a Government, bearing in mind that 40 per cent of specialist posts in hospitals are vacant? What role do you therefore have, as Cabinet Secretary, to encourage the professional colleges to do

gennych chi, felly, fel Ysgrifennydd y Cabinet, o ran hyrwyddo bod y colegau proffesiynol yn gwneud rhywbeth ynglŷn â hyn ar fyrder? Rydym wedi clywed tystiolaeth, er enghraifft, gan Goleg Brenhinol y Radiolegwyr am eu dymuniad i ddatblygu *imaging academy*, er enghraifft. Byddai hynny'n fodd i ddenu mwy o feddygon ifanc i eisiau bod yn radiolegwyr, er enghraifft. Pa fath o gyfarwyddyd a chefnogaeth y bydden nhw'n debygol o'u cael, felly, gan y Llywodraeth yn hynny o beth?

something about that urgently? We have heard evidence, for example, from the Royal College of Radiologists about developing an imaging academy, for example. That would be a way of attracting more young doctors to want to be radiologists, for example. What kind of guidance and support would they be likely to have from the Government in that regard?

[80] **Vaughan Gething:** I will deal with a couple of different points in there, Chair. On the point about GP training places and where, physically, people can be located, I would always want to look at, if there is oversupply and if there are more people who want to undertake training than is available in those training practices, how we try and manage that. That's actually got to be a solution that GPs themselves are part of, of course. They will often have ideas about how that could work, as opposed to simply expanding those practices that are there. I actually think that the clusters have been very helpful in getting GPs to work in a more collegiate way—to recognise that it is in their own interests for there to be that broader partnership.

[81] On the overall numbers of GP training places, I said before—and it goes a bit back into the comments I was having with Dawn—that if we get somewhere near to expanding, we can look again at places, and if, this year, we thought there was an oversupply, well, I would want to be as flexible as possible in accommodating those people who we think are over the line in terms of quality and to whom we would want to offer a place, rather than saying to five people, for the sake of argument, 'We are full, so go somewhere else.' There is something about trying to be pragmatic within our overall resource envelope.

[82] On the specific point you make about an imaging academy, well, that's part of what we want to do. We're awaiting a business case. We would like to see it happen, and it would help us in a number of ways, both in terms of our capacity, as well as in delivering the sort of workforce we want—and, again, people undertaking that training within the sort of environment in which we

want them to work. So, we don't have any difficulty with the Royal College of Radiologists pushing that as part of the answer. It's part of what I expect to see happening and coming through, because it is part of what the agreement over the south Wales programme was supposed to be. As ever, there's a challenge about pace on these matters. I imagine that Members around the table, as well as myself, would be a touch frustrated that we haven't been able to do more at a faster pace than we have done. But, we are very clear that that's the direction we want to move in.

[83] **Dai Lloyd**: Diolch yn fawr. Jayne Bryant sydd â'r cwestiynau nesaf.

Dai Lloyd: Thank you very much. Jayne Bryant has the next set of questions.

[84] **Jayne Bryant**: Thank you, Chair, and good morning, Cabinet Secretary. I would just like to focus on our recruitment and retention, particularly of GPs. Employment preferences, as we know, are changing, and there is more move to part-time working. We had evidence that there was less desire to become a partner in a GP practice, and the importance of work-life balance came across in much of the evidence that we had. Do you think that NHS Wales is responding well to these changes?

[85] **Vaughan Gething**: Well, this goes back to NHS Wales and our conversations with independent contractors. The BMA and the royal college of GPs have been really clear that they want to see the independent contractor model continue. I know that you will all have been lobbied by those organisations about the value of the independent contractor model. The honest challenge is that we all recognise—and the BMA at the recent local medical committees conference recognised—the point that you made, in fact: there are new entrants who don't want to work in exactly the same way. What we can't do is say that the independent contractor model is the only valid model to provide medical services. But, it is about how we make sure that we are flexible enough about the way in which we organise and deliver general medical services with and for the public.

[86] It will be the case that the independent contractor model, for the foreseeable future, will deal with the overall majority of care. But, for those who don't want to fall exactly in that, how do those independent contractors employ other doctors on different terms and conditions? Some of the announcements that I made recently at the local medical committees conference, I think, will be helpful, about a range of terms and conditions around that. But it is also about some of the newer models for organising

general medical services—so, the federation that is taking place in Bridgend, and the moves in south Powys regarding a community interest company. There is a range of GPs that are looking on with real interest at what that looks like. Again, going back to clusters, the way in which clusters are organised and how they employ not just GPs, but other staff. So, are those going to be people that are housed in the health board, effectively, as the employer, or will there be an opportunity—? If the federation appears to work in Bridgend, that could be a model that would allow GPs to employ other members of staff, other healthcare professionals, and what does that then mean for employing GPs on a different basis as well? Because we'd want to be more flexible about the GP workforce and how they can be employed, because, otherwise, the challenge is that we'll fill those places and that need in agency and locum terms, which is expensive and doesn't then properly allow people that want to have a career in medicine but on different terms to actually undertake that career in a way that makes sense for them and their family, often.

[87] **Jayne Bryant:** Thank you. With the backdrop of those challenges that you mention, you mention the importance of being flexible, but what more can we do to ensure that working as a GP, working in general practice, is seen as an attractive option for people, not just to recruit into that, but to retain? Because, some of the evidence that we had, it was pretty startling to hear about the retirement age, particularly for female GPs. So, how can we ensure that it's attractive for those going into it, but still attractive for those people who should remain in it?

