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

11/05/2017

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Rhun ap Iorwerth Bywgraffiad|Biography	Plaid Cymru The Party of Wales
Dawn Bowden Bywgraffiad|Biography	Llafur Labour
Jayne Bryant Bywgraffiad|Biography	Llafur Labour
Suzy Davies Bywgraffiad|Biography	Ceidwadwyr Cymreig (yn dirprwyo ar ran Angela Burns) Welsh Conservatives (substitute for Angela Burns)
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

Ruth Crowder	Coleg y Therapyddion Galwedigaethol College of Occupational Therapists
Alison Davies	Cyfarwyddwr Cyswllt Ymarfer Proffesiynol, Coleg Nyrsio Brenhinol Cymru Associate Director Professional Practice, Royal College of Nursing Wales
Mair Davies	Cyfarwyddwr dros Cymru, Cymdeithas Fferyllol Frenhinol Director for Wales, Royal Pharmaceutical Society
Philippa Ford	Cymdeithas Siartredig Ffisiotherapi Chartered Society of Physiotherapy
Mark Griffiths	Cadeirydd, Fferylliaeth Gymunedol Cymru Chair, Community Pharmacy Wales
Judy Henley	Cyfarwyddydd Gwasanaethau Contractor, Fferylliaeth Gymunedol Cymru Chair, Director of Contractor Services, Community Pharmacy Wales

Lowri Jackson	Uwch gynghorydd polisi a materion cyhoeddus ar gyfer Cymru, Coleg Brenhinol y Meddygon Senior Policy and Public Affairs Adviser for Wales, Royal College of Physicians
Louise Lidbury	Cynghorydd Gofal Sylfaenol, Coleg Nyrsio Brenhinol Cymru Primary Care Adviser, Royal College of Nursing Wales
Dr Gareth Llewelyn	Is-Lywydd dros Cymru, Coleg Brenhinol y Meddygon Vice President for Wales, Royal College of Physicians
Dr Brendan Lloyd	Cyfarwyddwr Meddygol, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Medical Director, Welsh Ambulance Services NHS Trust
Grayham McLean	Arweinydd Gofal heb ei Drefnu, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Unscheduled Care Lead, Welsh Ambulance Services NHS Trust
Suzanne Scott-Thomas	Cadeirydd, Bwrdd Fferylliaeth Cymru, Cymdeithas Fferyllol Frenhinol Chair, Welsh Pharmacy Board, Royal Pharmaceutical Society
Dr Alison Stroud	Coleg Brenhinol y Therapyddion Iaith a Lleferydd Royal College of Speech and Language Therapists
Martin Woodford	Is-gadeirydd, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Vice Chair, Welsh Ambulance Services NHS Trust

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

Sarah Sargent	Dirprwy Glerc Deputy Clerk
Sian Thomas	Clerc Clerk
Dr Paul Worthington	Y Gwasanaeth Ymchwil Research Service

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

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

[1] **Dai Lloyd**: Croeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. O dan eitem 1, ymddiheuriadau, dirprwyon ac ati, fe allaf i gyhoeddi bod Angela Burns wedi cyflwyno'i hymddiheuriadau ac mae Suzy Davies yma ar ei rhan fel dirprwy. Felly, croeso i Suzy i gyfarfod y pwyllgor iechyd. Croeso i'm cyd-Aelodau hefyd.

Dai Lloyd: Welcome to the latest meeting of the Health, Social Care and Sport Committee, here at the National Assembly for Wales. Under item 1, apologies, substitutions, et cetera, I can announce that Angela Burns has submitted her apologies. Suzy Davies is her substitute today. So, welcome, Suzy, to the health committee meeting. Welcome also to my fellow Members.

[2] Yn ogystal â hynny, fe allaf i hefyd gyhoeddi yn gyffredinol fod y cyfarfod yma, yn naturiol, yn 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 well ar sianel 2. A allaf i atgoffa pobl, yn benodol, felly, fy nghyd-Aelodau a minnau, i naill ai ddiffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall neu i'w rhoi ar dawel neu yn y modd sydd yn gyfystyr â bod mewn awyren? Nid bod yna unrhyw debygrwydd yn yr ystafell yma ichi fod mewn awyren. A gallaf i hefyd eich hysbysu yn bellach nad ydym ni'n disgwyl tân y bore yma? Felly os bydd y larwm yn canu, mae ishio dilyn cyfarwyddiadau'r tywyswyr a gadael yn y modd priodol.

Can I also let you know that this meeting, of course, is bilingual? Headphones can be used for simultaneous translation from Welsh to English on channel 1, or for amplification on channel 2. Can I remind everyone, please—my fellow Members and myself—to turn off our mobile phones and any other electronic equipment, or perhaps put them on silent, if you will, or in flight mode? Not that we're expecting being in this room to feel as though you're on an aeroplane. Can I also let you know that we're not expecting a fire this morning? So, if you do hear the alarm, please follow the directions of the ushers and leave the building in an orderly fashion.

09:31

Ymchwiliad i Ofal Sylfaenol—Sesiwn Dystiolaeth 3—Coleg Brenhinol y Meddygon
Inquiry into Primary Care—Evidence Session 3—Royal College of Physicians

[3] **Dai Lloyd**: Felly, gyda chymaint â hynny o ragymadrodd, fe wnawn ni droi i eitem 2, ymchwiliad i ofal sylfaenol—meddygon teulu a'r clystyrau. Hon ydy sesiwn dystiolaeth rhif 3, ac o'n blaenau ni'r bore yma mae dau hen ffrind o Goleg Brenhinol y Meddygon. Fel rydw i wedi cyfeirio eisoes, dyma'r drydedd sesiwn dystiolaeth. Rydym ni wedi derbyn eich tystiolaeth ysgrifenedig hefyd, felly diolch yn fawr iawn am hwnnw. Felly, croeso i Dr Gareth Llewelyn, is-lywydd Cymru, o Goleg Brenhinol y Meddygon, a hefyd Lowri Jackson, uwch-ymgynghorydd polisi a materion cyhoeddus Cymru, Coleg Brenhinol y Meddygon. Croeso i chi'ch dau. Fel rydw i'n dweud, mae Aelodau wedi darllen eich papur swmpus mewn manylder, ac felly awn ni'n syth i mewn i gwestiynau. Mae'r cwestiynau cyntaf o dan ofal Caroline Jones.

Dai Lloyd: With that introduction, then, can I turn to item 2, inquiry into primary care? We're looking at GPs and the clusters. This is evidence session 3, and before us this morning we have two old friends from the Royal College of Physicians. As I have already mentioned, this is the third evidence session. We have received your written evidence, so thank you very much for that. So, welcome Dr Gareth Llewelyn, vice-president for Wales, Royal College of Physicians, and Lowri Jackson, senior policy and public affairs adviser for Wales, Royal College of Physicians. Welcome to you both. As I say, Members have read your written submission in detail, so we'll go straight into questioning, if that's okay. The first questions are from Caroline Jones.

[4] **Caroline Jones**: Diolch, Chair. Bore da. There seems to be limited evidence regarding the impact of clusters. What quantifiable data are there about the impact cluster initiatives are having in terms of reducing, for example, the demand for hospital-based services?

[5] **Dr Llewelyn**: Thank you very much. I think you're right that the evidence is limited, but it's probably the way forward. I think that if we don't work together, not only within GP structures, but that there's a co-working between secondary and primary care, then the system won't survive as it is at the moment. The evidence is not there, so we need to provide or look for

that evidence. But our premise is that, as a college—and we're delivering specialist care within the hospital setting at the moment—is that that should be moved out into the community setting, and that primary care is not synonymous with GPs only. So, primary care involves other workers—pharmacists, opticians, therapists—and that we all work together to deliver for patients an appropriate level of care close to their home, rather than bringing them into the hospital setting.

[6] **Caroline Jones:** So, what sort of time frame are you looking at to present the data, the evidence of clusters—

[7] **Dr Llewelyn:** Well, I don't have a specific time frame. I think that, as a neurology lead within Aneurin Bevan, we work very closely with our primary care colleagues and set up electronic advice systems, but, actually—and it may be a double-edged sword—my knowledge of cluster structuring is pretty basic. So, there's a communication—

[8] **Ms Jackson:** I think that reflects, actually, the evidence we received from our members. So, we have 1,200 members in Wales, most of whom work across 30 medical specialties, most of whom are based in hospitals. They work, by and large, in unscheduled care. They are responsible for the hospital admissions that come in through accident and emergency. Once they've been through the emergency department, they become the responsibility, then, of our doctors. An overwhelming number of them said that they'd had very little engagement with GP clusters. Actually, even the specialty leads in certain areas said they hadn't had that much engagement with the clusters. So, there's a huge missed opportunity there to join up those two sectors. One of our doctors who is really engaged in her health board in restructuring unscheduled care said it's a huge missed opportunity that the clusters haven't actually done that much on unscheduled care. They're not that interested at the moment because they've got a lot on their plates trying to look at their own scheduled care side of things. But actually, overwhelmingly, we heard from our members that that's really the long-term solution: better working between clusters and secondary care, because otherwise you don't sort out the systemic problems in the first place.

[9] **Caroline Jones:** Okay, thank you. We've also heard concerns about demonstrating the impact of clusters. What do you think can be done to ensure that there is a robust evaluation of their work to ensure good practice and effective service models being rolled out?

[10] **Dr Llewelyn:** To try and measure outcome is quite a challenge, but I think that the model that we're looking for is different ways of communicating, so that, in primary care or in the community, if you were to set up specialist clinics, that they could be perhaps done through telemedicine. But our knowledge about the costing of those and how efficient they are is pretty basic. We don't have much data on their value other than patients think it's a very good idea. So, you're giving the patient a better-quality experience of their involvement with the healthcare system, but there's a bit more work that needs to be done.

[11] **Caroline Jones:** So, when you say that patients are telling you this, is that documented?

[12] **Dr Llewelyn:** Well, it's anecdotal experience. As a neurology service in Aneurin Bevan, we run clinics in community hospitals so that patients who have neurological conditions don't have to travel into the main hospital. The feedback that we get is that it's a highly valued service. They find that the parking is easier; the transport is easier; they don't need to take a whole day off. Services should be closer to the patient. Those who don't need to come into a hospital environment should be kept away from that environment.

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

[14] **Ms Jackson:** I think that's reflected in other projects that we run. We have a video clinic project in north Wales, working with palliative and chronic obstructive pulmonary disease, and working with respiratory medicine as well. In that particular project, we know that the patient satisfaction rates for that model, which is follow-up video clinics running out of community hospitals in rural Gwynedd feeding into the specialties who are based in Ysbyty Gwynedd—patient satisfaction rates are 80 per cent plus. They're really happy with that system. As Gareth said, what we don't know is actually a great deal about the cost—whether that saves costs or whether there is—. There is a good argument to say that there's much wider economic value to that, because you are not asking families to take time off work to transport patients, you're not asking patients themselves to take time off work, there are fewer cars on the road—there's a whole wide societal impact.

[15] **Caroline Jones:** So, it's difficult to measure.

[16] **Ms Jackson:** It's very, very difficult to measure, unfortunately. And we're not convinced—and neither are our doctors—that we're gathering that

data effectively. In terms of the GP cluster side of things, it may be that they simply don't have the time to be gathering that data in a robust—. Because it's all very well gathering data, but you then need to be able to use that data. You need to be able to analyse that data. There's no point collecting data if you're not going to then try and draw some conclusions from it, and that all takes time and capacity.

[17] **Dr Llewelyn:** But on your point as well, without the data, you can't plan.

[18] **Caroline Jones:** Yes, you can't plan or measure. Thank you. Finally, you touched, Lowri, on unscheduled care. So, I'm asking: what do you think clusters can do to put more emphasis on tackling unscheduled care?

[19] **Dr Llewelyn:** Well, I think that it's about understanding. So, by co-working, I need to understand what the pressures—what do the GPs want, what does primary care want from a specialist service? Likewise, primary care needs to understand what is appropriate to be sent into hospital.

[20] I think that the other thing is that in the community, now, we have nursing homes, care homes, and those patients are often sent to hospital without really needing to be there. Maybe there's an education that we need to do about how you manage those patients who are in nursing homes and care homes better, rather than just dialling for the ambulance and sending them in. Maybe the role, which we've been advocating, of a community physician—. It's working together, and that will undoubtedly reduce the pressure on unscheduled care.

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

[22] **Ms Jackson:** There's also a role, I think—. It's a two-way system, because, as Gareth pointed out earlier, it's not just about GP clusters reaching out, it's about secondary care reaching in, but it is interesting to note that, when you look at all of the strategies around GP clusters, it's all about the primary care workforce. It's all about—well, there's no real recognition there that, actually, the secondary care workforce could be part of that. It's still very siloed; even in the strategic planning that we are doing around new ways of working, it's still quite siloed.

[23] There's a lovely model in Rotherham, for example. The director of integrated care up there calls himself a community physician. He's a

respiratory secondary care specialist by trade, but he very much considers himself a physician working in the community. He runs a daily clinic. Rotherham is a post-industrial society, they've got an awful lot of chronic obstructive pulmonary disease and respiratory illness, and so it's far more helpful for him to be based out in the community. If a GP sees somebody who he thinks will benefit from a second opinion, he can refer him into a clinic that afternoon, and then that respiratory specialist can decide whether or not, within 24 hours, they need to enter the secondary care system or could they be referred back into primary care with medication or with follow up.

[24] That particular team in Rotherham also has physios and OTs based in the surgery, so, if a referral to the physio team comes in, but it's perhaps not quite appropriate and could go to the OTs instead, they just hand it across the desk to their colleagues. There isn't then a two-week wait while it gets sent in the post and then the OTs take two weeks to sort out who's going to be dealing with it and then they take another week or two to get a letter out. That's where the delays happen. Whereas if you are co-locating staff closer to patients, there are huge advantages to that, and huge advantages not only to patients but also to staff morale, because it's hugely dispiriting to work in a system where there are barriers up constantly.

