Agenda – Health, Social Care and Sport Committee – Fifth Senedd

Meeting Venue:
Video Conference via Zoom
Meeting date: 13 December 2018
Meeting time: 09.15

For further information contact:
Claire Morris
Committee Clerk
0300 200 6565
Contact@senedd.wales

Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

2 Evidence session with the Hospice and Palliative Care Cross-party Group

(09.30 – 10.30) (Pages 1 – 12)

Mark Isherwood AM, Chair of the Cross Party Group
Janet Finch-Saunders AM, Member of the Cross Party Group
Catrin Edwards, Hospice UK
Kathleen Caper, Hospice UK

Research Brief

Cross Party Group Hospices and Palliative Care Inquiry: Inequalities in access to hospice and palliative care

Break (10.30-10.40)

3 Rural Healthcare: Evidence session with Dr John Wynn-Jones

(10.40 – 12.10) (Pages 13 – 68)

Dr John Wynn-Jones, Chair, WONCA Working Party on Rural Practice

Research Brief

4 Paper(s) to note

(12.10)

4.1 Impact of the Social Services and Well-being (Wales) Act 2014 in relation to Carers: Additional information from Carers Trust Wales

(Pages 69 - 73)

4.2 Dentistry in Wales: Additional Information from the British Orthodontic Society on Orthodontic Postgraduate Fees

(Pages 74 - 76)

4.3 Letter from General Medical Council to Chair of Health, Social Care and Sport Committee

(Pages 77 - 89)

4.4 Letter from Llywydd to the First Minister of Wales

(Pages 90 - 91)

4.5 Letter from the Cabinet Secretary for Health and Social Services to the Chair of Health, Social Care and Sport Committee

(Pages 92 - 93)

4.6 Legal advice note: Equality Act and gender segregation in school sport

(Pages 94 - 95)

5 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of this meeting

(12.10)

6 Hospice and Palliative Care: Consideration of evidence

(12.10 - 12.15)

7 Rural Healthcare: Consideration of evidence

(12.15 - 12.20)

8 Impact of the Social Services and Well-being (Wales) Act 2014 in relation to Carers: Consideration of evidence

(12.20 - 12.30) (Pages 96 - 103)

Research Brief

Agenda Item 2

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Agenda Item 3

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Carers Trust Wales / Ymddiriedolaeth Gofalwyr Cymru

Inquiry into the impact of the Social Services and Wellbeing Act 2014 in relation to carers – supplementary evidence

Introduction

Carers Trust Wales exists to improve support, services and recognition for unpaid carers in Wales. With our Network Partners – local services that deliver support to carers – we work to ensure that information, advice and practical support is available to carers across the country.

During 2017-2018 the Carers Trust Wales Network reached over 34,000 carers, employed 480 staff and was supported by 475 volunteers.

Carers Trust Wales delivers practical support and information to carers and to those who work with them including: schools, social workers, nurses, pharmacists and physiotherapists. We also seek to influence decision-makers, the media and the public to promote, protect and recognise the contribution carers make, and the support they deserve.

Following giving oral to the committee we would like to provide supplementary evidence to highlight:

- **The role of third sector organisations in collecting data about carers**
- **The level of assessments undertaken by carers services as part of delivering preventative services effectively**
- **The role of third sector organisations in utilising carers' voice to shape services**

The role of third sector organisations in collecting data about carers

Third sector organisations that provide services to carers almost always undertake assessments of carers needs when they present to a service. For many carers this results in a detailed assessment of their needs and the development of a corresponding support plan.

Many young and young adult carers services routinely use Multidimensional Assessment of Caring Activities (MACA) and Positive and Negative Outcomes of Caring (PANOC)[1] which are recognised

1 **https://search3.openobjects.com/mediamanager/manchester/fsd/files/young_carers_multidimensional_assessment_caring_activities.pdf**

tools to understand caring needs and to inform conversations around support needs. These will be recorded and provide rich data about the levels of care undertaken at a local level.

Similarly, carers services use a range of tools to capture the needs of carers of all ages and the extent of their caring role.

However, as indicated in oral evidence, there are rarely routes for this information to be shared in a systematic way with local authorities, Local Health Boards or Regional Partnership Boards.

Individual Carers services put substantial effort in to meeting carers needs and therefore, within funding restrictions, are well placed to respond in an agile way to changes in local carer need. The richness and depth of data collected regarding the carers they support enables them to develop in ways that best meet carers' needs.

We are concerned that some public-sector bodies have indicated to us that funding streams, such as ICF, are too restrictive to enable them to work with the most effective organisations. For example, their inability to fund or work with national organisations to help them develop evidence-led decision-making processes can lead to commissioning approaches that don't make the most of the expertise available. Regions may duplicate research or fail to share learning because of an inability to commission research, evidence or information sharing at scale.

Just as local and regional carers services are experts in supporting and working with carers in our communities, it is also vital to recognise the valuable role that national third sector organisations such as Carers Trust Wales have in providing a Wales wide focus on unpaid caring. National organisations have a crucial role to play in delivering Wales wide research, innovation and co-produced solutions with and for carers and by supporting the professionals who work with unpaid carers directly.