[88] **Vaughan Gething:** Well, there's something there about people's expectations are different. If you're a GP and qualified some years ago, you might have had different expectations at the start of your career about what you would expect to do, and the commitment you would expect to give the job, and that was normal. I think it's quite healthy that people expect to have a life outside work, and that goes for men and women in the profession as well. And it is then about making sure that employment models and practices reflect that. We're talking of people who aren't always direct employees of the health service here. In fact, in general practice, the great majority of people—GPs at least—are not direct employees, they're contracting. So, it is a conversation with those organisations that provide medical services about how we can help them and how they can help themselves to make sure that, from an employment point of view, it's attractive. Equally, there's then that point about what does a career in medicine look like and how is that attractive: that is the opportunity to work with different professions, that is

the way that people have conversations with health boards and with Government, and there's all those different things around it to really highlight that there's actually still a really positive career to have in medicine, there's a really rewarding career to have in medicine and in general practice, and there's an understanding of some of the very real workforce pressures.

[89] That difference that people might want to undertake, whether it's an academic career as well as being in general practice, there's more flexibility and opportunity to do that. We need more GPs with special interests. That will help us on a range of things, for example, when we talk about community cardiology, part of the reason that's been successful in rolling out is there are a number of GPs with areas of special interest. And, actually, that's part of what should make medical and general practice interesting for people—not just seeing people on your list for 10-minute appointments, but actually the opportunity to do something else as well—and I think it will enhance our ability to reorganise and re-engineer the service. Because, if we want to see services move from secondary to primary, we'll need GPs with that special interest and they'll need to be supported in a different way to undertake that part of their career as well. So, it is very much seeing the whole picture and not just one narrow part of it, because, of course, that gets into other healthcare professionals and what they can do to take part of that work away from GPs, to make sure they're left with something they will generally find more interesting and rewarding. But the supportive environment question really does matter, and it's part of the reason we invest so much time and effort and energy into our relationships with GP stakeholders.

[90] **Jayne Bryant:** Thank you, Cabinet Secretary. I think Frank mentioned about post-foundation year doctors experiencing GP work. Do you have anything you'd like to add on that or are there any other ideas to get doctors to experience this before perhaps taking up a career as a GP?

[91] **Dr Atherton:** Well, you know, it starts at school, doesn't it? And I think, again, the experience here of the universities reaching out to schools and getting pupils who have a potential interest in medicine as a career into general practices so they actually see what's happening, I think that's a really good thing. In FY1 and FY2, making sure that people have opportunities to look at general practice as an attractive career is really important. I think part of challenge going forwards is to break down the old silos in working in the medical profession, both between specialties—we talked about the move towards generalism—but also between hospital doctors and primary care. I

think that's a very unhelpful divide, and it still exists to some degree, and I think we need to narrow that. So, giving people more exposure to general practice generally, and making sure that clinicians work across that divide, will be very important going forwards, as a way of working and a better way of meeting the needs of our population.

[92] **Dai Lloyd:** Just on the back of that, would you agree that for hospital speciality training—in other words, going to be a consultant—that it would actually be advisable to actually undergo a period of training in general practice, regardless of whether you end up in general practice or not?

10:15

[93] **Dr Atherton:** I'm not sure that putting a requirement would be the right way to do it. I think there are other ways of making sure that clinicians, through their training process, are working with GPs, and really understand and respect how GPs work. In my career, what I've seen is that the isolation of consultants within a hospital sometimes leads to that division, which can be problematic and which doesn't help to co-ordinate patient care. There are great models, I think, in Wales, of where, for example, paediatricians work out in the community in some of the areas around Cardiff, and that has helped to build alliances and to streamline patient flow, and the patients get a better experience. So, I think more work on that kind of model would be helpful, Chair.

[94] **Dai Lloyd:** Good. Angela, on this point.

[95] **Angela Burns:** Yes, just to follow up on the Chair's point, slightly. We've had quite a bit of anecdotal evidence that GP training can sometimes be really fraught, and, because there's so much pressure out there, that the trainees are very much in the firing line, and it tends to be a bit of a baptism of fire from time to time. I just wondered who monitors the training of a junior doctor in a community post of any sort.

[96] **Dr Atherton:** Well, the deanery is responsible for training overall, and they do monitor, and they have annual surveys, and of course we get headline figures on that, and Wales tends to do fairly well on trainee surveys, overall. But, where there are concerns, trainees are able to raise those with the deanery, and the deanery does consolidate those and feed them back so that Government can then have a conversation with the local health board. So, there are escalation processes that support that.

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

[98] **Vaughan Gething:** I'm sure you'll be aware of the survey evidence on the quality of training and feedback directly from doctors in training. I think, the last two occasions when the four nation surveys have been undertaken, Wales has finished top in terms of people's satisfaction with their training. It doesn't mean to say there's no room for improvement, but I wouldn't want to give the impression that, actually, training is an awful experience for doctors. There are real challenges in the profession, but we're doing well when it comes to people's experience of training in general terms.

[99] **Dai Lloyd:** Yes, and that's reflected in the evidence we've had from the junior doctors here. They've all been very impressed with the quality of training in Wales—very positive vis-à-vis training in other parts of these islands. So, that is part of our evidence base. Moving on, Julie, you've got the next fleet of questions.

[100] **Julie Morgan:** Yes, I think I'll go on to the junior doctors contract, and I wondered what you felt the effect had been in Wales in the fact that we haven't imposed a contract here. We've had mixed messages, actually, but I'd be interested to know what you felt.

[101] **Vaughan Gething:** We took a deliberate decision, which I absolutely believe is the right one, not to impose a junior doctors contract. I think it was deeply unhelpful to go down the imposition route, and every time I meet a group of junior doctors, the anger is palpable towards the UK Government. I think it is incredibly short-sighted, not just for now, but in the longer-term damage in relations between the UK Government and doctors, and you see that seeping into the conversation with consultants as well. It would be desirable, though, to have a contract that was broadly similar between the four nations, because, actually, mobility between the four nations, broadly, is a good thing for us. Because, actually, we recruit and encourage doctors from England and other parts of the UK to come here as well, so having contracts that are not massively different is something of an advantage for us, but that doesn't mean that we'll simply do whatever England do.