[25] **Dai Lloyd**: Ocê. Rhun, roedd gen ti gwestiwn atodol fan hyn.

Dai Lloyd: Okay. Rhun, you had a supplementary question here.

[26] **Rhun ap Iorwerth**: Efo'ch caniatâd, Cadeirydd, gwnaf i sôn yn fan hyn am y cwestiynau roeddwn i wedi bwriadu eu gofyn yn nes ymlaen. Ynglŷn â chynllunio gweithlu, rydym ni'n gwybod bod cynllunio gweithlu yn un o'r problemau mwyaf rydym ni'n eu wynebu—prinder staff, prinder meddygon teulu, prinder nyrsys ardal ac yn y blaen. I ba raddau mae newid systemau o'r math rydych chi'n sôn amdano fo, cael ysbytai a meddygfeydd, er enghraifft, i weithio'n well gyda'i gilydd, yn gam tuag at ddatrys y broblem gweithlu yna a'r diffyg staff? Hynny ydy, cael

Rhun ap Iorwerth: With your permission, Chair, I'll mention here the questions that I had intended to ask later. Regarding workforce planning, we know that this is one of the biggest problems that we're facing—a lack of staff, a shortage of GPs and of nurses in the community and so forth. To what extent does the change of systems of the type you've mentioned, having hospitals and surgeries, for example, working better together, take a step toward solving the problem in the workforce and the lack of staff, i.e. having more staff working more effectively, and

mwy o bobl yn gweithio yn fwy effeithiol yn hytrach na dim ond meddwl am gyflogi a hyfforddi mwy.

not just thinking about employing and training more?

[27] **Dr Llewelyn**: Mae'n rhaid inni benderfynu pa system ydym ni ei eisiau. Mae system gweithio mewn *clusters* i ni yn swnio'n wych. Mae'r syniad yn wych. Beth rwyt ti'n gorfod ei wneud wedyn ydy datblygu'r staff i weithio yn y system yna. Felly, efallai byddai meddygon sy'n gweithio mewn ysbyty yn treulio rhan o'r wythnos—nid yw nifer y staff yn newid, efallai, ond eu bod nhw'n gweithio yn wahanol. Byddai hanner fy wythnos i, efallai, yn cael ei dreulio yn y gymuned yn gwneud *clinics,* a byddem ni'n symud, efallai, gwasanaethau therapi allan o'r ysbyty i'r gymuned. Felly, efallai mae jest angen symud staff o gwmpas.

Dr Llewelyn: We have to decide what sort of system we want. The system of working in clusters, to us, sounds great. The idea is great. But what you have to do then, of course, is develop the staff to work within that system. Perhaps doctors working in hospitals would spend part of the time—the number of staff maybe doesn't change, but they work differently. Perhaps half my working week would be spent in the community holding clinics, and we might move, perhaps, therapy services out of hospitals into the community. So, maybe we just need to move staff around a little bit.

[28] Ar y funud, nid oes neb yn gwybod pa system ydym ni ei eisiau, felly nid oes neb yn gwneud dim byd. Rydym ni jest yn aros fel yr ydym ni. Felly, mae angen rhyw fath o arweiniad i ddweud, 'Reit, dyma'r system rydym ni ei eisiau, a dyma'r polisi i newid lle mae'r staff yn mynd i weithio.'

At the moment, nobody knows what sort of system we want, so nobody's doing anything about it. We're just standing still. So, we do need some sort of guidance to say, 'Right, this is the system we want, and this is the policy in order to change where the staff work.'

[29] **Rhun ap Iorwerth**: A'r cwestiwn atodol i hynny—pwy a ddylai fod yn gwneud hynny? A oes yna gnewyllyn gwaith yn dechrau ar gymryd trosolwg dros y gweithlu yna a phenderfynu pa systemau newydd sydd angen i dynnu'r pwysau oddi ar y gweithlu, ond hefyd lle mae angen

Rhun ap Iorwerth: And the supplementary question to that is: who should be doing that? Is there work that is starting to take an overview of that workforce to decide what new systems are needed to take the pressure off the workforce, but also where the training is needed,

yr hyfforddiant, ac yn y blaen?

and so on?

09:45

[30] **Dr Llewelyn:** Nid ydw i'n gwybod; nid oes yna ddim byd ar gael ar y funud. Y cwestiwn mawr ydy: sut mae'r system iechyd yn mynd i gael ei rhedeg yn y dyfodol? A ydym ni'n mynd i'w gymryd o fel corff ar wahân i'r Llywodraeth, fel bod o'n gweithio'n annibynnol a dy fod ti'n gallu gwneud, wedyn, penderfyniadau clinigol a gyrru'r rheini ymlaen, gyrru'r newidiadau ymlaen? Rydym ni wedi cael syniadau da am flynyddoedd. Rydym ni wedi bod yn siarad am y clystyrau hyn am dair neu bedair blynedd, ac nid oes lot wedi digwydd. Nid ydw i, fel arbenigwr sy'n gweithio mewn ysbyty, yn gwybod lot amdanyn nhw. Felly, mae yna ryw broblem yn fanna efo cyfathrebu beth sy'n digwydd yn y gymuned a sut rŷm ni'n mynd i weithio efo nhw. Felly, mae tipyn o waith cyfathrebu a phwsio'r agenda ymlaen, achos mae'r syniadau yno, jest bod yna ddiffyg—.

Dr Llewelyn: I'm not aware of anything available at the moment. The big question is: how will the health system be run in future? Are we going to take it as a separate body to the Government, so that it's working independently, because then you can make clinical decisions and drive those changes forward? We have had good ideas for many years. We've been talking about these clusters for three or four years, but not much has happened in relation to that. As a hospital specialist myself, I don't know much about them. So, there's a bit of a problem there with communication in relation to what happens in the community and how we're going to work with them. So, there's quite a bit of communication work necessary there and pushing the agenda forward, because the ideas are there, just that there's a lack of—

[31] **Ms Jackson:** The danger is that if you don't have—. The people working in that system—and this isn't just doctors; this is nurses, this is therapists, this is the wider healthcare sector—if they don't have that sense of ownership, it won't happen. As Gareth says, he's a specialist working in the field. He sits on various Welsh Government groups around neurology, and yet we were talking about the neurological conditions delivery plan—at no point does that delivery plan mention GP clusters. I said, 'Well, are there Welsh Government people in the room with you when you're talking about that?' and he said, 'Well, of course. It's a Welsh Government plan'. So, if there are Welsh Government people in the room, why are they not saying, 'How do GP clusters fit in with this?' So, there's a whole set of questions.

[32] I think there's also—. I think there is a real positive opportunity here. More and more, we're seeing—and we've talked about this in previous evidence sessions—a whole generation of trainees come up through the system who no longer want to do the traditional undergrad, straight into general training, straight into specialty, straight into consultant. That run-through model, actually, is less and less appealing and less and less attractive to secondary care specialists. Increasingly, we're seeing that doctors under the age of 40 are quite often saying, 'Actually, I'd like a year out to do a clinical fellowship', 'I'd like to do some research for a year', 'I might like to do a Master's in clinical leadership for a year'. And so they jump in and out of the training system in a way that, two or three generations ago, would've been unheard of, because the aim was to become a consultant as quickly as possible.

[33] We could take that as a real opportunity for Wales and say, 'Well, you know, we've got this cohort of trainees coming up who would welcome the opportunity to work out in the community, to help build new networks of delivery models'—that sort of thing. What we're not doing—. As Gareth says, there's this stagnation, because we don't know, we still don't really have a clear idea what the service looks like in 2050, we still don't seem to have a great deal of activity happening to plan for that to say, 'Well, what should we be teaching our trainees now about the service they'll be running in 30 years?' And they will; they are the ones that are going to be—. They'll be the specialty leads in 30 years, but we're not engaging with them now on the actual—. We're not engaging with them at the moment on how they actually want to work. We're just assuming that they want to do things the way they've always been done.

[34] **Rhun ap Iorwerth:** Diolch yn fawr iawn.

[35] **Dai Lloyd:** Ocê. Mae yna nifer o gwestiynau ac mae'r amser yn prinhau, felly Julie sydd â'r cwestiynau nesaf.

Dai Lloyd: Okay. There are a number of questions and time is moving on, so Julie has the next set of questions.

[36] **Julie Morgan:** Thank you very much. I wanted to ask you about the multidisciplinary team working. Obviously, you've mentioned the benefits of co-location. Could you tell us what you think are the advantages of being in a team of different disciplines in primary care and secondary care, really, and in the community?

[37] **Dr Llewelyn:** Yes. If you go back, general practitioners knew consultants and could phone them in the old—. This is when I started. You'd get a phone call from a GP and you'd communicate personally. So, that no longer happens. The workload is such that that no longer happens. So, co-locating is about learning and it's about teaching. In terms of general practice—. Again, I'm speaking from a neurology perspective, so, neurology is seen as a complex discipline and people are kind of scared of it and it's obviously worrying for patients, but also GPs don't have the training in it in terms of their undergraduate training. And so one of our roles is to try and educate GPs about what we would see as relatively common neurological conditions that are long term but can be managed—they don't need to be in hospital; they can be managed in a community setting. So, co-working is about teaching—you learn about experiences—and understanding what people need in terms of what should a specialist referral look like, when should you be referring a patient appropriately. One of the things that we have is that we have a GP working with us in the hospital setting, and we've learned so much from him about what type of letters should we send out, what kind of advice should we give to patients. So, the collaborative working has so many spin-offs.

[38] **Julie Morgan:** And any disadvantages of—

[39] **Dr Llewelyn:** I don't think that there are. I think you could say, 'Well, is it time?', but the same amount of time would be spent in a hospital clinic. I think that if you had to travel—so, travelling to, say, Bronglais from Swansea would be a two-hour drive—in terms of efficiency, that's not good for a specialist, but that's where telemedicine comes in. So, if you can deliver that clinic, which is being done, then time is saved. So, I can't see any disadvantages to it.

[40] **Julie Morgan:** Right. And what role does the physician associate play in all of this?

[41] **Dr Llewelyn:** Yes, so they're an important—. It's about restructuring of the—or looking to see, within the workforce, what we can utilise. The physician associate, which the college has been promoting—and we're delighted that a second cohort of places were allocated for Swansea and Bangor. So, they are a group of healthcare workers that we see as being a continuity factor. So, they can be either located in primary care, mental health systems, or in the hospitals, and so they would take away some of the

work that's done by junior doctors at the moment, but they don't replace junior doctors, and their role is—. I think that we need to expand their role a little bit more. At the moment, they can't prescribe, they can't order x-rays; I think that we'd be looking to see how we can make sure that that happens to make their job more efficient. But that's an exciting development.

[42] **Julie Morgan:** And is it being evaluated?

[43] **Dr Llewelyn:** Yes. Well, we're discussing this at the moment. It's something that we've been calling for. It's how, again—in fact, coming back to your point—you measure the outcome of what they're providing. Again, it's not easy. So, patient satisfaction would be one thing. Actually, there's a group that we've established that is going to be looking at this and setting out what factors do we need to measure to evaluate this. I think it is being—. Is it Birmingham that's evaluating it, or Liverpool?

[44] **Ms Jackson:** No. So, there is—. It is on the radar. I think it is worth mentioning that there is no formal evaluation planned of the bursary scheme so far. Gareth chairs the NHS Wales physician associate implementation group, which has health board and university representatives from around Wales, and there is some concern that Welsh Government doesn't seem to have a formal evaluation planned just yet. At the last meeting, we managed to get somebody from Welsh Government to come along, and she suggested that members of the group come back to her with suggestions on what should be evaluated. That's a long way from a formal evaluation, but it's a step in the right direction. I think it's worth emphasising that point across the board. We really need to make sure that we're collecting data and running proper evaluations on schemes like this, because, as Gareth says, we know anecdotally that patients find physician associates helpful; they free up junior doctor time to concentrate more on education and training, which can only be a good thing. But, at the same time, we need to make sure that that role isn't—we're not just pouring money into a role that could be more effective. So, that's something that we're pushing the Welsh Government very hard to do. In an ideal world, we'd like to see an independent evaluation, but we're not quite sure what the parameters of that evaluation are at the moment.

[45] **Julie Morgan:** Right.

[46] **Dai Lloyd:** Okay?

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

[48] **Dai Lloyd:** Materion cyllido clystyrau nawr. Dawn.

Dai Lloyd: The funding issues now. Dawn.

[49] **Dawn Bowden:** Yes, thank you. You haven't said an awful lot—well, you didn't say anything actually—in your written evidence about funding for clusters, but we have had evidence previously on this and the concerns around the funding being quite limited, that it's primarily tied up with funding staffing arrangements and so on. I just wondered what your views might be on whether you think that that limits the potential for the kind of innovation that clusters were initially designed to lead. I was taken by the comments that you made, Gareth, earlier on about independence from the LHBs and whether that would be an area that you think we ought to be looking at.

[50] **Dr Llewelyn:** Do you want to answer that?

[51] **Ms Jackson:** So, I think one of the reasons we didn't touch on it a great deal in our evidence is because, as Gareth says, very few of our doctors have had direct engagement with clusters, and so there's an element there of not wanting to tread on toes. The principle of clusters having their own budgets is—we'd find it difficult to disagree with that. It's not something we commented on because we haven't had that engagement. I think the innovation side of things makes sense, though. One of the things we've been talking about recently a lot is telehealth. There are so many pockets—that's a really good example of innovation, and there are so many pockets of good practice across Wales, but it's quite difficult then to draw all of those up to map out where those are happening.