The negative impacts of caring on carers themselves (and their families) mean planned support and sustainable investment for unpaid carers should now be prioritised as a national challenge. Delivered appropriately across sectors this will bring significant benefits to the health and wellbeing of carers and their families, save the economy millions of pounds and do much to support the pressure on our public services.

The level of assessments undertaken by carers services as part of delivering preventative services effectively

As highlighted during the oral evidence session and in our written evidence, not all carers will need a statutory needs assessment. For many carers their needs are adequately understood and met by local third sector organisations. It is important that any recommendations made by the committee recognise the value carers place on being able to access support without formalising their needs.

For many carers accessing help, support and advice through local, trusted, third sector organisations holds less stigma than achieving the same support through statutory services. Whilst it is important that the stigma of accessing appropriate support through statutory assessments is addressed it is equally important to recognise the current barrier this presents. Local third sector organisations are uniquely placed to work alongside carers to identify their needs and to find ways to meet them before they reach crisis point.

The preventative value of carers services cannot be underestimated and in large part this can be attributed to their accessibility for a range of carers. It is crucial to utilise the relationships carers services have developed within the communities they serve ensuring that carers are signposted to the most appropriate level of support, which most often will be the preventative services provided by carers services.

Our research shows that the co-location of services within centres is consistently described as contributing factor to improving carers' awareness of their rights and confidence to access the support to which they are entitled.

Additionally, carers services play a crucial role in securing funding for the support carers need. Based on their expert understanding of the needs of their local population carers services are able to develop innovative and impactful projects and approaches and are often responsible for generating the funding for them. In many cases, where carers services are commissioned to deliver statutory services, they will fundraise and work with grant giving bodies to supplement income in order to be able to deliver the service effectively. Carers services play an essential role in generating funding for preventative services and it's important to emphasise the value carers services have in both the delivery of services and ensuring their sustainability. Unquestionably the Integrated Care Fund and Transformation funds could create a much smarter, more sustainable pathway of support for unpaid carers. However, for impact to be maximised the expertise and insight of local and national third sector organisations (both in service delivery and the funding of impactful services) must be better captured and utilised.

The role of third sector organisations in utilising carers' voice to shape services

Third sector organisations are experts in engaging carers directly in the shaping of services. Whilst the challenging financial climate has made meeting demand impossible, carers services continue to ensure that their direction of travel is shaped by carers themselves.

For services to be effective it is essential that they are co-produced with carers. Carers must be supported as key contributors to the development of service specifications and involved in commissioning processes.

The National Population Needs Assessment identifies that improvements must be made to the involvement of carers in service development. Our Network Partners consistently highlight the

importance of involving carers in service design and development. However, at a regional level there remains concern about engagement being tokenistic or repetitive it is important to note that engagement needs to be meaningful and avoid repetition.

To join-up carer engagement it is important that strong relationships are built within each region between:

- Carers services
- Carers representatives on Regional Partnership Boards, and relevant associated groups that sit under them
- Carers Leads within local authorities and local health boards
- Community Safety Partnerships
- Public Service Boards
- Local and national third sector organisations that support carers

Some recognised approaches to involving carers in service development identified by our Network Partners include:

- Carers representatives on panels, boards or groups
- Developing carer forums and encourage strong links between service providers, commissioners and the carer forums
- Carers advocates or champions within services and on decision-making bodies and boards
- Focus groups to help inform the shape of services or how they're delivered
- Involvement in training for frontline professionals and decision makers

It is important to recognise that carers are often time-poor. Additionally, whilst they are experts in their lived experience they may not be practised in engaging in formal consultations or meeting processes. Therefore, our Network Partners reflect that engagement opportunities must be planned sensitively with adequate time, thought and investment put in to supporting carers to engage effectively. Some common good practices include:

- Providing replacement care
- Reimbursing expenses
- Time banking
- Developing buddy systems and opportunities for peer-to-peer engagement between carers
- Involving carers in the development of consultation resources and in the setting of agendas for formal meetings
- Circulating papers and questions ahead of meetings and consultation events both for feedback and to allow carers to prepare their thoughts and answers
- Developing shadow boards
- Holding pre-meetings to inform carers and to support them to engage effectively
- Consulting carers on appropriate venues and convenient meeting times

- Meeting with existing groups of carers to minimise the impact sharing their views has on their free time. This is something carers services are well placed to facilitate.

EE 4G 17:19 97%
record.assembly.wales

Dawn Bowden AM
12:51:13

Video

408 And rising, absolutely, yes. It was from the evidence that we'd had from the British Orthodontic Society. They were talking about orthodontic academic postgraduate qualifications and that Cardiff uni had one of the highest course fees —

Professor Alastair Sloan
12:51:35

EE 4G 17:19 97%
record.assembly.wales

Professor Alastair Sloan
12:51:35

Video

409 Not from this year onwards.

Dawn Bowden AM
12:51:36

Video

410 Okay. Great stuff.

Professor Alastair Sloan

Professor Alastair Sloan
12:51:37

Video

411 I had a robust conversation with the chair of our academic and recruitment panel, because we were significantly out of kilter.