[102] And in some areas of speciality there are particular challenges, because the contract that is being rolled out now in England, some speciality areas have significant financial incentives, and so we need to think about what we do in response to that, because otherwise there is a real risk that we

potentially get outmuscled in recruitment, just on the financial terms. We're still not really clear about the cost for the contract and that's part of the challenge. I'm not clear that, if you asked the Department of Health, they would be able to tell you exactly what the total cost of the contract will be and how that's going to be worked out and paid for, and I certainly don't see that flowing over our border in massive consequentials for the Welsh NHS. But, as I say, I think we did the right thing in not imposing. We're trying to learn from what is already happening in England because they've imposed a contract in a number of areas. We'll know more through the rest of the spring and the summer as to what that looks like and the real impact, but we're determined to ensure that the future for junior doctors in Wales and any contract is done via a process of negotiation, and that's been very well received by junior doctors here, and it's certainly been recognised by junior doctors on the other side of Offa's Dyke.

[103] **Julie Morgan**: So, you don't actually have any plan at the moment. You're waiting to see how things go.

[104] **Vaughan Gething**: No, we are. We offer regular meetings with the British Medical Association, and it shouldn't be a surprise that their junior doctors representative has been part of those meetings that we've had. Again, we're expecting there to be more from the BMA—feedback from their own membership base about what the junior doctors contract looks like, in practice, in England. So, yes, we're expecting to continue those conversations with the BMA to understand what that really looks like, and what we should then do here in Wales. Because there isn't a view that we should just do nothing forever and a day, but it is about understanding what the real impact is and, actually, when the contract rolls out into larger areas of the junior doctors workforce. What's been interesting is, for example, that one of the areas where they've already got financial incentives, histopathology, which has been a problem for us, we think that we'll get very near, if not completely, filling our own training places here. So, we need to understand why we think that is. Is it that because people value the different approach that we're taking here and that, actually, the short-term gain for some of the financial rewards on offer for that particular area of challenge and speciality isn't enough to persuade people that that's where they want to work?

[105] **Julie Morgan**: Certainly, the Welsh Government's approach was generally welcomed, but there were some concerns about the specialties where there were bigger payments in England.

[106] **Vaughan Gething:** Yes, and to be fair, the BMA are interested in talking to us about those areas because they don't want to get into a position where they're saying to the Welsh Government, 'We don't want you to do anything', and not recognising the fact that, for some speciality areas, you may need to do something as an interim point, if nothing else. But, certainly, I think there's an understanding that, at some point, we will need to get into much more material conversations about the junior doctors contract here. But they will be conversations and negotiations, and we won't have an air war conducted through the pages of the press where we're effectively denigrating doctors and the job that they do. That's part of the reason why they're so angry, because junior doctors are angry. In fact, they think that the UK Government misused statistical evidence. It's generally upset an awful lot of people. I don't think you could overstate how angry and upset people are, still.

[107] **Julie Morgan:** Thank you. To move on, we have heard evidence about the possible need for some trainees to move to England to have some specialty training. The deanery's evidence expressed concern about the risks to joint training programmes with England. So, have you got a view on this and any plans about how you're going to develop the links with England?

[108] **Vaughan Gething:** Yes, but we have some reciprocal arrangements in training. I guess that north Wales is probably the most helpful area to put that across—you know, going east and west and into north-west England for some of the speciality training. That's been much more helpful for doctors in training themselves. There is a challenge, though, about the English system wanting to have a properly co-operative relationship with us. We'd want to see further progress made. I don't want to use today as an opportunity to try and make things difficult, because I think there is real benefit for the Welsh system in having some of those where it seems to work, but it is about making sure that the landscape of the contract, that that doesn't get in the way of what should be a sensible training relationship that works for both Wales and for England. It's in our interests for doctors in England to be well-trained and content as well. We think there should be advantages to coming into Wales that don't simply rely on saying that you're being mistreated in England. That isn't a long-term strategy for persuading doctors to come to Wales and stay here and be generally happy with their career in medicine. So, yes, there are sensible and practical relationships that exist already, and, yes, we expect those to continue.

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

[110] **Dai Lloyd**: Reit. Diolch, Julie. Symud ymlaen. Bethan, mae'r cwestiwn nesaf gyda ti.

Dai Lloyd: Thank you, Julie. Moving on to Bethan with the next question.

[111] **Bethan Jenkins**: Ie, jest cwestiwn ynglŷn â hyfforddiant ar gyfer modelau gofal newydd. Mae yna dystiolaeth gan goleg y seiciatryddion—gan Broffessor Keith Lloyd—yn dweud nad yw modelau ar hyn o bryd yn gynaliadwy, a bod angen newid hyfforddiant i gyd-fynd â'r cyd-destun newydd o ddelifro ar gyfer gwasanaethau newydd. Rydw i jest eisiau deall os ydych chi yn cytuno â'r farn honno, a sut mae hyfforddiant yn newid er mwyn hybu pobl i allu gweithio o fewn ysbytai, ond hefyd o fewn cymunedau. Oherwydd rydw i'n credu beth roedd e'n trio dweud oedd nad oedd digon o staff arbenigol ar lawr gwlad, efallai, i wneud y gwaith hynny yng nghyd-destun y modelau newydd.

Bethan Jenkins: I have questions on training for new models of care. There is evidence from the college of psychiatrists—by Professor Keith Lloyd—that says that models at the moment aren't sustainable, and that there is a need to change training to correspond with the new context of delivering new services. I just want to understand if you agree with that view, and how the training is changing in order to encourage people to work in hospitals and also in communities. Because I think what he was trying to say was that there weren't enough specialist staff at grass-roots level, perhaps, to undertake that work in the context of the new models.