[52] The project that I mentioned earlier in north Wales, one of the reasons—. That project has been successful despite, I think it's fair to say, the turmoil at the top in Betsi at the moment. The clinicians and the nurses involved have kept that project going in the face of changing management structures, in the face of changing leadership, in the face of changing personnel, and, at times, they've really struggled with that. One of the things they told me about was that that lack of support from the health board and conflicting priorities from the top means that they've just missed a real opportunity, they think, to focus on something positive happening.

[53] But we were talking about this earlier, and, actually, could you argue

that, given that it is specialty care—. So, you could argue it is Ysbyty Gwynedd's specialty care reaching into the community, which is why the project sits with specialty care, and, to a certain extent, has been driven by clinicians in speciality care, because they saw that need. But it reaches into community hospitals and GP clinics, and at what point do you say, 'Well, actually, could the GP clusters pick that up?' Again, it's that two-way thing. So, I suppose you could argue that GP clusters could pick up some more of that responsibility for reaching into specialty care, as opposed to receiving that, if you will. And yes, in that situation, clearly, they'd need the funding to do that. Our understanding is that they don't have the corporate identity that means that they could manage their own money. So, that's probably something that we'd support.

[54] **Dawn Bowden:** So, maybe a different relationship with the health board—

[55] **Dr Llewelyn:** Yes. I think the risk is that you introduce another layer of bureaucracy, whether that stifles or whether that moves it forward. But, currently, from what we gather, obviously, it isn't working, because we've been talking about it for three or four years. Money has gone in but not much has come out as far as hospital services are concerned.

[56] **Dawn Bowden:** And I guess one of the issues is going to be the people who are leading the clusters, whether it's GPs or whether it's another group, and whether they would want that.

[57] **Dr Llewelyn:** Yes.

[58] **Dawn Bowden:** Because it's an awful lot of responsibility.

[59] **Dr Llewelyn:** It is, to manage a budget and—. Yes.

[60] **Dawn Bowden:** Okay. All right, thank you.

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

[62] **Jayne Bryant:** Thank you. You've mentioned the importance of services being closer to patients, and that those who don't need to go to hospital don't go. How effective do you think that clusters have been in tackling health inequalities and developing services outside the traditional medical model?

[63] **Dr Llewelyn**: Again, obviously, you will have gathered that our knowledge of how clusters work is rather basic, and that's maybe our fault. But, you know, the clusters have a significant role. That's what the advantage of cluster working would be—because they know the population, they would be able to help address those health inequality issues, as well as having Government lead them on obesity, smoking, air pollution, and things like that. So, I think that we can only win by working together. The idea is great but, as we've said before, the idea has been there for some time, but it's not somehow come into fruition. Our question would be, 'Why is that?'

[64] **Jayne Bryant**: Okay, thanks.

[65] **Dai Lloyd**: Mae gan Suzy y cwestiynau olaf. Mae'r atebion yn rhannol wedi cael eu rhoi eisoes, ond rwy'n siŵr y bydd Suzy yn gallu bod yn hynod greadigol, yn ei ffordd arferol, wrth ofyn y cwestiynau.

Dai Lloyd: Suzy has the final questions. Responses have been given partly, but I'm sure Suzy will be creative, in her usual way, in asking the questions.

10:00

[66] **Suzy Davies**: Yes, I just want to develop something that Dawn raised, actually—this independence of clusters—a little bit. Obviously, the local health boards are really singing big songs about these clusters at the moment. They're loving them, aren't they? But then you've mentioned yourself that your own knowledge of clusters is rather basic, and that's an observation that we've had from other potential partners in clusters, that the LHB is a little bit top heavy in this and that various partners don't feel fully involved. You've said that co-working is obviously the way forward, but that's only going to work if there's a level of equality in this. With any new model where people are coming out of silos, there'll be jostling for power and position. What are your members saying that they're experiencing on that front at the moment? How would they improve things for better working together?

[67] **Dr Llewelyn**: I think that the issue comes down to leadership and having the time to do that. So, at the moment, we're all kind of firefighting. Everybody is locked into their own little system and we're trying to deal with the workload that we've got. There doesn't appear to be that much space to promote the ideas that we all have to enable that delivery. I know that

something that the college has been very keen on is about—you know, staff have to have time to put their ideas into practice, and that creates a well-being for staff as well. Because, if you're working within healthcare and you can see even a small development that is positive and helps patients, that's an incredibly rewarding feeling. If, as Lowri was saying, there is just one thing after another and nothing happens, it creates a negative feeling. One of our concerns has been about morale within healthcare workers. So, the perception is that it's not great, and this sort of project, if we could move it forward, would improve that morale.

[68] **Suzy Davies:** Okay. So, if it's leadership, who should take that leadership? In your evidence, you say that physicians—so that's specialists—should take the lead in developing the special models of care that operate beyond the hospital walls. Should it be you? Should it be the health board? Should it be occupational therapists?

[69] **Ms Jackson:** So, I think, certainly in terms of developing the services—. What's interesting is that, actually—. We visit hospitals around the country, we meet up with our members on a regular basis, and it's the same old story. There are pockets of good practice everywhere, there are interesting case studies happening all over the place, but they're not necessarily joined up. And, where those case studies are happening, it is because an individual clinician, with the force of personality, has managed to really get behind an idea and push it through. One of our concerns is what happens when that particular physician moves on. And that happens time and time again. We see that. Also, how do you then scale up those projects? If you know a particular project is working well, how do you make sure that that's replicated then across the country?

[70] Where our physicians say they face barriers is in accessing funding or support or timely intervention from health boards. At the end of the day, health boards still control the money. So, even if you are a specialist with a great idea for a project that's going to improve patient care, you still need to have the ear of somebody who is going to have the power and resource to get that through. Our physicians don't hold budgets, by and large, and, if they do hold budgets, those budgets are usually pretty inflexible.

[71] **Suzy Davies:** So, are you saying that a bureaucratic set up, which is what we've got at the moment, actually prevents natural leadership emerging?

[72] **Dr Llewelyn:** Yes.

[73] **Ms Jackson:** To a certain extent, yes. And I think there's also something in there as well about national ambition and national leadership, and saying that health boards are often given a policy direction, but then left to implement that on their own. Whether health boards have the enthusiasm, the resource, the capacity to do that—there's a huge question mark over that, because they're all struggling with staff turnover, they're struggling with unscheduled care, they're struggling with all sorts of things. So, actually, at what point do we say, 'If there is a national vision, there should be more of a national role in implementing that', and whose role is that? As Gareth said earlier, is that the role of an NHS Wales body? Is that the role of Welsh Government? That's a set of questions that I think probably needs to be talked about more than it is.

[74] **Suzy Davies:** Okay. I know we don't have time, but there's quite a lot of paradoxes in this, I think. Thank you. Diolch.

[75] **Dai Lloyd:** Diolch yn fawr, Suzy, a dyna ddiwedd y sesiwn gwestiynu. A gaf i ddiolch yn fawr iawn i chi'ch dau am eich presenoldeb, a hefyd am y papur, fel rwyf wedi cyfeirio eisoes, ac mae eraill wedi cyfeirio, a gyflwynwyd ymlaen llaw efo'r dystiolaeth ysgrifenedig? A allaf i hefyd gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r trafodaethau'r bore yma, er mwyn i chi wirio eu bod nhw o leiaf yn ffeithiol gywir? Ni allwch chi rili newid eich meddwl am ddim byd, ond o leiaf fe fedrwch chi wirio bod y ffeithiau yn gywir. Felly, gyda chymaint â hynny, a allaf i eto ddiolch yn fawr iawn i chi am eich presenoldeb a diolch am eich cyfraniad y bore yma? A allaf i gyhoeddi i'm nghyd-Aelodau y bydd yna egwyl am bum munud cyn y sesiwn nesaf? Diolch yn fawr.

Dai Lloyd: Thank you very much, Suzy, and that's the end of that session. May I thank you very much, both, for being here today, and also for the paper, which I and others have referred to, which was submitted beforehand as written evidence? May I also let you know that you will receive a transcript of this morning's discussions for you to check for factual accuracy? You can't really change your mind about anything, but you can at least check that the facts are correct. So, with that, may I thank you again for your attendance and for your contribution this morning? May I let my fellow Members know we have a five-minute break before the next session? Thank you.

[76] **Dr Llewelyn**: Diolch am y gwahoddiad.

Dr Llewelyn: Thank you for the invitation.

[77] **Ms Jackson**: Diolch.

Ms Jackson: Thank you.

Gohiriwyd y cyfarfod rhwng 10:05 ac 10:11.
The meeting adjourned between 10:05 and 10:11.

Ymchwiliad i Ofal Sylfaenol—Sesiwn Dystiolaeth 4—Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Inquiry into Primary Care—Evidence Session 4—Welsh Ambulance Services NHS Trust

[78] **Dai Lloyd**: A allaf i alw'r cyfarfod i drefn wedi'r egwyl yna? Rydym ni nawr yn symud ymlaen i eitem 3. Rydym ni'n parhau efo'n hymchwiliad i ofal sylfaenol a chlystyrau meddygon teulu. Hon ydy sesiwn dystiolaeth 4 nawr, ac o'n blaenau mae aelodau o'r Ymddiriedolaeth Gwasanaeth Iechyd Gwladol Gwasanaethau Ambiwlans Cymru. Felly, rydym ni wedi derbyn papur fel tystiolaeth gerbron eisoes a diolch am hynny.

Dai Lloyd: Can I please call the meeting to order following that short break? We're now moving on to item 3. We are continuing with our inquiry into primary care and GP clusters. This is evidence session 4, and before us we have members of the Welsh Ambulance Services NHS Trust. We have received a paper from you as written evidence and thank you for that.

[79] O'n blaenau i roi tystiolaeth ar lafar mae Dr Brendan Lloyd, cyfarwyddwr meddygol Ymddiriedolaeth Gwasanaeth Iechyd Gwladol Gwasanaethau Ambiwlans Cymru, hefyd Grayham McLean, arweinydd gofal heb ei drefnu Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru, a hefyd Martin Woodford, is-gadeirydd Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru. Croeso i'r tri

Before us to give oral evidence we have Dr Brendan Lloyd, medical director, Welsh Ambulance Services NHS Trust, also Grayham McLean, unscheduled care lead, Welsh Ambulance Services NHS Trust, and also Martin Woodford, vice chair of the Welsh Ambulance Services NHS Trust. Welcome to the three of you. As I said, we have had a look at your written evidence. So, as is our normal practice, we'll go straight into

ohonoch chi. Fel rwyf wedi dweud eisoes, rydym ni wedi craffu ar eich tystiolaeth ysgrifenedig. Felly, fel sy'n drefn arferol nawr, fe awn ni'n syth i mewn i gwestiynau, ac mae'r cwestiynau cyntaf gan Caroline Jones.

questions, and the first questions are from Caroline Jones.

[80] **Caroline Jones:** Diolch, Chair. Good morning. I'd like to ask, please: there seems to be limited evidence on the impact of clusters—could you tell me what your views are on your experiences about the effect that various cluster initiatives are having in terms of reducing the demand for GP and emergency hospital services?

[81] **Dr Lloyd:** Shall I kick off? Thanks. Obviously, from our perspective, we're working predominantly in terms of unscheduled and emergency care. So, with regard to the evidence on access and demand on GP services, it's probably a bit difficult for us to comment, but I would say that there probably is a lack of hard data at the moment to support the effectiveness of clusters in that area.

[82] I think the second point, around whether the clusters can provide a more accessible route into care, is probably where we do have more of an impact. I think that if you were to look at the cluster work and has it had an impact on those areas where the health service has been under pressure, for example, the unscheduled care, the winter pressures, the management of the frail elderly, I think that we probably haven't seen as much evidence as we would like. We've had a couple of fairly difficult winters in terms of emergency care.

[83] I think that the evidence that we've collected through the provision of the community paramedic work—I think that we have got some very good evidence. I think we've been collecting data that demonstrate the effectiveness of the community paramedic in reducing conveyance, and we very much see that this is a model that could be supported and could be an essential part of the multidisciplinary team in primary care going forward.

10:15

[84] **Caroline Jones:** Anyone else? Okay. What do you think should be done to ensure that there's a robust evaluation of the work of clusters and that good practice and effective service models are being rolled out? What do you

think?

[85] **Dr Lloyd**: Certainly, I think this comes back to whether the clusters set up in a way that enabled data to be collected to demonstrate the effectiveness. This is one of the problems we regularly have in the health service, because, obviously, to have a major impact, you're looking at going across a whole system, and what we really need is some outcome data that demonstrate that patients are receiving the best care in the best environment. We know that we still have too many patients being conveyed to the emergency department and, very often, those are patient groups we know don't benefit from that—so, frail elderly and mental health conditions in particular. We've set up a couple of projects where we are collecting data, and what we can demonstrate is a reduction in patients who are being conveyed by that route. Now, you do have to bear in mind that those models are probably working on a preselected group of patients, but, certainly from our perspective, it does seem to be having an impact.

[86] I think that some of the work is very promising. Grayham, do you want to mention some of the data that we've been collecting so far?

[87] **Mr McLean**: Yes, of course. So, we are undertaking a couple of trials, one in Cardiff and Vale and one in Cwm Taf, where we're testing different models of working, and we are collecting data. The model in Cwm Taf is also being supported in terms of data collection by the Bevan Commission; so, they're helping us with that. And we've got advanced primary practitioners working there. They've seen 350 patients on behalf of GPs—so, they've done home visits—and of those 350 patients, 237 have been kept at home. So, it's a very good example of how we don't necessarily have to convey everybody to emergency departments. Now, that's a new role as part of the Pacesetter recommendations around a multidisciplinary team.

[88] What we are also testing in Cardiff and Vale is a different way of working, a joined-up system of working, and what we're seeing there is a paramedic, an advanced life support provider in a response car, working as part of that community, as a community-based paramedic. And they're also doing home visits. The difference is that they have to report back to the GP on their findings, unless the patient is very sick or very injured, then, obviously, they would convey to hospital. They've seen 162 patients, and of those 162, they've taken only 23 to hospital. So, one is a different way of working, and one is a new role, and both are very effective.