Dawn Bowden AM
12:51:46

Video

412 Okay, and that's been addressed.

Professor Alastair Sloan
12:51:47

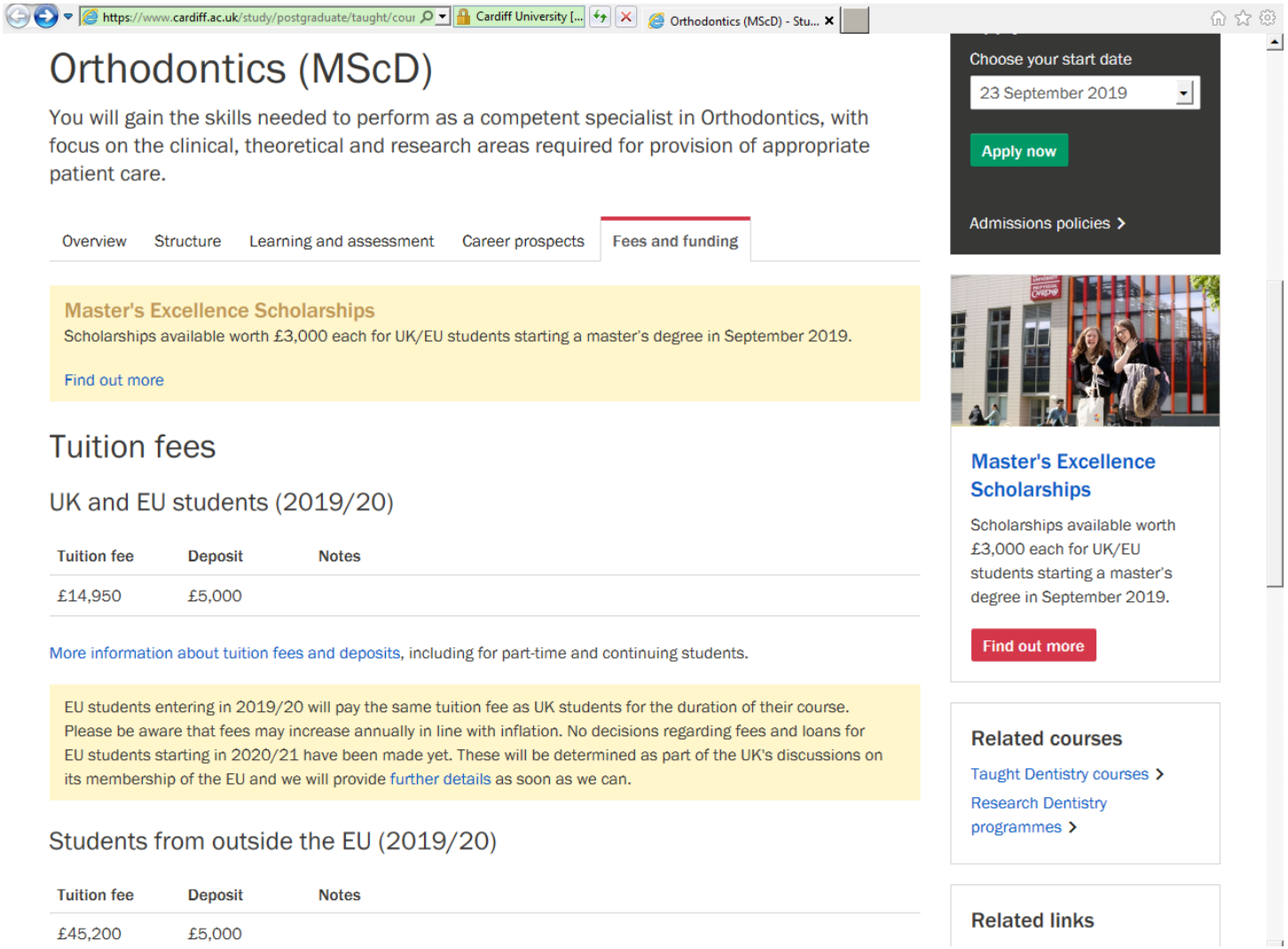
Video

413 That's been addressed.

Dawn Bowden AM
12:51:48

Video

414 Excellent, excellent. Okay, just a final question from me to the deanery, really. Your written evidence refers to dental care professionals and skill mix. Can you tell us what you consider is the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General Medical Council

Regent's Place
350 Euston Road
London NW1 3JN

[redacted]

30 November 2018

Dai Lloyd, AM
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear Dr Lloyd

Zholia Alemi

I am writing to update you on the recent case of a Zholia Alemi and how we are responding to protect patients. We recently became aware that Alemi used a fraudulent qualification to join the medical register in 1995 and worked as a doctor until June 2017.

We are acutely aware of the serious issues that this case has highlighted and we are investigating them urgently. It is clear that in this case the steps taken in the 1990s were inadequate and we apologise for any risk arising to patients as a result.

The Welsh Government is taking this matter very seriously and the Chief Medical Officer has written to all Health Boards in Wales in relation to it so that they can explore any further specific patient concerns which arise from it. We have also brought the actions of Alemi to the attention of police and other agencies, including NHS organisations and the Royal College of Psychiatrists, so that they may also take any necessary action to support patients who may have been affected. We are working closely with them so that we may take any necessary action to support patients who may have been affected.