[112] **Vaughan Gething**: Yes, we recognise there is a need to change the way that doctors' training works. As I said earlier, you can't expect someone to be trained for one model of patient care and delivering that, and then going out and finding out that, actually, there's a very different expectation. It is the same Professor Keith Lloyd who's also the dean at Swansea, and I was in Swansea recently opening part of the new college of human and health sciences, and, again, they're deliberately looking at training people in a multi-professional environment, and that's really important. It's important for those other healthcare professionals, the other therapists and nurse practitioners, and it's important for doctors in training as well. So, I wouldn't disagree with his assessment. It's part of the challenge for us as elected representatives, actually. If we accept that models of care are changing and need to change, then that means the way that healthcare is delivered will change as well. All of us will know that we'll get asked from time to time to stand up for and defend what currently happens, and to say that, actually, we

don't need to change we're currently doing. I actually think that in lots of healthcare we really do, because it's in the interest of the staff and ultimately the patients who rely on the services. So, when you go into, say, GP training practices, I think that you would expect now, compared to, say, 10 years ago, more therapists working in and around that service. There's been a proper turnaround—turnaround is the wrong phrase, but I think there was a concern from the BMA and the royal college of GPs that the drive to have more therapists and nurse practitioners, advanced nurse practitioners and advanced paramedics in and around primary care was a desire to simply exchange people where there should be doctors. I think there's now a greater recognition that, actually, it's a good thing to have a multidisciplinary team, and they need to work in different models. That means that the numbers of GPs—. You need to look at how many you need—and you do need to have GPs leading those teams and working alongside people—but also that you can safely and properly have other healthcare professionals undertaking large parts of that patient care. So, if that's what you're going to experience in reality, then the way that you train as a GP, for example, should reflect that too. So, I have no difficulty at all in agreeing with what Keith was saying.

[113] **Bethan Jenkins**: But do you think it's changing fast enough? I can only use my personal experience, because I haven't heard the evidence here, I'm afraid, but for example, in Port Talbot, GPs are now having to—and I think in other parts of Wales—take on phone triage because of not having enough GPs. If a nurse or another practitioner could be put into that practice in a timely fashion, then that would then potentially alleviate the GPs from having to do this. Because, quite often it's not out of choice, it's because they've been forced into doing this. Is the system changing fast enough, knowing that GPs are retiring now, and that we are facing a potential crisis in this particular area—that we can then filter new and different types of staff into GP practices that can aid them in their work? Because, at the moment, we see pockets of that happening very well where the health centres have changed in what they do and what they provide, but in other areas of Wales the progress is very slow on that.

[114] **Vaughan Gething**: That's part of the challenge of working with GPs and other primary healthcare professionals. You mentioned the telephone triage in Port Talbot; I went to the Neath pacesetter, and it was really interesting talking to the GP who's running the service there and her view on what it means in terms of a better use of GP resources. She thinks a telephone triage is a good thing, and she would prefer to have a GP doing

telephone triage. You have GPs who then see people and GPs who do the telephone triage and see people as well. Those resources are used and, actually, they've then got a hub where they've got other healthcare professionals—physiotherapy being an obvious example, but also mental health provision, as well—where they can refer people to as well. And her very clear view is that that's the future. She was upfront about the fact that she thinks the challenge in GP numbers is part of the driver for doing that, but in any event, even if it wasn't, this is a better way to make use of GP resources, and ultimately it's a better service for the public.

10:30

[115] She was completely honest about the fact that not every healthcare professional was an enthusiastic champion for changing the way that they have always worked, and that not every member of the public was initially delighted about it. But, you know, that's part of the challenge of change: not everyone enjoys it and will sign up to it. But then in a different part of Wales, in Brecon, for example, they have nurse triage and they think that works for them. So, there's something about understanding what we need to do consistently, what could that and should that look like, and then how do we persuade people to come with us, bearing in mind that lots of people we're talking about in primary care, GPs in the great majority, are independent contractors, and we can't simply say, 'You will'. So, it isn't quite so simple in terms of command and control. We don't have that direct relationship with lots of these people, but I think the best champions for change are GP leaders themselves who can talk about their experience in general practice and why changing the way that they work has made a real difference and how and why it's positive and the downsides that do and don't come with it.

[116] Because I've got responsibility, of course, and there are occasions when I think I might even be persuasive, but it's much more persuasive to hear a fellow GP talk about their job and how it's changed, and why they think it would be a better reason and a better path for other GPs to take on the same sort of working practice. That's why we deliberately draw people together in clusters, it's why we have opportunities for clusters themselves to talk to each other, it's why we held a national primary care event last autumn and it's why I want to repeat that this autumn to make sure that momentum happens, because I don't think you can just rely on the incidental sharing of good, better or best practice. I think we need to give it a real push, because otherwise, my concern about pace comes in. You may have great models of care that aren't being taken on in other parts of the country, and you

potentially have something falling over before you do something different, and I don't think we should do that. We should choose to do things, not allow change to happen to us because it comes at a time of crisis.

[117] **Bethan Jenkins:** But that's what I'm trying to say, really. I'm not saying that phone triage is necessarily a bad thing, but they feel forced into it. So, you're having these discussions, but how are you doing it in a strategic way, so that you can identify—whether it's a rural area, whether they have, say, more cases of an eating disorder in one area so that they would be able to have more specialisms in that area? How are you forming an opinion nationally on that, but talking to them, obviously, not forcing them to change? How is that working so that we don't get to a position where surgeries are just having to close because the GPs are retiring and there's nobody else there to take up the job?

[118] **Vaughan Gething:** Well, some of this is about people's appetite for change. You know, let's remember that we're dealing with human beings here; not every one of them will want to carry on and work differently. We would rather that they did, and that's why I say the most persuasive people to have that conversation are the GPs who have changed the way that they work. I wouldn't say that people are being forced in to working differently, but the health service always has to work differently, because what comes through the door changes and because our ability to do things changes sometimes positively and sometimes less so.