[89] In terms of consistency, I think it's the key to work with the clusters. We're an all-Wales service, and it would be extremely difficult if there were different evaluation frameworks in place across the 60-plus clusters. We would love to see a set of standard measurements for each cluster and how they would develop their work and their models of care with us. I think that would be very helpful.

[90] **Caroline Jones**: So, when people have been treated at home and have stayed at home, is there going to be evidence to show that that has been the end of what their issue was originally, or have people, at a later date, been readmitted with something more complicated as a result of staying at home?

[91] **Dr Lloyd**: We do collect figures on recall rates. So, if they come back through the emergency service, we collect those figures, and we haven't seen a significant increase in recall rates, so it does appear that there is an effective one-stop treatment being provided. I think that the other point, really, is—and from my background in general practice, I'm aware of the pressures on that system, as well as the pressures on the emergency services—I think that the clinical handover and the close working between paramedics in the community and a group of GPs has demonstrated that we can manage a significant number of these patients who have accessed the emergency services for primary care problems, quite possibly due to the pressures on the GP system.

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

[93] **Dai Lloyd**: Martin can come in, and then—

[94] **Mr Woodford**: It's just an observation—[*Inaudible.*]—the Welsh ambulance service. It is a pertinent debate: when do you evaluate these initiatives? When have you accumulated enough data and what is the responsibility of the board to say, 'Yes, we've got the outcome for this; we can now proceed to scale up'? And we've had that debate earlier in the week—probably a bit early, as yet, with the initiatives that we've got, because we're only three months in. I guess, Brendan, you'd be looking ideally for six months' data to say that this is a concrete outcome measurement that we can then use to decide whether to go forward.

[95] **Dr Lloyd**: Yes, we would ideally wish to do that. What I would say is that the preliminary data that have been collected would demonstrate the effectiveness of this model, and in terms of scaling up at pace, I think this is

one of the few projects that I could see we could actually be putting in place ahead of the next winter pressure.

[96] **Dai Lloyd:** Okay. Dawn.

[97] **Dawn Bowden:** It's just a quick supplementary—thank you, Dai—on that. I remember, in a previous life, when I was a Unison official, we were talking to Welsh Government about just this type of arrangement. I just want to talk about the practical application. So, you're talking about paramedics signposting to other care pathways, basically. So, rather than bringing them into hospital, you're attending the scene, you're assessing the situation, saying, 'This doesn't need to be a hospital admission, and we'll get a GP or another relevant professional out to see you.' Is that how it's working?

[98] **Mr McLean:** That's pretty much what it is, yes. The difference is—and there is a fundamental difference—in terms of Pacesetter, as we all know, they've recommended a multidisciplinary team, and there are some issues around that. The Welsh ambulance service have helped the clusters with that in terms of indemnity. There have been some real issues around that. So, we have advanced paramedics who are doing exactly what you've just described, but what we've tried to do is to tie in to the cluster working. So, as opposed to not only going out on 999 calls, they can be tasked to calls by a GP. So, they are working closely with St John's practice, and the GP can ask them to go out. Now, that's very new.

[99] They have a number of pathways that they can access, and try and advise a patient, or close the patient's episode of care at that point. That's a new role. What we've done in Western Vale is: we're using a paramedic—not an advanced paramedic; a paramedic with good advanced life support skills—who is already in the area, and we've literally linked them together with the cluster, so it's a working relationship. So, a similar sort of thing: the paramedic will go out, as a result of the GP asking them to go out, to see a patient, or they'll attend a 999 call. Either way, their first point of contact, then, rather than trying to navigate through a number of pathways, which may not be available and have different times of working—their point of call would be back to the GP, who is the clear historian of the patient, and they'll have that conversation.

[100] **Dr Lloyd:** There is one other point there: I think it doesn't give the model justice if you get the impression that they are simply signposting to other services. The paramedic service has come on significantly. We are

developing people with new clinical skills. A significant number of these patients can be just managed by the paramedic. But you're absolutely right, one of the other problems is the availability and consistent availability of other services in the community as an alternative to being transported to the emergency department, and there is considerable variation across Wales in that area.

[101] **Dai Lloyd:** Ocê. Symudwn ymlaen nawr, ac mae'r cwestiwn nesaf o dan law Julie Morgan.

Dai Lloyd: Okay. Moving on, then, and the next question is from Julie Morgan.

[102] **Julie Morgan:** I was going to ask similar questions to Dawn about how the multidisciplinary team works and how your staff interact, and you've mentioned some issues. Are there any other disadvantages that you could highlight, or any problems that you run up against in working in this sort of way?

[103] **Dr Lloyd:** I think if you're talking about the potential barriers that we have been discussing, one is the employment issue. We have had instances where practices, particularly those that have had difficulty recruiting, and even health boards that have difficulty supporting practices, have recruited paramedics and advanced paramedics to support their work in primary care. Now, that's fine for the practice but it does mean that we are losing some of our more experienced practitioners, and what we would like to see is a system whereby they are retained with Welsh ambulance but possibly have a rotation through primary care, so that we build up the skills, build up that relationship with the community. The other barriers are that if they are going to be employed within primary care—because primary care, as you're aware, works predominantly on a contractor basis—we have to sort out the indemnity, because the paramedics will have indemnity working for us within a scope of practice, and if that is going to be extended as they take on more skills in primary care, we would have to negotiate those. That's not insurmountable. We've had discussions with the Welsh risk pool. If there's a will, there's a way that we can manage that.

[104] So, those are the main issues that we have been facing. So, it's the employment status, and the other one that may be pertinent to discussion is the funding, because if we are going to put these community paramedics in place, we need to have some guarantee that there is ongoing funding. At the moment, as I understand it, too many of the clusters are finding that they only have the funding for a year, can't plan far enough in advance, and

therefore can't build up the multidisciplinary team that would benefit patient care to the maximum of its potential.

[105] **Julie Morgan:** So, you would need much longer-term planning.

[106] **Mr Woodford:** Can I just prompt my colleagues? If you think about barriers around the ability of our professionals, our paramedics, to refer to other community-based professions, such as district nursing—that ability is not always there. Is there not also an issue about our ability to access care plans for individuals as well, i.e. access to health information?

[107] **Dr Lloyd:** Yes, I mean, I think if we were looking for something to come out specifically on unscheduled and emergency care, there would have been areas that we would have like to have seen promoted, such as having care plans in place for all patients with chronic diseases, and particularly those with end-of-life situations, and also a directive to sort out some of the problems around the management of the unscheduled care flow. From our perspective, a significant amount of that comes from healthcare professional calls. By working with general practice, and particularly if we had community paramedics picking up some of those calls earlier in the day, it would stop what we currently see, which is a peak of calls coming in at midday at the end of the morning surgeries and at the end of the evening surgeries, and that would help with some of the backlog that we have seen with ambulances queuing up outside the emergency department. So, by working with colleagues in general practice, I think we've got the potential to actually influence the whole of the system, which I think is really what we should be aiming at.

[108] **Julie Morgan:** And what about co-location? We have had evidence that some of the premises are not too good in any case. I mean, in terms of—

[109] **Dr Lloyd:** Our premises or GP premises?

[110] **Julie Morgan:** Both.

[111] **Dr Lloyd:** Right, okay—

[112] **Mr McLean:** I think that's a very good point.

[113] **Julie Morgan:** Would you see there would be opportunities to actually co-locate? Is that something that you would look for?

[114] **Mr McLean:** Yes. I've had the privilege of working for the last year and engaging with all cluster leads, and that's something that's really coming to the fore. There's a great opportunity to share premises, but it's not just the physical state: I think it's that working relationship that we're seeing develop between clinicians. You know, it's more of that community approach, then, and in terms of the estate, it's also very helpful if you have an advanced life support provider alongside primary care, because if somebody should present at a primary care centre who's very sick or very injured, it's very helpful if, in proximity, there's an advanced life support provider as part of that team.

[115] **Dr Lloyd:** So, we would have our major estate strategy that we're working through in terms of where our major ambulance stations would be, but in terms of a community paramedic, they would be working from what we call a rapid response vehicle, and they could easily be co-located with new GP surgeries.

[116] **Mr Woodford:** We've got a good track record of collaboration with police and fire services and there are a number of examples of that across Wales, including the resource centre at Wrexham. So, we've got the willingness and the keenness to do that, we just need to push harder with primary care to extend that.

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

[118] **Dai Lloyd:** Hapus? Symudwn ymlaen nawr i gwestiynau gan Rhun ap Iorwerth.

Dai Lloyd: Happy? Moving on now to questions from Rhun ap Iorwerth.

[119] **Rhun ap Iorwerth:** You've partly answered, actually, some of the questions that I had in terms of workforce planning and your fear of the creation of an internal market, as you describe it in your written submission, when you lose staff that could be in rotations. There's a kind of assumption, in my mind at least, that the creating of clusters and the sharing of staff should be a means to take the pressure off the workforce. Could you just expand a little bit on where you think the risks are and the opportunities within clusters when it comes to planning for the workforce?

[120] **Dr Lloyd:** Well, I think we're actually in a very fortunate position in the ambulance service, because we are not facing some of the recruitment issues

that are being seen in medical staffing, nursing staffing and some of the therapies.

10:30

[121] We've actually got a very committed workforce; we've got students coming through. The Welsh ambulance service, for other reasons, is now being seen as a very attractive area to work in, and we could actually be employing more paramedics, but the problem comes back to the resources, obviously, in terms of that, and that's where we would be looking to have these posts funded, if it was felt that that was the way forward. So, in terms of the multidisciplinary working, I think that paramedics would fit in very well into an expanded primary care workforce.

[122] **Rhun ap Iorwerth:** And it's happening.

[123] **Dr Lloyd:** And it's happening. I think that that is one of the questions around the sustainability we're talking about, and I think it's absolutely essential that we have that sustainable primary care offering within the NHS. I just think that that's perhaps not going to be sustaining the current model and that we have to be a bit more adventurous around how we provide a more sustainable primary care workforce in the future. I think that the answer is going to be in expanded multidisciplinary team working, with the GPs, obviously, at a central pivotal role.

[124] **Rhun ap Iorwerth:** Yes. Is the introduction of advanced paramedic practitioners into multidisciplinary teams creating a new challenge for you—a challenge that you say you can step up to—or is it, in some ways, taking the pressure off you in other parts of the work that you do?

[125] **Dr Lloyd:** I would see that far more as an opportunity than a challenge. I think that paramedics and their training are undergoing considerable change. You're aware that we are moving to a degree model. There's going to be more education for people coming out of from the university. That extra time is going to be spent on the medical model—the types of chronic conditions, as opposed to purely focusing on the emergency conditions: the cardiac arrests, the road traffic accidents. So, we're going to have a workforce that is going to be more experienced and more capable of handling the types of problem that we are seeing with the changing demographics in the population in Wales. So, we're going to have an increasing elderly population with more frailty, more chronic disease

problems, and we are trying to gear our education and training to meet those problems. The next step up is going to be the further advantage of using the advanced paramedic practitioner with even more skills in those areas. So, I think that that's a huge opportunity that we can integrate into a new system, but we do need a little bit more thinking about how that system works rather than thinking about professional silos.

[126] **Mr McLean**: I was going to say, in terms of paramedic practice, I think it gives us an absolute competency framework that we've been working on for some time now. So, it supports that competency framework. So, what we could see is paramedics in response vehicles, based in a community and a working system, working closely with GPs and with that multidisciplinary team, but still undertaking their core duties of ambulance responses. Then, alongside that, you could see the advanced paramedic practitioners working in that multidisciplinary team. So, you sort of have a competency framework and that career pathway in place. You could be a paramedic in a response car, working in a community, responding to 999 calls, and having additional clinical support from a multidisciplinary team or the GP, and then, as you progress through your career, you could actually become an advanced paramedic practitioner working in the multidisciplinary team and doing far more assessment, diagnostic work and treatment. So you'd have that sort of clear step and it does complement the previous work we've done around competencies. So, it's a real opportunity for us.

[127] **Mr Woodford**: And just to add quickly, you'd assume that, over time, we would see fewer 999 calls because we're tackling issues sooner and locally. It should help us. We've got to gather the evidence, but it should help us in terms of that vast group of patients who are classified as amber calls where, in our response times, we need to improve those, because more people will be seen locally and more quickly.

[128] **Dr Lloyd**: It also has the opportunity to increase the equity of service across both rural and urban areas of Wales.

[129] **Rhun ap Iorwerth**: One more as well, if I may, Chair. It seems to me that you feel on top of your workforce challenges—that you have no real shortages—but gaps in the workforce in other parts of primary care will affect the work that you do, and you don't have direct control over that. Are you confident that there is oversight from wherever it should be provided—the Government, the top of the NHS—of the general picture of workforce planning, which we know is one of the, if not the biggest challenge facing the

NHS?

[130] **Dr Lloyd:** It is certainly being reviewed as part of the work. I think that, traditionally, when it comes to workforce—as I've mentioned previously—there's probably been a little bit too much of a focus on individual professional areas rather than system approaches. I think that there are opportunities that could be maximised by looking at a slightly broader picture and actually saying, 'Well, what are the patient needs? What do we know are the problems that we are looking at here?' and then addressing those through a more multidisciplinary approach, taking advantage of those areas where we have got potential for increasing the workforce, rather than necessarily focusing on a more traditional model, shall I say.

[131] **Rhun ap Iorwerth:** Physicians were saying the same thing.

[132] **Mr Woodford:** It probably does involve a different kind of dialogue with health boards at top level about, 'So, what's the game plan, what's the blueprint going to look like and how can we plan for that', rather than focusing on individual pilots and whether we can scale up. So, we're talking about how we increase our dialogue with health boards to have that conversation quite quickly.