I can reassure you that our processes are far stronger than they were when Alemi was accepted onto the medical register. We are confident that, 23 years on, our systems are robust and would identify any fraudulent attempt to join it. A doctor applying to join the register in these circumstances today would have their primary medical qualification verified with the relevant university overseas by an organisation called the Educational Commission for Foreign Medical Graduates (ECFMG) and the majority would sit and pass both parts of the Professional and Linguistic Assessments Board (PLAB) test.

All applicants must also attend our offices for an in-person ID check where documents are examined in detail. In addition, applicants are required to provide a comprehensive employment history and references from their most recent five years of

practice, and a certificate of good standing from any country in which they had practised during that period.

The legislation that governed the route she used was repealed in 2003 and it is no longer open. But we have now initiated an immediate review of all licensed doctors who joined the register via this route.

You will find attached to this letter two briefing notes about

- Her registration and practise, including all fitness to practise complaints that were raised with us and the action we took.

- An overview of how revalidation is intended to work in practice and the recommendations from Sir Keith Pearson's review of 2017. This includes information about our call to the Department of Health and Social Services to implement the changes to the Responsible Officer Regulations* that Sir Keith felt were necessary to make the revalidation process of locum doctors more rigorous and that we hope the UK Government will now progress as a matter of urgency in consultation with the Welsh Government.

Supporting your constituents

Finally, it is possible that your constituents may contact you directly about the case. Should that happen, we suggest you refer them our helpline on 0161 923 6602 or the information on what they should do on our website†.

I hope you have found this update helpful. We are committed to responding to this incident in a transparent and proactive fashion. If you have any questions or would like further information about the steps we are taking to address any patient concerns, please e-mail us at [redacted] or call on [redacted].

Yours sincerely,

[redacted]

[redacted]
Chief Executive Officer and Registrar

Enc:
- Briefing note on Alemi's registration, practise and fitness to practise complaints.
- Briefing note on how revalidation is intended to work in practice and the recommendations from Sir Keith Pearson's review of 2017.

* http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents
† https://www.gmc-uk.org/concerns/information-for-patients/local-help-services

General Medical Council

Briefing Note: Revalidation and Locum Doctors

1 Revalidation is a process through which doctors regularly demonstrate that they are up to date and fit to practise. It has been in place since 2012, and is the means by which doctors keep their licence to work in the UK. Revalidation should give confidence to patients that their doctor is being regularly checked by a senior doctor and by us. It helps doctors improve the care they give and to address any problems early.

How does revalidation work?

2 All doctors with a licence to practise collect supporting information from across their scope of work to demonstrate their practise which they discuss at an annual appraisal. They have to gather and demonstrate:

- Patient feedback
- Colleague feedback
- Quality improvement activity (most commonly a clinical audit)
- Continuous Professional Development activity
- Complaints and compliments
- Incidents and significant events

3 The doctor and appraiser will also agree a personal development plan for the coming year that will be reviewed at the next appraisal. Appraisers are trained through their local organisations and should also receive regular top-up training to ensure their skills remain current.

4 Under the law, a doctor should be connected to a 'designated body' with a 'Responsible Officer' (RO). This is normally a senior doctor or Medical Director. There are about 600 ROs across the UK. The RO should have systems to quality assure the appraisals of doctors in their designated body which can include obtaining feedback from doctors and appraisers about their appraisal systems and reviewing appraisal documentation to check content and quality. There are several tools available to use for the quality assurance of appraisals.

5 If a doctor needs extra support, or if there are concerns about their practise, the RO can take local action to address this straight away including local investigation, additional development activities or remediation. If an RO needs more time to obtain

the assurance they need that a doctor remains up to date and fit to practise, they can defer the doctor's revalidation to given them time to obtain the additional information or complete any local process. This is referred to as a 'deferral' in the rest of this note.

6 If a doctor is not engaging with local clinical governance including appraisal, the responsible officer can notify the GMC that the doctor is failing to engage with revalidation and we can take a series of steps to encourage the doctor to engage and if not, remove their licence to practice. This is referred to elsewhere in this note as 'non-engagement'.

7 The outputs of the appraisal are shared with the doctor's RO who will consider all of the outputs from appraisals throughout a doctor's revalidation cycle (usually 5 years) as well as any other clinical governance information before making a revalidation recommendation to the GMC.

Training and quality assurance of locum Responsible Officers

8 NHS England is the designated body for ROs of locum agencies in England. This means that it has oversight responsibility for quality assuring the governance processes used by the RO in these agencies. Locum agency ROs are expected to complete NHSE Responsible Officer training and regularly attend NHS England Responsible Officer Network meetings which are also attended by the GMC employer liaison advisers.

9 NHS England undertakes Higher Level Responsible Officer Quality Assurance visits of designated bodies including locum agencies in England to identify good practice and make recommendations for further development of governance systems underpinning revalidation. These reports are not routinely shared with the GMC although we have requested that they should be on a number of occasions.

10 NHS England also completes an Annual Organisation Audit of designated bodies (including locum agencies) in England each year which is a self-reported questionnaire designed to collect information about governance systems, appraisal rates and other revalidation related data[*].