[119] But, you know, if we're going to have that—. We do have that conversation nationally. The team here, they talk to stakeholders in the royal college as well as the BMA. And, to be fair, there's a proper constructive relationship with those partners as well. It certainly isn't the case that Charlotte Jones comes and agrees with every single thing that we say. But there's a proper conversation that takes place. There's a conversation with primary care leaders in different health boards, there's a conversation that goes into the ambulance trust as well. So, that conversation does take place, but the reason why I asked for a national event last autumn and why I want to have another focus again is that there's got to be a clear focus about the importance of primary care and the importance of primary care change, because if we don't choose to change primary care then change will happen to us and we'll be left firefighting, which is the wrong thing to do. And, again, it's about bringing forward and making sure there are deliberate opportunities, not just for the government to say, 'This is our view on what should work.' But, actually, so that people running and leading those

services—GPs and their healthcare colleagues—actually have a deliberate opportunity to talk to each other about what is working.

[120] So, you know, the different drivers exist and are there. There's the stuff that we can put into the contract where we require people to work differently. You know, the new and enhanced services that were announced recently—that's a change. There's also the drivers about people recognising that, when there's a different way for you to use the money you've got within your clusters, you then make a choice about whether to change and re-engineer your service, and actually understanding what someone a few miles away is doing with a broadly similar population. Because if you work in rural healthcare in mid Wales, there'll be other practices in mid Wales doing different things, and in north Wales, and actually at the top of the Valleys—there's huge rurality there as well. So, this isn't just a geographic challenge in one part of the country. The proof will, of course, be in how quickly we see change and whether we see improvements in GP feedback and healthcare professional feedback on what they're doing, as well as some of the more objective measures we have about the number of patients that get seen, how quickly, and then what their outcomes ultimately are as well. I think that's much more difficult territory to measure outcomes in primary care in many instances. I'm convinced that were moving in the right direction, but I wouldn't tell you or anyone else that we can be completely satisfied that everything is working as it should do. There's certainly no time and no opportunity to put your feet up and relax.

[121] **Dai Lloyd**: Symud ymlaen tuag at y diwedd nawr. Dawn.

Dai Lloyd: Moving on to the end now. Dawn.

[122] **Dawn Bowden**: Thank you, Chair. You spoke very positively in your evidence, and we've also had some positive evidence presented to us, about the Train, Work, Live campaign. So, I just wanted to explore a little bit more with you about how that's developing and what you've seen as being the key successes of that. Have there been any failures, really, or do you feel that it's so far produced the results and you're carrying on the same vein?

[123] **Vaughan Gething**: I'm really positive about Train, Work, Live, because that's the direct feedback we've had from the people we're targeting. The additional interest we've had in Wales—. We can probably give you some of the facts and figures on the social media profile in particular areas that we've targeted as well. The challenge will come in converting that interest into people who want to undertake places, either to train or to work permanently

in Wales. We had a focus on all three aspects: train, work and live—so, what it is to train in Wales, what it is to work and the opportunities of working in a different system and to be positive about our differences, say, to England, for example, but also to live in Wales. Because, in the past, I don't think we've properly sold what it is to live in Wales and actually the life you can have outside work as well as your life in work. There's got to be a balance in all of those aspects, but we'll review again through the rest of this summer how successful it's been, because the next stage of Train, Work, Live is going to be a launch immediately ahead of the Royal College of Nursing congress, and then we'll have an event there in terms of looking at nurse recruitment—Train, Work, Live for them. And then we'll have other healthcare therapists and another focus on them in the third stage of the campaign later in the year. We'll also be looking to gear up to go back to the British Medical Journal's careers fair this autumn as well. So, it isn't a single-shot campaign. It is about learning what's worked and been successful.

[124] **Dawn Bowden:** And presumably you'd be quite happy to look at other campaigns that have worked well. We did hear evidence from north Wales about some particularly unorthodox kind of campaigns that they were running, with some success. Now, whether that would work everywhere—but you'd be happy to look at—

[125] **Vaughan Gething:** Oh, definitely. I suspect you may be talking about Linda Dykes, who is a proper force of nature. She worked at looking at what it is to live in north Wales and the opportunities to do that and to work in a different way—so, a proper focus on mountain medicine: 'You can do all these different things by living here as well as an opportunity to work in this environment.' So, it is about looking at the job as well as looking at the opportunities to live somewhere as well. Even if you don't have the specifics of that particular offer—it may be different in Pembrokeshire, for example, and would be different, say, for someone who wants to live or work in a city. Because some doctors don't want to work in a rural environment; others positively do. So, it is about understanding the different parts of the message, how that's focused, and what learning we're taking on board.

[126] **Dawn Bowden:** You're tailoring it where need be.

[127] **Vaughan Gething:** Absolutely, yes. And that's definitely what's been done in north-west Wales. You can't replicate Linda, but what you can do is understand the quality of leadership and what that does for a whole workplace environment, having a team where people do generally feel

supported and that radiates out. People are happy to confirm that's the environment in which they work, and that point about positive thinking: 'How we can make sure to job matches up with what people will expect, and to make it the best possible fit for the job, and then how do we say you've got all these other opportunities too. So, you can learn a lot from what she's done successfully, and you can take lots of that out and say, 'How do we then make sure we have the best possible prospect to replicate that in different parts of Wales?'

[128] **Dawn Bowden**: Yes, okay. Thank you, Chair.

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

[130] **Julie Morgan**: Thank you very much, Chair. What assessment has the Welsh government made of the effect of leaving the EU on the workforce?

[131] **Vaughan Gething**: I think this is a really big risk for the whole national health service, not just in Wales. In our White Paper, we've been really clear about the impact on a whole range of workforce challenges. I'm sure you'll be aware of the evidence from both the BMA and the survey that they undertook, and also the GMC undertook their own survey on doctors and EU nationals working in the UK. They don't feel as valued, they're more uncertain about their futures and significant numbers of them are thinking about leaving. That's a really big problem for us.