[133] **Dr Lloyd:** And general practice, of course, has changed vastly, dare I say it, from the days when Dai and I were starting out, and I think that we're dealing with a different workforce with different demands, and I think that we need to think a little bit more expansively around how we meet those demands by putting the needs of the patient at the centre and then looking at the workforce capabilities to meet those demands.

[134] **Mr McLean:** And in my experience, working on behalf of WAST with the directors of primary care and health services, the taskforce work that's going on around workforce planning has been really helpful. And I know those messages are being discussed on a regular basis and being fed in. So, that's within that context of planning as well. That's been my experience.

[135] **Rhun ap Iorwerth:** Thanks. That's useful, thank you.

[136] **Dai Lloyd:** Iawn. Troi at faterion cyllido, Dawn, ac rydw i'n credu bod y cwestiwn yn rhannol wedi cael ei ateb. Dawn.

Dai Lloyd: Turning to the financial issues, please, Dawn, and I think that some of those questions have been partly answered. Dawn.

[137] **Dawn Bowden:** Thank you. They have, I think, been answered, but it's a kind of follow-on, really, because in your evidence you were talking about the funding needing to be a bit more strategic—in clusters, now—and a bit of concern that too often it's been used to deal with primary care staffing shortages. Do you want to just say a little bit more about that, in terms of how you think that ought to be working? Because I know you gave an example in here about Hywel Dda, and how you have these kind of recharge arrangements with Hywel Dda. So, I just wondered if you wanted to expand a little bit more on your views around that.

[138] **Dr Lloyd:** Yes. I think there are two issues. One is: could the funding be directed a bit more strategically? And the second one is: could the funding be a bit more flexible? So, in terms of the strategic funding, yes, we would like to see, perhaps, a bit more direction on the clusters being tasked to identify the problems and come up with some solutions to the main problems that we know we are facing as a health system. And if that was scaled up at a higher level, then I think we'd be in a better position going into winter—we'd have some more solutions that were tangible and evidence based. I think that that then comes back to the second part, which is that funding needs to be somehow channelled into an area where we can make the services sustainable. Because there's absolutely no point in trying to employ a community paramedic on a 12-month contract with no guarantee of what is going to happen at the end of that. I think that a decision has to be made based on, 'Have we got sufficient evidence to say that this is contributing to a sustainable primary care service?' And if it is, the funding has to be channelled in that direction. We can't provide that funding ourselves, we're a commissioned service.

[139] **Mr McLean:** What would be helpful as well is, obviously each cluster produces a plan on how they're going to spend the money and, again, as an all-Wales service it would be very helpful if we saw a consistent set of actions against an envelope of funding in each of those plans. And I appreciate it's early days and that those plans are evolving, but I think from the very outset, engagement—. Because it's going to be very difficult for Welsh ambulance services to deliver 60 different sets of actions across Wales without any consistent funding. Until we get that consistency of actions, we really can't attribute funding to sustainable services, can we? So, I think that's going to be the main interaction with clusters as we go forward.

[140] **Dawn Bowden:** Although you would accept that there is no one size

fits all. It's not going to be—. There will be variations.

[141] **Mr McLean**: Exactly, yes. So, a multidisciplinary team in Cwm Taf will look slightly different to a multidisciplinary team, maybe, in Wrexham. However, the multidisciplinary team is what is the overarching action, if that makes sense. Until we get that sort of consistency, it's very difficult to get that stream of funding against that.

[142] **Dr Lloyd**: We could accept some variation in the way the teams are put together, but they should have reduced variation in the outcomes for the patients achieving the best quality of care.

[143] **Mr Woodford**: It does beg the question about the role of the ambulance services commissioner where the dialogue is about how we shift away from conveyance to hospital towards a community-focused service, which is what we're very keen to do. So, that's a strategic discussion. It begs the question as to whether any of those discussions we've highlighted around the development of community paramedicine should be channelled through the ambulance commissioner route, which is, after all, acting on behalf of health boards. That's the question, really.

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

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

[146] **Jayne Bryant**: I think you've answered a few of my questions around funding in your response to Dawn and I know in my own area, in Aneurin Bevan, I've seen some great examples of the falls response team. They've worked really well and I think they're keeping four out of five people out of hospital in that multidisciplinary team. But, just to reiterate, do you believe that the fact that we can't perhaps—? Do the funding issues stifle, perhaps, scaling up in terms of innovation? Do you think that that's a problem?

[147] **Dr Lloyd**: I think that what we need to have is a clear strategy and vision of what we're trying to achieve and then, how the funding supports evidence-based interventions to achieve that. I think, at the moment, I suspect that we're probably struggling a little bit on that. We have some very good models—you mentioned the falls prevention and we are accumulating more evidence on that. I think that there's sufficient evidence now to say that falls, which is one of the main points of call for the emergency services, can be managed in a different way to the traditional 'send an ambulance' and,

invariably, a large number of those patients would end up outside emergency departments. I think we've got a lot of evidence demonstrating that a multidisciplinary team approach using physiotherapists, occupational therapists and paramedics can actually manage a large number of those patients at source, not only treating the patient, but also advising on the home condition so that there's a preventative element contained within that work.

[148] **Mr McLean:** The driver for all this is that the Welsh ambulance service has signed up with the Bevan academy to prudent healthcare, and that's the driver. What we're trying to do at the moment is that we're developing a number of pilots, tests, where we can show that, for the minimum amount of funding, we can produce the best results on behalf of the patient. But at some point, those tests of incremental change have to be evidenced and if there is really good evidence, which we are now producing through robust evaluation, at some point, we have to sit down and agree on how they're going to be scaled up at pace, through good funding. That was my point, really, about the cluster plans. We need to see, for example, in each cluster plan, a falls prevention service or a falls response service, a multidisciplinary team involving advanced paramedics or involving a working system with current paramedics in response vehicles. It may vary depending on the health board need or the local population need, but those very key strategic dots in the plan so that we can then negotiate the funding around that.

[149] The Welsh ambulance services may not actually have that funding, because we have core funding, as Martin rightly says, from our commissioners to provide an emergency service. But this links into that wider unscheduled care primary care service. We recognise that if we put these very good models of care in place, it'll have a good impact on the emergency service. So, that's really where we're at. You're absolutely right. There are a number of really good pockets of innovation working really well, but the challenge is how we then push that forward and the key to that will be funding.

10:45

[150] **Mr Woodford:** It's worth saying that we balanced our books last year, but it's always very tight. So, the scope to speculate with the lack of so many other successes is quite limited. We'd like to think that, over time, if this builds up, and we see a lower level of conveyance to hospital, in the end, we generate the financial daylight to enable us to build on it, but, in the short

term, I think it's probably a case of pump-priming finance to get this off the ground on a scale that's going to make a difference.

[151] **Mr McLean**: I think a key measure—speaking to GP colleagues about this at cluster level a lot, it's a difficult one to measure, and we've tried to work out how we can. One of the main drivers for this is that we recognise that the GP is the senior clinician in that multidisciplinary team, and the whole point is to try and give that GP more capacity to see the more complex co-morbidity cases. So, for example, in the western Vale, where we've got that response paramedic going out, one of the things we are quite keen to find out is how much GP time that's given back to the GP to see patients. Rather than travelling extended distances for two or three home visits, it's about giving that GP or that group of GPs more capacity to see the more sick patients and the patients who require more complex assessment and allow us to do our bit in the community, but still be available for 999 calls. So, that's the key measurement in terms of the funding flow, but that's a difficult one to measure. That's really, really difficult.

[152] **Dai Lloyd**: Ocê. Mae'r cwestiwn olaf dan law Suzy Davies.

Dai Lloyd: Okay. The final question, Suzy Davies.

[153] **Suzy Davies**: Thank you. Well, first of all, congratulations on the new collaborative model of working that you're trying out. Other witnesses have told us that they would actually like to see less health board involvement in the clusters and that they would have more autonomy. Brendan Lloyd, you said that you want more direction from, potentially, the health board or possibly even higher up. Which part of the system should take the lead? Should it be the health board? Should it be GPs, as you've also suggested, slightly paradoxically, or should it be physicians as our previous witnesses have told us? Who's the best leader?

[154] **Dr Lloyd**: I don't think there's a question of more or less. I think that what we would like to see is a better integration and unity between the cluster plans and the strategic plans from the health boards, which are probably aimed at a higher level. From what I've seen that's been provided, it does seem that quite a number of the more local plans are a little bit short term and perhaps don't address the bigger issues that we know we are facing. I'm not saying that they're not effective, but I think that, if we are looking at it from a wider health system perspective, there perhaps needs to be little bit more direction around, 'Well, these are the wicked issues that we are facing' and we need a bit more collaboration and joined-up thinking,

going across the systems, of which the clusters would be an essential part, to address those issues in a strategic way.

[155] **Suzy Davies:** Just one more on this one: does that mean, then—? Are you saying that, at the moment, the clusters aren't in the right place to be assuming autonomy over their money—you know, to go straight to the health boards, saying, 'Give us the money. We'll sort it out'? They're not quite ready for that yet.

[156] **Dr Lloyd:** So, again, I think you have already received evidence from other people saying that the clusters are at different levels of maturity and leadership, and that is certainly one of the problems that we have faced. We are having different types of discussion, based on the levels of autonomy, leadership, and maturity of the clusters. So, I think that we will reach a place where we're having a more mature and effective discussion, but, at the moment, there is not the consistency that we would like to see across Wales.

[157] **Suzy Davies:** Okay. Thank you.

[158] **Mr McLean:** Sorry, just to support your thinking on that, to give you an example, we're not—I think from WAST's point of view, what we're proposing is that there be some collective thinking around the key wicked issues—

[159] **Suzy Davies:** I like this 'wicked issues'.

[160] **Mr McLean:** Sorry, the challenges to the system.

[161] **Suzy Davies:** No, I understood it.

[162] **Mr McLean:** The challenges to the system, and those three or four challenges to the system could be then developed locally via the cluster leadership, but, from a WAST point of view, we'd like to have that consistency of thinking through the plans. That's what we're saying.

[163] **Mr Woodford:** It's about autonomy within a clear framework, isn't it, I think.

[164] **Mr McLean:** Yes.

[165] **Suzy Davies:** That's lovely, thank you. Much appreciated.

[166] **Dai Lloyd**: Grêt, diolch yn fawr. Dyna ddiwedd y sesiwn gwestiynau yma, felly diolch yn fawr iawn ichi am eich presenoldeb. Diolch hefyd yn fawr iawn ichi am eich tystiolaeth ysgrifenedig a wnaethom ni ei derbyn o flaen llaw.

Dai Lloyd: Thank you very much, and that's the end of that session. Thank you for coming today and thank you very much for your written evidence, which we received from you in advance.

[167] Hefyd, a allaf i gadarnhau y byddwch chi'n derbyn trawsgrifiad o'r trafodaethau'r bore yma er mwyn ichi allu cadarnhau bod y materion yn ffeithiol gywir? Felly, byddwch chi'n derbyn trawsgrifiad o'r trafodaethau ichi ei wirio. Felly, diolch yn fawr iawn ichi am eich presenoldeb y bore yma ac am eich tystiolaeth ar lafar. Diolch yn fawr.

Can I also let you know that you will receive a transcript of today's discussions so that you can check that for accuracy? So, you will be receiving one of those so that you can check it. Thank you very much for being here and for your oral evidence. Thank you.

[168] A allaf i gyhoeddi wrth fy nghyd-Aelodau y gwnawn ni dorri am egwyl o 10 munud rŵan a bydd y sesiwn dystiolaeth nesaf yn dechrau am 11 o'r gloch?

[169] Can I let my fellow Members know that we're going to have a 10-minute break now and the next evidence session will begin at 11 o'clock?

Gohiriwyd y cyfarfod rhwng 10:50 ac 11:01.
The meeting adjourned between 10:50 and 11:01.

Ymchwiliad i Ofal Sylfaenol—Sesiwn Dystiolaeth 5—Cymdeithas Fferyllol Frenhinol a Fferylliaeth Gymunedol Cymru
Inquiry into Primary Care—Evidence Session 5—Royal Pharmaceutical Society and Community Pharmacy Wales

[170] **Dai Lloyd**: Croeso i bawb i adran ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. Rydym ni'n symud rŵan at eitem 4 ac yn parhau efo ein hymchwiliad i ofal sylfaenol a sut mae clystyrau meddygon teulu yn

Dai Lloyd: Welcome back, everybody, to the latest section of the committee here at the Assembly. We now move on to item 4 and continue with our inquiry into primary care and how GP clusters operate. This is evidence session 5, and before us are

gweithredu. Sesiwn dystiolaeth rhif 5 ydy hon nawr, ac o'n blaenau ni mae aelodau'r Gymdeithas Fferyllol Frenhinol a Fferylliaeth Gymunedol Cymru. Felly, a gaf i groesawu'r pedwar canlynol i'r bwrdd: Mair Davies, cyfarwyddwr Cymru y Gymdeithas Fferyllol Frenhinol, Suzanne Scott-Thomas, Cadeirydd Bwrdd Fferylliaeth Cymru, Cymdeithas Fferyllol Frenhinol, Mark Griffiths, cadeirydd Fferylliaeth Gymunedol Cymru, a hefyd Judy Henley, cyfarwyddwr gwasanaethau contractwyr, Fferylliaeth Gymunedol Cymru? Croeso i'r pedwar ohonoch chi. Rydym ni wedi derbyn tystiolaeth ysgrifenedig o bron bob man, rydw i'n credu, ac mae'r Aelodau wedi'i darllen gyda manylder. Felly, fel sy'n draddodiadol, awn ni yn syth i mewn i gwestiynau ar y pwnc yma o sut mae clystyrau meddygon teulu yn gweithio. Felly, mae'r cwestiwn cyntaf gan Jayne Bryant.

members of the Royal Pharmaceutical Society and Community Pharmacy Wales. Therefore, may I welcome the four of you to the table: Mair Davies, director for Wales, Royal Pharmaceutical Society, Suzanne Scott-Thomas, chair, Welsh pharmacy board, Royal Pharmaceutical Society, Mark Griffiths, the chair of Community Pharmacy Wales, and also Judy Henley, director of contractor services, Community Pharmacy Wales? Welcome to the four of you. We have received written evidence from nearly everywhere, I think, and Members have read that evidence in detail. Therefore, as is traditional, we go straight into questions on this subject of how GP clusters work. Therefore, the first question is from Jayne Bryant.