[*] The most recent Annual Organisational Audit Report is available on the NHS website (https://www.england.nhs.uk/wp-content/uploads/2018/03/annex-c-aoa-2017-18.pdf

11 There are currently no locum agencies with designated body status based in Scotland, and two in Wales. Doctors working in locum posts in Northern Ireland are connected to locum agencies in England. There are currently no locum agencies with designated body status based in Northern Ireland.

12 GMC employer liaison advisers routinely meet with ROs of locum agencies (and all other designated bodies) to discuss any Fitness to Practise and revalidation issues associated with doctors who work for them. They provide advice on referral thresholds for fitness to practise and revalidation recommendations especially multiple deferral and non-engagement recommendations about doctors.

Taking Revalidation Forward

13 As part of his review into how revalidation has been delivered throughout the UK, Sir Keith Pearson made a number of recommendations specific to its effectiveness in relation to locum doctors. He noted that:

"We need to strengthen assurance around locum doctors…It is increasingly common for doctors to work as locums, for lifestyle or other reasons. That is not a problem in itself – most of these doctors are good doctors, and many healthcare providers rely on them and speak highly of the contribution they make….

[However,] I [do] have some concerns about the current position for revalidation of locums. There is some confusion as to where prescribed connections lie for secondary care locums in England, especially where the doctor is employed by a sub-contracted agency. This situation appears to be caused by a lack of clarity in both the RO Regulations and the CCS Framework Agreement. I heard that not all locum agencies are properly fulfilling their responsibilities as designated bodies in terms of ensuring that locum doctors are up to date with appraisal and supporting them to collect and reflect upon the evidence required.

I regard the lack of clarity around revalidation arrangements for locums as unacceptable. The public has the right to expect that governance arrangements are of the same high standard, regardless of the size or type of organisation that is responsible for a locum doctor's revalidation;

I would like the Departments of Health in England (in consultation with Scotland and Wales) and Northern Ireland to look again at the provisions in the RO Regulations for connecting locum doctors to a designated body to make sure that locum doctors have a clear connection to an organisation that is accountable and has robust clinical governance systems.

I am also concerned about the potential for information about a locum's revalidation and appraisal history to be lost when a doctor moves between

***provider organisations and roles**. My starting point – and one that I am sure the public would share and expect – is that, when a doctor moves between designated bodies, and between postings, information pertaining to their revalidation should move with them. So there needs to be a clear obligation to share information on an appropriate basis where this is relevant to a doctor's revalidation.*

14 Sir Keith went on to make two associated recommendations:

- Government health departments should review the criteria for prescribed connections for locums on short-term placements
- The GMC, working with others, should address weaknesses in information sharing in respect of doctors who move between designated bodies

The GMC's actions to strengthen revalidation for locums following the Pearson report

The GMC accepted Sir Keith's recommendations, and has now delivered all of those that it is within our statutory powers to do so. Our full response to the review and the steps we've taken since its publication is available on our website[*]. In particular, we have:

- Worked with partner organisations across all four countries to create UK-wide principles for sharing information. The principles provide clarity about what doctors should tell their RO and what information an RO can share about them. We have also asked the Government to update the RO regulations to place a legal obligation on ROs to share information in this way[†].

- Gathered intelligence from our employer liaison service to identify the kinds of issues doctors who work in multiple locations face with revalidation. We used this information to create a checklist for both ROs and designated bodies summarising their main responsibilities. These checklists emphasise that local systems should be put in place to support locums and others who work in more than one location.

- Developed and published a handbook on effective clinical governance for the medical profession. It focuses on the development robust and effective clinical governance systems in designated bodies and other healthcare organisations. We worked with stakeholders to review and update the handbook to capture learning and best practice from healthcare organisations. We have also expanded the handbook so it covers the whole RO function. This includes appraisal, responding to concerns and pre-employment checks. Following RO feedback, we have also developed a self-assessment tool to help organisations review their governance arrangements.

[*] https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/revalidation-resources/monitoring-and-evaluating-revalidation

[†] The Medical Profession (Responsible Officers) Regulations 2010 as amended by the Medical Medical Profession (responsible officers) (Amendment) Regulations 2013

- We worked with partners to establish a framework and accompanying 'best practice' measures to make sure we can continue to understand how revalidation is working in practise and whether it is achieving its aim. The framework sets out ways of tracking whether revalidation activities are happening and what the impacts are. ROs can use these measures to understand whether aspects of revalidation are working as expected in their designated bodies.

- We have begun an analysis of decisions to defer a decision on revalidations on the part of ROs, as well as non-engagement with the process on the part of the doctors on our register. This will ensure that we can better understand the nature of these recommendations and the groups of doctors impacted including locums.

Actions by Government agencies to strengthen revalidation for locums following the Pearson report

15 NHS England have published guidance for locums and doctors in short-term placements along with accompanying guidance for supporting organisations engaging with locums and doctors in short-term placements. We are not aware of any similar guidance being published in the devolved nations.