[132] We've been talking about the challenges in medical recruitment and what that looks like now, with those doctors currently working, providing direct high-quality care with and for our communities. If numbers of them leave, well, there's no guarantee we'll replace them readily and easily because the impact of leaving the European Union isn't just on recruiting European Union nationals; it is something also about how other doctors from outside Europe see this country as well, and whether they feel welcome. Because part of the evidence also is that other doctors who are not originally from Britain don't feel welcome and valued either. I think we've been really clear as a Government that we value those people not just because they provide high-quality healthcare services, but actually they're a part of the communities that we live in, and they're a part of this country.

[133] I think the challenge is, if the message is, 'You're welcome here for a period of time, but we want to train lots of our own people, then you can go home', I think that message came out in the autumn from the UK

Government and I think that was deeply unhelpful. That resonates and that is felt in other parts of the world. If you look at some of the press in India, for example, that's been really, really unhelpful. And there's a real tension here between what health departments want and some of the different policy drivers, for example, in the Home Office, where there is an honest challenge about what the Home Office want to do. And you've seen the recent issue about having charges made for healthcare professionals coming in from outside Europe as well; well, that's deeply unhelpful, deeply unhelpful. It sends out the wrong message about whether people are welcome and whether we want them to be here or not. We know we have recruitment challenges that we need to address and part of addressing that is about recruiting doctors from outside Europe and within it, so it's a really poor message on that front, but also at a time when everybody knows there are challenges about NHS finance, to then say, 'The NHS will have to pay an additional sum to recruit people who want to come here to provide patient services that we all recognise that we need', I think it's incredibly unhelpful and short-sighted.

[134] So, I generally do worry about the reality of Brexit as the national debate continues. Because the national debate is not a kind one; it is not a generous one. The fact that European Union nationals do not have their rights as citizens guaranteed still, I think is, again, deeply unhelpful. And, again, this Government has been really clear that we think that European Union nationals should have their positions confirmed. It should not be used as a bargaining chip.

[135] As I said, there's real anger—very real anger—and very real upset on this. So, this is not a synthetic point that is used for the purpose of bashing the UK Government or that is a party-political point of view, it's real and it's obvious. I know that if you talk to politicians in other parties they'll say, 'Well, those people have said that to me as well.' Simple anecdote: I went to north Wales on Monday, early journey on the train, and I met someone that I know who, again, told me very directly that as a Dutch citizen he didn't feel welcomed in this country in the way that he had felt completely accepted in previous years. It's a real problem. We can't properly assess the impact though, because we don't know what's going to happen.

[136] **Julie Morgan:** Do you feel that this delay in knowing what's going to happen is making things more difficult?

[137] **Vaughan Gething:** Well, we want certainty. I think certainty for the

position of EU nationals would be really helpful and would go some way towards undoing some of the unnecessary damage that I think has been done. But the challenge with certainty is that some people ask, 'What is a good and a bad deal?' But, actually, because none of us know what the UK Government really wants to achieve, we can't know. And that uncertainty is not going to be helpful in terms of people who are currently here and will make choices about whether they stay or whether they go and try to practice medicine somewhere else, as well as our ability to recruit and retain people who are not here already. So, I'm due to meet the BMA to talk specifically about this issue in the coming months, but I think it's incredibly difficult and it's done real damage to healthcare right across the UK, not just in Wales. We're going to live with this challenge for a period of time because, unfortunately, I don't think there are grounds to be wildly optimistic that we're suddenly going to see helpful certainty created by the UK Government, despite the very clear view, not just of this Government, but others, and of politicians in all parties, that this is something that the Government could and should act on now.

10:45

[138] **Julie Morgan**: And then just to end on a positive note on ways of welcoming people from overseas, I know you're aware of the British Association of Physicians of Indian Origin, and we had evidence to the committee by the health boards saying how positive their initiative was. Do you think there's space for a lot more of that sort of work to be done, and also to be done to recruit possible GPs?

[139] **Vaughan Gething**: Yes, the relationship with BAPIO is incredibly positive. They're genuine partners who want to do the very best for Wales and at the same time, they're proud of the fact that they're doctors of Indian origin, so they want to talk about their links into India, as well. They've been really helpful on the medical training initiative, which is about bringing more high-quality doctors from India to undertake training, and it brought us some service provision at the same time. So, I would like to see a relationship that looks and feels like BAPIO with all of our doctors, including the doctors from the European Union, because they recognise that they're valued and they value the access that they have both to Frank and to officials in Julie's department, to discuss what they'd like to do, because they want to make the very best possible case for people to come and train and work within Wales and to train and work within our national health service. So, yes, a really good example of what the future could look like and what I would definitely

want the future to look like with doctors from within the European Union, as well as outside.

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

[141] **Dai Lloyd:** Bethan, a oedd gennyt ti gwestiwn?

Dai Lloyd: Bethan, did you have a question?

[142] **Bethan Jenkins:** [*Inaudible*.] to expand on this a bit, just in relation to finding out, not just about taking people in, but in relation to how our medical professionals have a chance, potentially, to work internationally so that they can go and practice a specialism and then bring that back. How are you mapping potential areas of development in Wales in certain areas, so that you can have a two-way process as opposed to us talking negatively about losing people? How are we sending people away and then bringing them back with more skills, so that they can develop the Welsh health diaspora in that regard?

[143] **Vaughan Gething:** Well, given that we've had someone return from an international career to return to the UK system with the CMO, and not just your own experience, but actually what we're already doing, so, I think Frank will be a helpful person to answer that.

[144] **Dr Atherton:** There are a number of dimensions there. I mean, one of the things I've been very impressed with in coming here is the Wales for Africa links and the fact that the various health boards do have ongoing quite deep links with various programmes and projects in parts of Africa, and that's a really positive thing. I was very pleased to see that local health boards have generally taken the guidance from Welsh Government to make those opportunities available to staff, to give staff leave of absence and to make sure that their indemnity arrangements are covered when they do that. So, that's one kind of dimension to it.