[171] **Jayne Bryant:** Thank you, Chair. We've heard and we all know about the evidence to make sure that we're keeping as many people as possible out of hospital who don't need to go into hospital, and about treating patients closer to home, but perhaps we've had very little evidence—hard evidence, anyway—on the impact of clusters. Perhaps you could elaborate on the visible, tangible effects that various cluster initiatives have in terms of reducing those demands?

[172] **Ms Scott-Thomas:** Okay. I think the pharmacy profession have been very supportive, and continue to be very supportive, of the primary care clusters. Initially, the clusters decided it was a priority to have more pharmacists to work in GP practices with them, and we now have over 100 pharmacists working in GP practices across Wales. They are doing a variety of different initiatives with patients in those clusters depending on what the population needs of that cluster are. One of the impacts is that pharmacists

are going into care homes and undertaking medication reviews in these vulnerable patients with multiple conditions, where perhaps polypharmacy is an issue and that polypharmacy is leading to harm for certain patients that don't need those medicines anymore, or in fact is causing a problem to them fulfilling their quality of life. So, they're able to go in and do de-prescribing where it's appropriate, and we have a number of evidences of the impact of this de-prescribing and the reviews into polypharmacy within care homes in particular, but also in the wider community as well—that initiative of the pharmacist focusing on how medicines should be used appropriately, and, where they are used inappropriately, making those interventions using their independent prescriber skills and knowledge.

[173] So, I think that's probably hard evidence. I haven't got figures for you, but I've got lots of evidence of where that's been taken forward as a priority in clusters. And that does have an effect of patients not being admitted—reducing admissions through medicines-related harm or inappropriate use of medicines. So, I think that's one area where that's happened.

[174] **Ms M. Davies:** I think one of the issues is that we've got a lot of pockets of best practice. There's a lot of pilot work going on, and Pacesetter work. I'll particularly talk about one in Powys, where there's been some very innovative practice, with very good collaboration between a GP practice and a community pharmacy, which has been fully supported by the local health board. And whether it's reduced people going into hospital, the evidence isn't there for that, but certainly the result of that is something like a reduction of 21 per cent, over, I think, six months, in GP consultation for common ailments. And why has that worked? It looks as if, because of this collaboration, the community pharmacy has been supported to become an independent prescriber. It's being fully supported and the collaboration is there—the will to make this work. And there are more examples across the country. But I think what is needed now is that clusters need to think, 'That works—we need to adopt that model, we don't need to go looking at a different pilot, a different Pacesetter.' If something is demonstrated to work and both parties and patients are happy with it, why aren't we thinking of how to roll it out?

[175] **Jayne Bryant:** That was very eloquently put, I think, there. We've talked about also the need for data and evidence, and an evaluation of some of these Pacesetters and some of the projects that are going out. What do you think should be done to ensure that evaluation is there, and what more could we be doing?

[176] **Ms Scott-Thomas:** I think there is a need for hard data and also good evaluation. I think there is also a lot of evidence to suggest, for instance, the polypharmacy and medication reviews are certainly the right thing to do, so actually doing it is the right thing to do. So, the evidence is there of the actions that need to be taken, particularly with medicines. What perhaps we haven't got are the data around what is the local impact within each cluster where this is happening. But the evidence is there that the actions that are being taken are the right actions. But if we wanted an all-Wales picture of what is the impact and joining the dots then, to date, we haven't got that and I think that would be very valuable going forward. It is incredibly difficult sometimes to show that your action has actually avoided an admission, because that's very subjective. So, how you say that that particular action prevented that for people on the ground, then, is difficult to write down on a piece of paper and collect those data on a day to day basis. It's almost as much work as the work that you're doing. We need to find a way, and I'm not a researcher—it's not my expertise—but there will be people who could look at that and find an easier way of evaluating what has that intervention that you've done—what actually did it avoid; on a cumulative basis, what's the impact into the community.

[177] **Ms M. Davies:** One of the things that we have been calling for is for strategic leads and for a pharmacy perspective on the leadership boards. And one of the skills that we would envisage that sort of person having would be research and evaluation skills, because, unless you know what you're going to evaluate, you can't actually put that into the service you're providing. So, if we were to have strategic leads that have got interest in research at a leadership level in clusters, they would be able to make sure that nothing is going to be developed that isn't going to be evaluated, and then to look at quality improvement into that, with the plan-do-study-act cycles to improve it. Because, you know, the first time, you probably won't get it quite right, but if you have the resource in there to be able to look at it—'Yes, this is what we did'—evaluate it properly, you do it a little bit differently next time. But you actually do need that strategic lead with a research interest at a very high level in the clusters.

[178] **Ms Scott-Thomas:** Can I just add to that? One of the options, maybe, to consider, in how we achieve that, is having a consultant pharmacist role in those community clusters, or across a number of clusters, because they bring that research element into that environment, and that may be an option that we would consider.

[179] **Dai Lloyd**: Okay. Mark.

[180] **Mr Griffiths**: With the evolution of the new pharmacy contract, obviously the money is available for all of the extra services that we believe will greatly enhance the patient experience—the outcomes. I think there is an opportunity for some services that could be rolled out and piloted. For instance, the experience I have in Merthyr is that we have the opportunity to do medicines use reviews in the home environment. One of my pharmacists did that last year, and 50 per cent of the patients that he visited required him to contact the surgery for a doctor intervention or a nurse intervention. Well, obviously, that makes a heck of a difference because, hopefully, we can keep those people out of hospital, out of secondary care. And I think that, even though it's not documented, has a striking financial value—so, prudent healthcare.

[181] **Dai Lloyd**: Iawn, Jayne? Julie **Dai Lloyd**: Okay, Jayne? Julie is next. nesaf.

[182] **Julie Morgan**: Thank you. I wanted to ask you about working in a multidisciplinary team, and I think you've already referred to this. You do say you'd prefer a more national approach in your evidence. I wondered if you could expand on that.

[183] **Ms Henley**: From a national perspective, it would be useful to have a steer to the clusters in relation to the engagement with, particularly, community pharmacy contractors, because that hasn't been the case across Wales currently. So, there's a difference and a variation across the 64 clusters in relation to how they've engaged with community pharmacy. We've got examples in Hywel Dda, where they've gone out to community pharmacy contractors and invited expressions of interest to take part and be part of those clusters. Some of the pharmacists who are already taking on those roles are finding them exceptionally valuable, and opening discussions where you wouldn't necessarily expect them to going. So, we've just recently had a falls public health campaign, and because of the pharmacists talking to the cluster near Llanelli about falls and the public health campaign, they're actually starting to look at developing a pilot enhanced service there as well, because they've identified that as a particular need in their cluster. So, what we've found when we've gone to do talks to the clusters about services that community pharmacies do is that the services, even the ones we've been doing for years—actually, our GP colleagues and the rest of the

multidisciplinary team aren't always aware of what we currently do, and where we could go in the future as well. So, actually having some steer to involve us to start those conversations would be really useful.

[184] **Julie Morgan:** But you weren't thinking that there should be a fixed model.

[185] **Ms Henley:** No. I suppose it's about—. The 64 clusters are completely different in different areas of Wales, but some guidance to encourage them to involve the local primary care community contractors—whether that's us, or whether it's optometrists or dentists, and actually making sure that it's not purely GP focused.

[186] **Mr Griffiths:** I think there could be an opportunity with the terms of reference of the clusters for it to be stated that the community pharmacist should be part of the group, because I think they seriously add value to that cluster.

[187] **Julie Morgan:** We've certainly heard the evidence about that. Are there any disadvantages of multidisciplinary working, do you think?

11:15

[188] **Ms M. Davies:** I don't know if it's a disadvantage, but I think there needs to be a recognition that if you're working in a multidisciplinary team, there are different skills you need to bring into that team. And we need to make sure that that team is a team, and not a lot of individuals working in their own silos, because it still happens. It's very different if you are a genuine multidisciplinary team. I would support what Jodi has said—we really do need pharmacists to be in with the multidisciplinary team: they need to learn together because people who learn together can work together. We need to make sure that they've got the team-working skills—every member of that team—and we need to make sure that the leaders have got the skills for mentoring and training and being inclusive of the whole team—that it's not, 'I'm the leader and these people are supporting me', but, 'We are a team; what skills—?'. You know, get everybody—every member of that team should be working right at the top of their licence. So, there are different skills when you start working in a multidisciplinary team.

[189] **Julie Morgan:** And is there much learning together happening now, do you know?

[190] **Ms Scott-Thomas:** I think that is an area that is starting to be recognised that would add a huge value to primary care. I think that pharmacists who come out of university—so, they've done their four-year Master's and they do a pre-registration—tend to split into either community pharmacy or hospital pharmacy. So, the community pharmacists have a good view of primary care, it's fair to say, and hospital pharmacists have a good view of the clinical and perhaps the multidisciplinary team, but what we want to try and do is bring those together and use that portfolio of skills for the benefit of all.

[191] We're aware that Betsi Cadwaladr have started very innovative training last year of their pre-reg as an integrated pre-reg, and Cwm Taf and Hywel Dda are picking that up this year, where the pre-registration pharmacists spend time in the community, in secondary care and now in primary care as well. So, I think that's very valuable, but what we need to have now is: what are the opportunities for the multiprofessional training from the start? As Mair said, when you train together, those connections are maintained and there's an appreciation at a very early stage of what each brings to the party, so the team then is more than the sum of the parts. That's the place that we need to get to.

[192] So, I think there is a huge opportunity. We need to put some pace behind that, because it takes a long time to build a new way of training from the start. But what can we do post graduate? What can primary care do to support the training of that multiprofessional team? We can avoid a lot of duplication, because it's not just pharmacists—there are a lot of other professions now going into primary care who have no experience of primary care and I'm sure they all need to know the same things. So, what could we do in a multiprofessional way to bring them together more and have a better understanding of what each can bring for patient good? Because that's what we're all there for at the end of the day. So, yes, I think it's a huge opportunity.

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

[194] **Dai Lloyd:** Symudwn ymlaen, a Rhun sydd efo'r cwestiynau nesaf.

Dai Lloyd: We will move on and Rhun has the next questions.

[195] **Rhun ap Iorwerth:** Bore da i chi i gyd. Mae llawer o'r hyn rydych wedi

Rhun ap Iorwerth: Good morning to you all. Much of what you have been

bod yn siarad amdano fo'n barod yn ein harwain ymlaen at drafodaeth ehangach, rwy'n meddwl, ar gynllunio gweithlu. Yn aml iawn, pan rydym yn sôn am gynllunio gweithlu, rydym yn meddwl am ddiffyg staff, ond o ddarllen yr hyn rydych wedi'i gyflwyno—eich dau sefydliad chi a'r CCA hefyd—a yw'n deg dweud o bosib nad diffyg fferyllwyr, ond diffyg gwneud yn fawr o'r fferyllwyr sydd gennym ni'n barod ydy'r her fawr, a chael fferyllwyr i weithio, fel rydych chi'n ei ddweud, ar dop eu cofrestriad?

talking about already leads us on to wider discussion on workforce planning. Quite often, when we talk about workforce planning, we think about a lack of staff, but from reading what you have presented—your two institutions and the CCA—is it fair to say, possibly, that it's not a lack of pharmacists, but a lack of making the most of the pharmacists that we have already that is the biggest challenge, and having pharmacists to work, as you say, at the top of their registration?

[196] **Ms M. Davies**: Shall I start? I think there are two issues with this. We've got 100 pharmacists working in clusters at the moment—where have they come from? The majority have come from secondary care. There have been rumours— and where they came from, I have no idea—that there are too many pharmacists in Great Britain. Believe me, there are not too many pharmacists—there certainly aren't in Wales, anyway. This has resulted in a drain, certainly, from the band 7 pharmacists in secondary care.

[197] We've got pharmacists working in community pharmacy who have not, at the moment, been fully engaged with clusters. They have got exactly the same basic five-year Master's degree, followed by a year's pre-registration training. So, they have got the underpinning knowledge and skills to work in primary care, but we haven't actually engaged with this group yet. I think that's something that we need to do; otherwise, secondary care is—. Everybody is saying, 'Yes, we need more pharmacists', but we need to start using the community pharmacy as well. That network is there; it's a strong network. There's an opportunity with the new contract to work in a different way.

[198] Again, they will need training into this new primary care model. We've met with RCGP, and the one thing that RCGP were telling us was that the ethos is different in a GP practice. So, that basic understanding needs to be in there, but that is an urgent piece of work that needs to be done. Use the workforce that we have. And I'm sure there are pharmacists there who would love to work—in community pharmacy—who would love to be part of a GP

practice.

[199] **Dai Lloyd**: Mark.

[200] **Mr Griffiths**: In the next generation of the pharmacy contract, there are going to be funds available for backfill within pharmacy contractors, and I think this is a great opportunity for community pharmacists to work on clusters, obviously with their local GPs, and have the backup of a locum going in and covering them while they're doing this. I think that works in many ways, but one of the biggest things I think it will do is that it breaks down some barriers. So, you would start to realise that, you know, we're all pushing in the same direction: all we really want to achieve is better patient care, and I think that that is hopefully coming now in October time, I think.