Outstanding Department for Health and Social Care actions to strengthen revalidation for locums following the Pearson report

16 To deliver on Sir Keith's recommendations, the Government would need to lay a negative statutory instrument before parliament. We have made a number of suggestions where the legislation could be amended to reinforce the responsibilities of ROs and make local systems more robust. They include delivery of Sir Keith's recommendations in relation to locum doctors.

17 Our understanding is that the regulations are currently under review and that Ministers have agreed that such changes should be publicly consulted on over the course of 2019, with the statutory guidance that supports the regime being revised in parallel.

18 It should be noted that the GMC has raised the need for these reforms with officials over a period of several years. In 2016, we commissioned legal advice in relation to locum agency issues and shared that advice with the Government. We remain concerned that the UK Government have not clarified the status of locum connections and, specifically, the status of locum frameworks and subcontracting agencies under the relevant regulations

Other ongoing initiatives

19 In early 2019, NHS Employers will update its guidance on the appointment and employment of NHS locum doctors. This guidance safeguards the quality of patient care by setting the standards for appointing and assessing NHS locum doctors.

General Medical Council

Briefing Note: Zholia Alemi

Her registration and practice

Zholia Alemi applied to register in 1995. On the basis of her fraudulent qualification, she was granted a type of registration known as provisional registration. This meant that she could only work in supervised posts in the NHS and would need to complete a year in practice, under supervision, before she could be recommended for full registration. She completed that year's practice in two hospitals in Northern Ireland and was granted full registration in 1997 following recommendations from her supervising consultants.

We know that she worked in a range of locations, in the twenty years from that grant of full registration until we suspended her from the register in 2017 and that she worked as a locum for a significant period of time. We also know that she sat and passed the Member of the Royal College of Psychiatrists exam in 2003. At the time, this was a two part exam with both written and clinical parts. The MRCPysch, as it is known, is awarded to those doctors who have completed at least three years training in psychiatry and who pass the two part test. The College subsequently recommended her for entry to our Specialist Register in 2012 in psychiatry with learning disability. This meant that the College was satisfied that she had demonstrated the knowledge, skills and experience required to be appointed as a substantive consultant in the NHS.

Her fitness to practise

Since we confirmed Zholia Alemi gained registration fraudulently in 1995 we have been reviewing all fitness to practise complaints that were raised with us about her. In all we investigated nine complaints during the 23 years that she was on the register, and in the majority of these referrals we took action to address the issues raised.

- A concern about Zholia Alemi was raised with us in 1998 when there was a complaint about inappropriate personal comments made by her to a patient. This was closed by the GMC but the matter was handled locally - restrictions and supervision were put in place to address the issue.

- In 2004 we received a complaint which culminated in Alemi being given formal advice about the need to demonstrate sensitive communication with families.

- The next time that concerns were raised about Alemi was in December 2010 – this led to her receiving a warning in 2012. From December 2010 until the warning was given in July 2012 we investigated the concerns that had been raised, as well as some new concerns that came to light during the course of that investigation. Matters arising from the warning were later referred to a hearing, which took place in 2017 and at which she was found not impaired by a medical practitioner tribunal. In 2018 she was given a 12 months suspension following a further medical practitioner tribunal.

A more detailed timeline, the nature of these concerns and the action we took on each occasion is provided at Annex A.

Her revalidation

Alemi was revalidated in 2013. At the time, her designated body was a locum agency called Pulse Healthcare Ltd. This agency later merged with some others to become Independent Clinical Services. They have sent us all the paperwork in relation to the recommendation they made to us at the time and we are currently reviewing it in detail. What we do know is that the doctor who appraised her work in 2013 was a psychiatrist as was the Responsible Officer of Pulse Healthcare at the time.

Please refer to the separate briefing note for an overview of how revalidation is intended to work in practice and the recommendations from Sir Keith Pearson's review of 2017. This includes information about our call to the Department of Health and Social Care to implement the changes to the Responsible Officer Regulations that Sir Keith felt were necessary to make the revalidation process of locum doctors more rigorous and that we hope it will now progress as a matter of urgency.

Annex A: Zholia Alemi's fitness to practice history

June 1998, Sperrin Lakeland Health and Social Care Trust

Concern: Patient complaint of inappropriate personal comments by Alemi.

Action: Allegation denied. Not sufficient to consider GMC restricting practice but local restrictions and supervision put in place to address alleged behaviour.

Result: Closed February 1999.

September 2004, Manchester Mental Health and Social Care Trust

Concern: Complaint from family of a patient with learning difficulties. Allegations were that Alemi showed an adversarial attitude towards the patient's family. They also complained about inappropriate prescribing and decisions regarding the patient's stay in a residential unit.

Action: Following a full investigation two aspects were considered – poor communication and inappropriate prescribing. GMC case examiners, one lay and one medical, decided communication issues did not meet our threshold for restricting her practice, removing her registration or issuing a warning. They did consider that formal advice should be given to Alemi about the need to demonstrate sensitive communication with families. Concerns were expressed that she had prescribed medication without a proper monitoring plan in place but noted her prompt action when concerns were raised.

Result: Formal Advice issued to Alemi in April 2005.