[145] There's also a need to look at academic links and opportunities for doctors here to look to other parts of the world—to the US and to other developed countries—to go and gain experience there, and there is a study—

[146] **Bethan Jenkins:** And, you're using that as part of the recruitment process, is what I'm trying to say, so that people, when they try for a job here, can see that they've got that potential to go and work abroad for x amount of time, and it's a sweetener, potentially, to come in and work in the

NHS.

[147] **Dr Atherton:** It's a good idea. I'm not aware of any specific initiatives around that, but it's certainly something that can be built in, because the more 'sweeteners' as you put it, the more opportunities that you build into the programme, the more attractive it becomes. We've talked a little bit about leadership. Doctors often want to step into the leadership space, but they find it difficult to do that, and so, we have a culture again, in Wales, of building leadership training into postgraduate training. For some doctors, that's very attractive. There are international fellowships that physicians from Wales can opt into—the Harkness fellowship in the US is a good example. So, I think it is an area that we need to probably explore more in terms of giving people rounded opportunities and again making Wales a very attractive place.

[148] **Vaughan Gething:** Do you want to talk about the global health posts, as well?

[149] **Ms Rogers:** Yes, okay. Just to add on to that, really, and to reassure you that when we were compiling the evidence and the business case for the Train, Work, Live campaign last year, what we did discover was that, actually, we'd not been terribly good, I suppose, in promoting the things that are on offer in Wales. Traditionally, we just relied on people finding out about it through the deanery. So, one of the aspects of the campaign was actually unearthing lots of these things that we do have on offer. But, there's more to do on that, I suppose, and with the second phase of the campaign, it's something that we'll be emphasising more strongly, because, certainly, a lot of the feedback from junior doctors is that, actually, they want that experience more broadly. They want to be able to go away, they want to be able to travel, and if we can incorporate training with travelling, that would be fabulous. So, that is an aspect of it. But we do have posts available, and there are global health posts that we do advertise and provide those opportunities to people to apply for those, and those are proving very successful and attractive.

[150] **Dai Lloyd:** Grêt. Jest dau bwynt bach i orffen sydd yn deillio o dystiolaeth rydym ni wedi ei chael yn flaenorol— eto, rwy'n mynd yn ôl at feddygaeth deuluol. Wrth gwrs, mae yna ddigon o dystiolaeth ei bod hi'n

Dai Lloyd: Great. Just two points to finish, deriving from the previous evidence that we've received—again, going back to general practice. There's enough evidence showing that it's difficult to get locums as

anodd iawn cael *locums* fel meddygon teulu, ac un o'r cwestiynau a godwyd gan rai o'r meddygon iau yn gynharach oedd beth ŷch chi'n ei feddwl am alluogi meddygon iau sydd yn F2s i weithredu fel *locum GPs*. Nid ydyn nhw'n gallu gwneud hynny ar hyn o bryd. Roeddwn i jest yn meddwl a fuasech chi'n credu bod hynny yn fodd i helpu'r sefyllfa. Ar ben hynny, pan fydd gennych chi feddygon teulu sydd yn aeddfed ac yn gyfiawn yn feddygon teulu, ond wedi bod yn gweithio yn Lloegr neu bellach i ffwrdd a ddim yn gallu dod nôl ar y rhestr perfformwyr meddygon teulu yma yng Nghymru, pa waith sydd yn mynd ymlaen i wneud yn siŵr—? Mae rhai ohonom ni ar y rhestr perfformwyr yma yng Nghymru sydd ddim yn annhebyg, y buaswn i'n disgwyl, i'r rhestr perfformwyr meddygon teulu yn Lloegr, ond, ar hyn o bryd, os ydych chi ar y rhestr honno, nid ydych chi'n gallu bod yn gweithio yn fan hyn a'r ffordd arall draw. Pa waith sydd yn mynd ymlaen yn y cefndir jest i helpu'r sawl sydd eisiau dod nôl i Gymru fel meddygon aeddfed i allu gwneud hynny?

GPs, and one of the questions that came up from some of the junior doctors was what do you think about allowing F2 junior doctors to be locum GPs. They can't do that currently. I was just wondering whether you thought that that would be a way of helping the situation. In addition, when you have GPs who are mature and are full GPs, but have been working in England or further afield and can't come back to be on the performers list for GPs here in Wales, what work is ongoing to make sure that—? There are some of us on the performers list in Wales that is not dissimilar, I would presume, to the performers list for GPs in England, but, at the moment, if you're on that list, then you can't be working here and vice versa. So, what work is ongoing in the background just to help those who want to return to Wales as mature GPs to be able to do so?

[151] **Vaughan Gething**: On the point about GPs returning, we've done all that we can to make it easier for people to be based on both performers lists in England and in Wales. It's not as easy as we'd like it to be, and it does require some co-operation from colleagues across the border. But in terms of people returning, not just from England but from other parts of the world, that was something that, to be fair, GP representatives themselves brought up, and it's something that Richard Lewis, our head of primary care, has taken on board as well, in terms of trying to make that process easier, so we have a single point of contact so you don't need to go and run around the

houses to find out what's going on. The initial view, I think, is that that's been helpful, and we've got specific examples of doctors who are returning from working internationally, who are coming back, and that process appears to be smoothing the process for that to happen. So, rather than anecdotes, we should have some more evidence about that developing through the rest of this year.

[152] I guess, just while we're on the GP training posts, I should say we expect to have numbers at the end of March from the first round. So, I don't know when you're planning to do your report, but I did want to just indicate that. When you're planning on the drafting of it, I'm happy to share those numbers with you so they can be taken account of in your report, as opposed to us providing the numbers the week after you've published your report, which you might be frustrated about.

[153] **Dai Lloyd:** We look forward to receiving that evidence. About the point about F2 locums.

[154] **Vaughan Gething:** I'm happy to consider it. There'll be a lot of things about, 'Well, what would make sense?' and, actually, because these are people who are already providing some direct patient care—so it's about making sure that we can do something that would help from a service point of view, without compromising their ability to undertake training and all the points about making sure that we can reassure ourselves and them about the quality of care that is being provided. But I'm certainly open-minded.