[201] **Rhun ap Iorwerth**: On this issue of making sure that all healthcare professionals, and pharmacists in particular, work at the top of their registration, how much pressure do we need to put on making sure that our pharmacists are skilled as much as they can—becoming independent prescribers and so on—and how much that helps?

[202] **Ms Scott-Thomas**: I think that is absolutely essential. The majority of pharmacists aspire to be independent prescribers. There is a funded opportunity within the managed sector for that to happen. The pharmacists who are currently working in the GP practices, in fairness, have been supported to become IPs as much as we can, but there is still oversubscription to those IP courses year on year, and there has been a reaction from academia to put more on, but it's not enough. What we haven't got is the wherewithal for community pharmacists—I do think that's fair, Mark, isn't it—to have that opportunity in a fair way, such as the managed sector. I think that is essential.

[203] I am aware of health boards—and I'll put my hand up and declare that I am a chief pharmacist in Cwm Taf health board. We supported five community pharmacists in the last two years to become IPs, working with their GP practice. It was seen as quite innovative, but, unfortunately, we've not seen a momentum gathered after that. We should have. We hoped that that would sort of open the door for some central funding for that. That hasn't happened, but I think that if we are to wake up that sleeping giant of community pharmacy, then that initiative, or just some pump priming, would really get some momentum going, so people could be working at the top of their licence far more.

[204] **Dai Lloyd**: Mark.

[205] **Mr Griffiths**: The landscape is changing all the time, so I think that there is a perception amongst the community pharmacy network in Wales that going down the IP route is a really good way—. And I think that opportunities will arise over the next few years for this to be used properly in community pharmacy. I put one of my pharmacists through the IP course three, four—well, maybe four or five—years ago and, as she developed and got the qualification, you actually realised that, at that time, the environment was very, very difficult for her to use those qualifications in a community pharmacy setting. I believe that that is totally changing.

[206] **Rhun ap Iorwerth**: Just to expand little bit on that, what was difficult, and what's getting better?

[207] **Mr Griffiths**: Well, it's actually getting into a position where you can use the qualification within the community pharmacy position. So, if you're an IP—. I mean, I could have set up a travel clinic and things like that so we could do injections and things like that, but, actually, if you wanted to do anything sort of like warfarin testing or things like that, it would have to have been done within a GP surgery. I think the opportunities are now starting to arise where that could be done within a pharmacy. You know, the pressure is taken off the surgery then, and it's done in the pharmacy. Obviously, as soon as you know what their figures are, you just go straight and give them the dose of warfarin that they require.

[208] **Ms Scott-Thomas**: What we have at the moment are the foundations and enablers that are starting to be put into place to allow the full use of an independent prescriber within the community pharmacy to happen in a safe and appropriate way. So, across Wales, we are rolling out—and I think it'll be pretty much implemented by the end of the year—the Choose Pharmacy IT platform. That will allow access into the GP record for certain services. That has yet to be agreed, but I'm aware that good progress is being made in that area.

[209] We also are committed to rolling out the common ailments scheme. So, in Cwm Taf, for instance, that will be rolled out across the whole health board by the end of June. We are using PGDs, patient group directions, to actually supply prescription-only medicines on the common ailments scheme. Why? We should be using IPs, which would then mean that we could

do a lot more through the common ailments scheme. That will be rolled out. I have the assurance of a lot of the other chief pharmacists in Wales that they are keen to get that rolled out totally across Wales. How does that change the landscape then? How does that change the patient pathway across Wales? I think that then starts to build the foundation for moving things like the management of long-term conditions to the community pharmacy at a pace and on scale.

[210] **Rhun ap Iorwerth**: Forget the clusters, IPs could work just with a single GP surgery. It could work well.

[211] **Ms Scott-Thomas**: Yes.

[212] **Rhun ap Iorwerth**: How can we maximise the potential of clusters? How could the growth of IPs bring out the best in clusters?

[213] **Ms Scott-Thomas**: I'm aware that certain clusters have their priorities. The Merthyr cluster, in fact—cardiology is there and the care of cardiac patients. We are currently training a secondary care specialist cardiology pharmacist, who already is an IP and practices as an IP within secondary care, to do arrhythmia clinics in primary care, and that's across the cluster. So, the GPs from that cluster will refer to her and other GPs—she's working in parity with GPs in running those clinics—and that's across the clusters. So, there's that sort of intermediate care, or pulling secondary care back into primary care. So, I think that's quite a good example.

[214] **Rhun ap Iorwerth**: And different pharmacists with different specialities working within a cluster area could provide a whole range—we've heard of other examples with diabetes, for example.

[215] **Ms Scott-Thomas**: Yes.

[216] **Rhun ap Iorwerth**: Okay.

[217] **Ms M. Davies**: I think one of the fundamental problems has been—and it doesn't mean it can't change—that the cluster is seen as being around a GP practice. None of the other contractors have been included to date. Is that what a cluster should be or should we be including community pharmacy optometrists? Because we want to change the journey for the patients so that they're not going to the GP surgery unless they really need to. So, we need to be using optometrists. We need to be using community pharmacy maybe as

the gateway, and they can have the referral pathways, they can manage long-term conditions—the medicines management issue of that—they can give lifestyle advice. I think now the time has come to start thinking broader than 'What is a cluster? What should it be covering?'

[218] **Rhun ap Iorwerth**: That point was made by the physicians as well.

[219] **Dai Lloyd**: Mae'r cwestiynau nesaf o dal ofal Dawn Bowden.

Dai Lloyd: The next questions are from Dawn Bowden.

[220] **Dawn Bowden**: Thank you, Chair. I think it follows on from that point, because you set out in your evidence quite strongly that you were concerned about the funding model for clusters at the moment. Do you want to say a bit more about that? Because we've had differing evidence from some organisations saying there should be more autonomy for the clusters and they should have more control over the finances. Your evidence seems to be saying, 'No, that really ought to be something that is controlled by the health board', and that it should have a wider reach, basically. Did I misinterpret what you were saying?

11:30

[221] **Ms Scott-Thomas**: No, I think what we're saying is that the funding model needs to be sustainable. So, perhaps one of our concerns is that we have 100 pharmacists working in GP practices the moment. If the funding model changed, would GPs decide not to continue having them as a priority for the cluster? It's sort of having that assurance that that funding is sustainable in that way. I think, in terms of where the funding sits, it just needs to be equity of access to funding for the primary care professions across the cluster. Where it sits, I don't think we're particular about it—certainly, I'm not. But I think we also need to look at how the health board does support the clusters. So, for instance, the pharmacists that are working within the GP practices now are employed by the health board on behalf of the clusters. The health board pharmacy departments have all stepped up and are managing those staff. So, they've recruited them, they've done the training for them, they continue to do the, sort of, line management of them, in terms of managing their sickness, their appraisals et cetera—the GP practices don't have to do any of that, and perhaps that's skill that the health board have got, but that's not perhaps seen as supporting the clusters. So, there's still quite a lot support going on, and why would we want GPs doing that? That's where they shouldn't be spending their time. So, I think that we

need to need to look at that sort of collaboration—it could be quite positive between the health board because they've got to be the wherewithal of all the HR and everything in that area.

[222] **Dawn Bowden:** And release the professionals to do what they have to do.

[223] **Ms Scott-Thomas:** Exactly, yes.

[224] **Dawn Bowden:** And what about the question of innovation, then? The purpose of setting up the clusters was to allow them to—. What is it? A thousand flowers bloom, and all that kind of thing. It was to allow them to innovate and develop in new ways. Do you think that this is possible with the way that the system is funded at the moment, the way that it's being set up at the moment, or do you think we need to be looking at different ways of—?

[225] **Mr Griffiths:** I think the landscape, as I said earlier, is changing. So, I think that the opportunities are going to be greater now for pharmacists, for their positions to be funded, and that any extra services can be funded. The health boards have a pot of money to spend now, and they know they have to spend it. Therefore, there's absolutely no reason why, for these things, we can't think of innovative ways of using that money that involve community pharmacists, doctors, whatever. Obviously, for our money, it's community pharmacists—for ways for us to be doing things that enhance the patient—

[226] **Dawn Bowden:** So, it's your point of view that that is part of the innovation—the involvement of a pharmacy in a different way.

[227] **Dai Lloyd:** Judy on that point.

[228] **Ms Henley:** Some of the concerns have been, before the change in contract coming in, in relation to the innovation of providing, say, a pilot service to a community pharmacy, especially if it involved significant training for the pharmacy to take part. As to what happens when the pilot ends, and when the clusters have a finite pot of money, and they were looking at it for just this year—that can work as a barrier for pharmacy contractors in actually taking part, because if they can't see it progressing past the pilot, especially if they've got to, obviously, engage in terms of training time—.

[229] **Dai Lloyd:** Mair.

[230] **Ms M. Davies:** I'm not involved with the funding model as it is, but what I do recognise within that model, and what we recognise—and we have mentioned it earlier—is the need for strategic leadership for more than one profession at that level. Once that happens and there is a proper multidisciplinary look at how we can provide for our population in a better way, then all of that will come in, and the funding, then, would be streamed to where it needs to be for that population, and it might well be the best place in rural Wales—there are no GP practices but there are quite a few community pharmacists. So, it would differ. But if you have the right professions up there—with social services as well, not just the profession—they need to be at the strategic level making those decisions and saying, 'How can we make this work? This is the problem—what do we contribute to this?'

[231] **Dawn Bowden:** Okay, Chair.

[232] **Dai Lloyd:** Mae'r cwestiwn olaf o dan ofal Suzy Davies:

Dai Lloyd: The final question is from Suzy Davies.

[233] **Suzy Davies:** On that point, really—I've heard your evidence about how you'd like the Welsh Government to intervene in order to give some strategic direction on this, but we have had evidence from other sources that the clusters would like more autonomy, more control over their finances and decisions made by clinicians. Do you think those two positions are reconcilable, and how difficult would it be to do that, when we've got such a variation in the maturity of clusters of at moment, which you've also mentioned? Because your points have been very strongly made today.

[234] **Ms Scott-Thomas:** I think it comes back to Mair's point, really, about having the right people around that sort of cluster leadership table.

[235] **Suzy Davies:** Who's on that leadership table, in your view? Who should be there?

[236] **Ms Scott-Thomas:** I think it should be a multiprofessional leadership. It was initially seen as a GP leadership, and that's how it started, and that's fair, but I think, now, we need to move them—and some have moved already. At Aneurin Bevan, for instance, one of the cluster leads is a pharmacist. Another one is a nurse. So, as you say, there is a wide variation in the clusters, and there probably always will be a variation, but we just need to move them all in that direction rather than perhaps trying to squeeze them

to be all the same, and a homogenous sort of—. Do we want that? Because I think the cluster is about reflecting what that population needs, but I think for us it is about seeing the wider view of the multiprofessional view, and having the leaders of that profession around the table so you get that most strategic view, and what the opportunities are of doing things differently.

[237] **Suzy Davies**: Well, the previous witnesses mentioned perhaps having a framework within which quite a lot of autonomy and variation could sit, but that the framework itself would be designed at a higher level, so that you've got that strategic direction flowing through it.

[238] **Ms M. Davies**: I think one of the important things for any framework is we need to get everybody out of their silos, so the funding model has to encourage people out of their silos. I'm not an economist and I don't think I've got the answer to that, but one thing I think is really important, going forward—I'd like to mention it—is we can put all these systems in place, but the one thing we have to do is to change public behaviour, if we want this to work. And the one thing I would really call for is for the Welsh Government to start thinking about a public behavioural change programme, because if you want them to go to the community pharmacist, if you want them to see the pharmacist, or the occupational health, or the physiotherapist as the first port of call—. Everybody wants to see the GP, the doctor, you know—

[239] **Suzy Davies**: Yes, so, it's about revising the Choose Well strategy.

[240] **Ms M. Davies**: They need confidence in this, and it has to be a national programme so that you don't turn up in one place and, 'Oh, well, actually we haven't got that service running here.' You have to give the public confidence they're getting the best care, and I don't think we're engaging in that at the moment.

[241] **Suzy Davies**: Thank you. Diolch.

[242] **Dai Lloyd**: Pwynt da i orffen arno fe. Diolch yn fawr iawn i chi. Dyna ddiwedd y sesiwn gwestiynu benodol yma, felly diolch yn fawr iawn i chi am eich presenoldeb. Diolch yn fawr iawn i chi hefyd am eich tystiolaeth ysgrifenedig y gwnaethom ni ei derbyn o flaen llaw.

Dai Lloyd: A good point to end on. Thank you very much. That's the end of this specific session, so thank you very much for your presence here today. Also, thank you for your written evidence that we received beforehand. I can now announce that you will receive a transcript of this

Fe allaf i bellach gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r drafodaeth yma, er mwyn i chi allu cadarnhau ei fod e'n ffeithiol gywir. Ond gyda chymaint â hynny o eiriau, a allaf i ddiolch yn fawr iawn i chi unwaith eto? Fe allaf i gyhoeddi i'm nghyd-Aelodau: fe gawn ni egwyl fer nawr, a thoriad am chwarter awr, gan ddod yn ôl am 11.55 a.m. Diolch yn fawr.

discussion so that you can check it for factual accuracy. So, with those few words, may I thank you very much? And I can let my fellow Members know that we will have a short break now for 15 minutes and return at 11.55 a.m. Thank you very much.

Gohiriwyd y cyfarfod rhwng 11:38 a 11:57.
The meeting adjourned between 11:38 and 11:57.

Ymchwiliad i Ofal Sylfaenol—Sesiwn Dystiolaeth 6—Coleg y Therapyddion Galwedigaethol, Coleg Brenhinol y Therapyddion Iaith a Lleferydd a Chymdeithas Siartredig Ffisiotherapi
Inquiry into Primary Care—Evidence Session 6—College of Occupational Therapists, Royal College of Speech and Language Therapists and Chartered Society of Physiotherapy

[243] **Dai Lloyd:** Croeso nôl, felly, i adran ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad Cenedlaethol. Rydym ni'n symud ymlaen i eitem 5 rŵan, ac yn parhau efo'n hymchwiliad i ofal sylfaenol a gweithgareddau clystyrau meddygon teulu.