December 2010, Rowan House (Care Principles)

Concern: Following concerns about her practice and conduct Alemi's contract was terminated and a review was undertaken by her employer. The review revealed a number of concerns about her behaviour towards a number of other staff members, failing to engage with multi-disciplinary teams and inappropriately agreeing contracts with patients regarding their medication.

Action: Investigation opened. During investigation we received further information from other organisations relating to Alemi, including a historical conviction for careless driving which she had failed to declare to the GMC, misuse of work email, inappropriate comments and behaviour to patients and staff, misrepresenting posts on her CV, failing to disclose the ongoing GMC investigation to her employers and undertaking work requiring S12 Mental Health Act approval when she didn't have that approval.

Case examiners considered all aspects individually and collectively. The case examiners considered that some allegations fell significantly below the standards expected. Given the departures from expected standards they determined she should be issued with a warning.

Result: Warning issued – addressing the driving conviction, failure to inform the GMC, working without S12 approval, misleading details on her CV and failure to declare the GMC investigation. Alemi accepted this warning in July 2012 – it was to appear on her public medical register records for 5 years.

September 2012

Alemi asked for a review of the decision to issue her with a warning.

Action: Alemi's request was considered through the legal process set out in our FTP Rules (Rule 12). In July 2013 we re-opened the case on the basis of that parts of the original decision should be looked at again but also on new information received. Further evidence was required on some of the allegations and an investigation took place.

The reopened investigation also considered:

Concern: We received information that Alemi failed to disclose a previous speeding conviction. (December 2011)

Concern: Referral from a colleague regarding bullying and unprofessional behaviour received in June 2013 from Ivydene Willowhay LTD (Care Principles). We opened an investigation which uncovered further allegations such as failure to declare the GMC investigation to her employers and over-stepping boundaries with a patient.

Concern: In January 2014 The Metropolitan Police Service notified us that Alemi had allegedly assaulted a police officer. Alemi had failed to disclose this to us.

Interim Orders Tribunal: Alemi was given conditions on her practice in October 2015. These stayed in place until 25 January 2017 when the High Court refused an application by the GMC to further extend the conditions, while investigation was ongoing.

Result: In October 2016 some of these allegations were referred to a Medical Practitioners Tribunal.

A Medical Practitioners Tribunal took place between May and July 2017. The allegations included: rudeness, inappropriate behaviour, inaccurate declaration.

MPTS outcome: The Tribunal found most of the facts found proven but did not make a finding of misconduct.

June 2013, St George's Healthcare Trust

Concern: Allegation that Alemi attempted to obtain a copy of leave form and pharmacy prescription card for fraudulent purposes.

Action: Investigated.

Result: Closed for lack of evidence in December 2013.

June 2016, The Cumbria Partnership NHS Trust

Concern: We received information Alemi had been arrested on a charge of theft from a dwelling. She was subsequently found guilty on 18 October 2018 and imprisoned on in relation to the following offences:

Interim Orders Tribunal: Alemi was suspended in June 2017. This suspension stayed in place until she received a substantive 12 month suspension in August 2018 (see below).

Action: Investigation had been conducted and Alemi had been referred to a Medical Practitioners Tribunal.

Result: Tribunal will not take place following discovery that Alemi's primary medical qualification was fraudulent. Alemi has been removed from the register for a fraudulent application.

July 2017, Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

Concern: We received information that Alemi had applied to renew her Mental Health approved status but had not declared she was subject to an ongoing GMC investigation.

Action: In 2018 this was referred to a Medical Practitioners Tribunal which took place 15 – 17 August 2018.

Result: Alemi was suspended for 12 months.

Agenda Item 4.4

Elin Jones AC / Llywydd
Cynulliad Cenedlaethol Cymru
Elin Jones AM, Presiding Officer
National Assembly for Wales

Rt Hon Carwyn Jones AM
First Minister of Wales
Welsh Government
Cardiff Bay
CF99 1NA

Your ref:
Our ref: EJ/CE

4 December 2018

Dear Carwyn

At the Chairs' Forum meeting, on 28 November 2018, we discussed the role of the Assembly and its committees in scrutinising Brexit-related legislation. Chairs raised an emerging concern about the role of the Assembly in the process of legislating for Brexit.

Chairs reported that the Welsh Government has sought delegated powers for Welsh Ministers in a number of Brexit-related UK Bills, rather than bringing forward its own Bills for scrutiny by the Assembly. In terms of the subordinate legislation needed to correct the statute book ahead of leaving the European Union, I understand that you have agreed to a significant proportion of this legislation being made by UK Ministers, using concurrent powers on behalf of Welsh Ministers.

Whilst I, and the Chairs' Forum, understand that you have made these decisions on the grounds of efficiency for the governments involved in the process, the concern expressed by Chairs is that this comes at a cost of the Assembly's role and therefore Members' ability to effectively represent the interests of the people of Wales in the process of legislating for Brexit.

In representing the views expressed to me by Chairs, and acting in the interests of the Assembly's position in the Brexit process, I have concerns that the cumulative effect of these Welsh Government decisions is an inadvertent bypassing of the Assembly's role.