[155] **Dai Lloyd:** Angela had one final question.

[156] **Angela Burns:** Just one clarification, because I've had representations that the issue isn't just a performers list between Wales and the rest of the UK, but between health boards, as well, and that you have to be logged with—if you are, for example, a GP or whatever in, say, ABMU and you've been asked to go over and do some hours with Cardiff and Vale, then you've got to have made sure that you've registered with them and that whole process. If that's correct, would we not be better off to have a national register that would just work across all health boards, without having this duplication of effort and time?

[157] **Ms Rogers:** I'm happy to take that. We have made some changes in the last year, and I think we need, really, to promote those, so, hopefully, speaking about it today will help with that. We have streamlined the

processes. The Cabinet Secretary referred to the single point of contact, which makes it much easier for people. What we are doing now is, actually, once we know somebody who needs to come back, we're putting them on the list straight away and that list is being managed on an all-Wales basis by the NHS shared services partnership, so there is a list for Wales. But what there are, though, is individual employment checks for individual health boards at the moment, so we're looking at how we could streamline that and make that simpler. We've cracked it for junior doctor trainees in the GP land, but we haven't yet done it for those people who are already qualified. So, it's a work in progress, but we have made efforts to streamline it already, and to hold that as a single point of contact for the whole of Wales.

[158] **Angela Burns**: Have you got any idea of when that might occur? Because one of the points that has been made to me is that GPs are not fond of all the extra paperwork, and therefore there's a reluctance, if you're already a GP, established somewhere, to fill in another health board's endless paperwork and another health board's endless paperwork. That would surely free up hours very, very quickly.

[159] **Ms Rogers**: Absolutely. So, portability of those applications is really important and that's something that we have. We have a consistent standard and a consistent set of forms. What we've done is we've cut those back considerably. So, in terms of getting back onto the performance list, that's being streamlined and we're looking now at the things like the disclosure and barring service checks and the health and safety, and those sorts of things that need to be done where people are being directly employed. As much as we can streamline, it's really important to do that.

[160] **Dai Lloyd**: Diolch yn fawr. Dyna ddiwedd y sesiwn gwestiynau. A gaf i ddiolch yn fawr iawn i Ysgrifennydd y Cabinet, Vaughan Gething, a hefyd ei swyddogion, Julie Rogers a Frank Atherton, am eich presenoldeb, am y papur gerbron a hefyd am ateb i'r cwestiynau mor raenus y bore yma? Diolch yn fawr iawn i chi.

Dai Lloyd: Thank you very much. That's the end of this session. Could I thank the Cabinet Secretary, Vaughan Gething, and also his officials, Julie Rogers and Frank Atherton, for being here, for the paper you submitted and also for answering the questions? Thank you very much.

[161] A gaf i jest cadarnhau y byddwch chi'n derbyn trawsgrifiad

I would just like to confirm that you will receive a transcript of this

o'r trafodaethau jest i'w wirio a gwneud yn siŵr ei fod yn ffeithiol gywir. Nid ydych yn gallu newid yr agwedd ynglŷn â dim byd, ond o leiaf fe fedrwch chi wirio'r ffeithiau. Diolch yn fawr iawn i chi.

meeting, just to check for factual accuracy. You can't change the view on anything, but you can check the facts. Thank you very much.

10:56

Papurau i'w Nodi
Papers to Note

[162] **Dai Lloyd**: Rydym ni'n symud ymlaen at eitem 3, a'r papurau i'w nodi. Bydd Aelodau wedi darllen y llythyr oddi wrth Rebecca Evans, y Gweinidog Gwasanaethau Cymdeithasol ac Iechyd y Cyhoedd, sy'n hysbysu'r pwyllgor ei bod yn bwriadu cyflwyno gwelliannau'r Llywodraeth yn ystod Cyfnod 2 i wneud y newid y gwnaethom ni ei argymell fel pwyllgor, sef y dylid diwygio adran 92 o Fil Iechyd y Cyhoedd (Cymru) i godi'r cyfyngiad oedran arfaethedig ar gyfer triniaethau tyllau mewn rhannau personol o'r corff o 16 oed i 18 oed. Mae hynny'n ganlyniad cadarnhaol i ni fel pwyllgor, ac yn deillio yn union o'r dystiolaeth a wnaethom ni ei derbyn gerbron.

Dai Lloyd: We'll move on to item 3, papers to note. You will have read the letter from Rebecca Evans, the Minister for Public Health and Social Services, notifying the committee of her intention to bring forward Stage 2 amendments to make the change that we recommended as a committee, namely that section 92 of the Public Health (Wales) Bill be amended to raise the proposed age restriction for intimate piercing from 16 to 18. That's a positive outcome for us, directly arising from the evidence that we received.

[163] Mae yna ail bapur i'w nodi hefyd gan y Gweinidog, a byddwch chi wedi gweld ei bod hi wedi derbyn rhan fwyaf o'r argymhellion hynny hefyd.

There's a second paper to note from the Minister, and you will see that she has accepted most of those recommendations as well.

10:57

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

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac o eitem 1 o'r cyfarfod ar 23 Mawrth yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting and for item 1 of the meeting on 23 March in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[164] **Dai Lloyd:** Felly, gyda hynny o drafodaethau, a gaf i, gyda'ch caniatâd chi, gynnig, o dan Reol Sefydlog 17.42, ein bod ni'n penderfynu gwahardd y cyhoedd o weddill y cyfarfod yma, ac y bydd y trafodaethau ynglŷn â'r dystiolaeth heddiw yn cario ymlaen ar ffurf sesiwn breifat? Diolch yn fawr iawn i chi.

Dai Lloyd: So, with that, could I then, with your permission, move on to item 4, a motion under Standing Order 17.42 to resolve to exclude the public for the remainder of the meeting and for the discussions on the evidence to carry on in private form? Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:57.
The public part of the meeting ended at 10:57.