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Elin Jones AC, Llywydd
Cynulliad Cenedlaethol Cymru
Elin Jones AM, Presiding Officer
National Assembly for Wales

I am sure that you would agree that the scrutiny of legislation that falls within the competence of the Assembly or Welsh Ministers, particularly relating to important areas of policy affecting citizens, benefits from far greater Wales-specific scrutiny when considered by the Assembly.

The limited opportunity for scrutiny offered by legislative consent conventions and associated procedures is incomparable with the Assembly's full legislative scrutiny processes.

Further, legislative scrutiny by the Assembly offers a more accessible and transparent process for Welsh stakeholders and the public, and also ensures the law is made in both of our official languages.

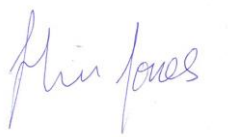
Just as you have striven to ensure a role for the Welsh Government in the Brexit process, I must ensure that the Assembly, and its Members, are enabled to play the full role they were elected to perform.

I understand that Assembly committees are planning to undertake further work in this area and I am sure that they will continue to raise issues with you and the Welsh Ministers.

In the meantime, I ask that you consider the concerns that have been raised and I would be grateful for your thoughts on how you might ensure that the Welsh Government does all it can to enable the Assembly to play its full part in legislating for Brexit.

I have copied this letter to Chairs of the Assembly's committees, the Leader of the House, and the Cabinet Secretary for Finance (in light of his role in the Brexit process).

Yours sincerely



Elin Jones AM
Llywydd

Agenda Item 4.5

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MA-P-VG-4127-18

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

6 December 2018

Dear Dai,

Spending on Primary Care

In my evidence session to the Health, Social Care and Sport Committee's scrutiny of the Draft Budget on 7 November 2018, I agreed to provide a note on spending on primary care.

Capital Spending

In December 2017, I launched a pipeline of 19 primary care projects across Wales to be delivered by 2021. Of these, 15 are capital schemes and 4 are revenue funded schemes. The schemes are a combination of refurbishment and redevelopment of existing NHS assets and new build projects. These are subject to provision of successful business cases by the relevant NHS bodies.

When the pipeline was launched with £68m identified to support the delivery of the pipeline over the period 2018-2021. As the business cases for the schemes are being developed, further funding requirements are being reported. As a result, the draft budget provides additional capital funding of £4.5m in 2020-21. The provision of a new generation of integrated health and care centres through this pipeline is a key commitment in *Taking Wales Forward* and a cornerstone of the Health & Wellbeing Policy in *Prosperity for All*.

Revenue Spending

With regard to revenue spend you asked for the amount of funding going to primary care in each of the last three years. I can confirm the amounts are as follows:
2015-16 £1,365m
2016-17 £1,374m
2017-18 £1,436m, which in each year represents 21% of the total health budget.

In 2018-19, we would expect the investment to increase by approximately £27.7m to reflect the agreed DDRB increase for GPs and dentists and in 2019-20, subject to IMTPs, we will expect further investments in primary care in addition to the agreed DDRB increase.

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I trust the Committee will find this information helpful.

Yours sincerely,

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

Pwyllgor Iechyd, Gwasanaethau Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-35-18 Papur 6 / Paper 6

Gwasanaethau Cyfreithiol | Legal Services

LEGAL ADVICE NOTE TO THE HEALTH, SOCIAL CARE AND SPORT COMMITTEE ("the Committee")

THE EQUALITY ACT 2010 AND GENDER SEGREGATION IN SCHOOL SPORT

This legal advice note sets out the circumstances in which gender segregation in school sports may be permitted.

The Equality Act 2010 ("the 2010 Act")

The 2010 Act forbids discrimination in relation to access to benefits, facilities and services; however, competitive sport is exempt from some aspects of the 2010 Act in particular, discrimination in a gender-affected activity.

Section 195 of the 2010 Act permits single-sex sports and applies to participation in any sport or game, or other activity of a competitive nature, where the physical strength, stamina or physique of the average woman (or girl) would put her at a disadvantage in competition with the average man (or boy).

Also, section 195(4) of the 2010 Act stipulates that " in considering whether a sport, game or other activity is gender-affected in relation to children, it is

appropriate to take account of the age and stage of development of children who are likely to be competitors".

So, in a school setting this exception would permit single sex sports for older children as it could be considered to be objectively justified and/or proportionate due to differences in average physical strength/physique between sexes. It might be less easy to justify for younger children i.e. infants whom ordinarily are not segregated for physical activity. Notwithstanding this, it may still be justifiable to segregate younger children. An assessment would have to be undertaken on a case-by-case basis.

Whilst section 195 would permit a mixed school to have a boys-only football team, a school under the Equality Act 2010 would still have to allow girls equal opportunities to participate in comparable sporting activities. It would also, be unlawful discrimination for a school to treat one group (i.e. girls) less favourably than another group (i.e. boys) for example, by providing the boys' hockey or cricket team with much better resources than the girls.

To date, there have been no reported cases in relation to gender segregation of sports in a school setting under the Equality Act 2010.

Legislative competence

Under Schedule 7A to the Government of Wales Act 2006, the Assembly does not have competence to modify provisions of the 2010 Act in relation to this particular matter. It is reserved to the UK Parliament.

Legal Services

December 2018

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