Dai Lloyd: Welcome back to the next section of the Health, Social Care and Sport Committee here at the National Assembly. We're moving on to item 5, and continuing with our inquiry into primary care and the activities of GP clusters.

[244] Hon ydy sesiwn dystiolaeth rhif 6 nawr, ac o'n blaenau mae aelodau o Goleg y Therapyddion Galwedigaethol, Coleg Brenhinol y Therapyddion Iaith a Lleferydd, a'r Gymdeithas Siartredig Ffisiotherapi.

This is evidence session 6, and before us we have members of the College of Occupational Therapists, the Royal College of Speech and Language Therapists, and the Chartered Society of Physiotherapy.

[245] Felly, o'n blaenau, rwy'n falch i groesawu Ruth Crowder o Goleg y

Before us, I'd like to welcome Ruth Crowder, College of Occupational

Therapyddion Galwedigaethol—bore da, Ruth—Dr Alison Stroud o Goleg Brenhinol y Therapyddion Iaith a Lleferydd, a hefyd Philippa Ford o'r Gymdeithas Siartredig Ffisiotherapi.

Therapists—good morning, Ruth—Dr Alison Stroud, Royal College of Speech and Language Therapists, and also Philippa Ford from the Chartered Society of Physiotherapy.

[246] Rydym ni wedi derbyn tystiolaeth ysgrifenedig, yn naturiol, eisoes. Gyda'ch caniatâd, yn ôl y drefn arferol, fe awn ni'n syth i mewn i gwestiynau. Mae'r cwestiwn cyntaf o dan law Lynne Neagle.

We have received written evidence, of course. If it's okay with you, we're going to go straight into questions. The first question is from Lynne Neagle.

[247] **Lynne Neagle**: Thank you, Chair. There seems to be limited hard evidence on the impact of clusters. Can you tell us what you think are the visible and tangible effects these clusters are having on reducing demand for GPs and secondary care?

[248] **Ms Ford**: Thank you very much. Bore da and thank you very much for inviting us to give evidence. If I can start, Lynne, it's quite early days, really, I think, with regard to the development of clusters. They've been going for a couple of years. There have been some Pacesetter pilots that have been undertaken, and there are some multidisciplinary models within that, but, at this stage, we haven't seen the evidence of the results of the evaluation of those. So, it is, at this stage, quite early days. However, we've got quite a bit of evidence that we've collected as professions about the impact of some of our roles that we have in general practice and primary care. So, there's evidence that we're collecting alongside, but we haven't seen official evidence. Certainly, some of our evidence shows that we are decreasing demand on GPs.

[249] **Lynne Neagle**: Okay, thank you.

[250] **Dr Stroud**: I can give an example if that's helpful at this stage.

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

12:00

[252] **Dr Stroud**: So, in speech and language therapy, and all the therapies, really, the age range of where our referrals are coming into what's currently

specialist care trots along like that from 20 to 50 and then, around about 70 to 80, starts to take an enormous hike, so, they are the elderly population that's got increasing complexity.

[253] All the allied health professionals can help change services to take some of the pressure off GPs for that increasing demand. In particular, speech and language therapy: nursing homes have got—10 per cent of stroke patients end up in those sorts of care homes, and 70 per cent of residents in those care homes have got speech and language needs, and swallowing and eating needs.

[254] Currently, in the old, traditional system, the GP would go in, refer to speech therapy, and there'd be this whole complicated pathway to get care for them. Some of the clusters in Wales have been purchasing innovative services where speech therapists are going in and either training the staff in the care homes or they're directly taking the referral themselves, instead of going via the GP.

[255] There's been a pilot in Cardiff that, using every single parameter, has shown a reduction in demand for admissions to a home and demand for GPs. There are currently swallowing services in Blackpool, Sandwell and Cwm Taf that have shown decreased demand onto the GP where the multidisciplinary team can manage them with direct access.

[256] We've all got direct access. We're all autonomous practitioners. So, GPs don't need to refer. It's just the clusters using that knowledge now to pump-prime and get those direct access quick services going, to take pressure off them. We've got evidence of the money it's been saving and the time it's been saving.

[257] **Ms Crowder:** Where we've had services developed, we've found clear evidence of our ability to reduce admissions, to help people to avoid falls, and also to actually draw people back out of hospital if they've had an acute admission. It's been very clear. The example we gave in our written evidence, of the south Pembrokeshire cluster, where we've assisted GPs in avoiding admission—I think that's been a really important impact, that we offer that alternative to calling an ambulance if there's a crisis. There's clear evidence, when we work with paramedics and first-point services, that actually we can help keep people at home as an alternative. It's important to then be linked in with accessing some of those social care and support services that help make that alternative.

[258] Keeping people in work and helping people to return to work, particularly those with mental ill health, has also been a strong area. Obviously, along with the frailty teams that we've been working in, where we've been focused on frailty interventions, we've also been involved in the well-being into work and we have practitioners who are the primary mental health practitioners under the mental health Measure. So, there's a significant impact in helping avoid long-term reliance on social care, reducing pressure on hospitals and A&E, and actually reducing repeat calls to GPs as well.

[259] **Lynne Neagle**: Okay, thank you.

[260] **Ms Ford**: And, from a physio perspective, a couple of the Pacesetter projects have looked at first-contact practitioner physiotherapists. One in five appointments to the GP are for musculoskeletal conditions. So, if you can put physiotherapists in there to triage and look at and sort out all the MSK for the GP, that actually supports them so that they are only doing what only they can do—take away that pressure on them.

[261] So, there are pilots that are being evaluated, and, certainly, from our initial stages of information that we've got, we're showing that physio can actually save time for GPs. So, their appointment times can go from 10 minutes to 15 minutes—that's been shown in the pilot in Scotland—and you can actually reduce the number of people coming back for repeat appointments into surgeries. So, that's where the kind of savings that you're talking about, or the pressure release on GPs, are being seen.

[262] **Lynne Neagle**: Okay, thank you. You've mentioned evaluation a couple of times—that there is some evaluation going on but that that's not been made available yet. How satisfied are you that Welsh Government has got the evaluation of these arrangements right and are going to be able to roll out the good practice in a timely way?

[263] **Ms Ford**: That's a very good question. I think that the Pacesetters—. I haven't seen the outcomes of the Pacesetters yet, and I don't know if Welsh Government has seen the outcomes of those. So, it will be very useful for not just the Welsh Government but wider organisations to be able to evaluate what comes out of the Pacesetter programme. So, I think there's a lot to be done around that. I don't know whether they have necessarily got that right at this stage.

[264] **Dr Stroud**: What needs to happen is to wait for them to mature a little bit—you know, this is early days—and learn from where we've got to.

[265] **Lynne Neagle**: Okay, thank you.

[266] **Dai Lloyd**: Hapus? Julie sydd efo'r cwestiynau nesaf.

Dai Lloyd: Happy? Julie has the next questions.

[267] **Julie Morgan**: Yes, thank you very much, Chair. I know you're all committed to multidisciplinary working and it's the way ahead. What are you finding are the barriers to multidisciplinary working and how can they be overcome?

[268] **Ms Crowder**: I think you're absolutely right. We're all extremely used to working in multiprofessional teams and the advantages of that are that the population that we're working with in the community has very, very complex needs. So, it's important to make sure that we get the right person with the right skills—and to be able to, very quickly and in a very timely and responsive way, get that right person in there.

[269] So, I think, if we're looking at the existing services, in terms of barriers, actually, we're very used to working with them. We usually find ways around any issues that we've experienced quite creatively, because we all understand what each other can bring. On a more structural level, I suppose some of the barriers, particularly, that we identified in our evidence are how we actually embed some of those existing community teams into general practice.

[270] So, the community resource teams have been developed and are functioning very skilfully and are quite responsive in several areas, but sometimes they're not actually sufficiently responsive to what a GP might need if they arrive at somebody's house and find somebody with a crisis that day. So, we need to find ways through the structural barriers to actually get very fast, responsive interactions. That's why we feel very strongly that actually having AHPs embedded within general practice and within primary care settings is really, really important.

[271] **Dr Stroud**: So, you're absolutely right, the evidence from the NHS Benchmarking Network UK has shown that patient outcomes improve proportionally to the number of professions around that patient and helping

them. So, that multidisciplinary team does have improved outcomes for patients, and it is how we're going to facilitate a rapid response. We've got these frailty teams, these community resource teams, but there needs to be some facilitation of making those rapid access too. We've all described, I think, rapid—

[272] **Julie Morgan:** How could that be done? How could you get that rapid response?

[273] **Dr Stroud:** I think it does need some kind of seed funding to get it going, and then it will pay for itself—it is an invest-to-save, but it does need some encouragement and facilitation to get going.

[274] **Ms Ford:** Funding models are something we'll probably come back to; I think it's a key issue. Again, thinking about silos and where money is, that's another issue that is a bit of a barrier with regard to how things are funded and which pot of money it comes from and who is sitting back and waiting to see whose pot is going to fund the actual post. So, there needs to be much more joint working between the clusters and the local health board primary care divisions to make sure that that kind of thing doesn't happen.

[275] **Ms Crowder:** I think—sorry, if I may—one of the other things to make sure is that we don't create some kind of brand new but stand-alone multidisciplinary team. We mustn't forget that, actually, people with complex needs need services that are integrated across health, social care, housing, primary, mental health, and all the ages. So, it has to be very, very flexible and very skilled, lean team working that is around the person and that person's needs. We mustn't get too embedded into structures that say, 'We're this team', 'We're that team', and actually there's no linkage between them, when that is the integration that an individual needs.

[276] **Julie Morgan:** Right. And is there any issue where professions overlap? Does that cause any difficulties?

[277] **Ms Ford:** Who wants to go first? [*Laughter*.]

[278] **Dr Stroud:** Yes. Personally, as a speech therapist in a multidisciplinary team, when you're dealing with one patient, you know how to put the wheelchair next to the chair because you've learnt that—it's sort of cross-fertilisation in knowledge. You know how to support—make sure the stroke patient's arm is on the table. You probably understand how to break down

the language too, because you've worked in the multidisciplinary with a speech therapist. So, there is blurring of boundaries, but there's also very unique selling points from each one.

[279] **Ms Crowder**: We all bring very, very separate and very different skills and it's important to maintain that. This isn't about having a blurred, generalist approach. For us, it's about having very, very clear access to different professional skills, so that you have not got some general toolbox, but you can make sure that you have highly skilled interventions for the right thing for the right person. But when you work in a good team—and there's lots of evidence out there—what you actually start doing is learning, at a less specialist level, the skills of each of your team members. You understand what those team members bring. You know when they're better placed to interact than you are, and it's that ability to work together without poor handoffs, which leave people with gaps and no support network, so that they can't fall through and drop out of the system. That is absolutely critical.

[280] So, that blurring, that understanding, that making sure, particularly if you're in a rural setting, that we don't send out six people to somebody's house when the other five things are at reasonable levels where we might be able to share skills. That's really critical to a good use of resource, and it's a good use of somebody's life. People don't want to spend their lives seeing us; they want to spend their lives doing things that matter to them. So, it's really important that we pull together and don't counteract each other's interventions, as well.

[281] **Ms Ford**: I think, also, the complexity of patients that our clinicians are dealing with out in the community setting means that actually having that wider multidisciplinary team with all the skills is for the benefit of patients, so they can access the right person, at the right time, in the right place. So, I think it's really fantastic to have that kind of wealth of professionals and the blurring of the boundaries actually enhances that.

[282] **Julie Morgan**: Thank you very much.

[283] **Dai Lloyd**: Rydym yn symud ymlaen rŵan, ac mae'r cwestiynau nesaf o dan ofal Rhun ap Iorwerth.

Dai Lloyd: Moving on now, and the next questions are from Rhun ap Iorwerth.

[284] **Rhun ap Iorwerth**: On workforce planning, you have made some very clear points in your written submissions—a range of concerns, it's fair to say.

There's an assumption that sharing staff across clusters is a way of perhaps addressing a shortage of staff and getting the most out of staff and getting more bangs for your bucks. One, in principle, is that the right approach? And, two, in practice, is that what we're seeing?

[285] **Dr Stroud:** In principle, it's the right approach for many things.

[286] **Rhun ap Iorwerth:** In practice, not.

[287] **Ms Crowder:** I think I would say—and we definitely raised this point—for us, as I said earlier, we don't want to see—. I know you've all experienced casework where an occupational therapist employed in the NHS does one assessment, and then an occupational therapist in a local authority goes out and does something else, and we have got rid of that and that is absolutely essential. We've now got clear services across most areas of Wales where, actually, the occupational therapist follows somebody in if they're admitted to hospital and pulls them back out into the community. What we want to see is a workforce where our staff who are working in primary care understand what it's like when somebody's in hospital, but more importantly, perhaps, the staff who are in hospital understand what it's like for primary care, so that they understand how people can be supported, with really complex needs, in the community.

[288] So, in principle, sharing staff is really key. In practice, we've found, again, the example in the report that we published last autumn, which is mentioned in our evidence, that actually embedding somebody within the practice who is part of the local health board staff retains those links, so they're still able to access those community equipment and community adaptation services; they're still able to access supervision and specialist advice if they need it, to be able to draw into other services. So, for us, in practice, we think that's really key.

[289] **Dr Stroud:** Yes, we agree that clinical governance is best served by—. Our preferred model would be that the allied health profession staff are employed by the LHB, but with a service level agreement to either one or two GP clusters, depending on what the service was going to be, because that's a safer way of ensuring that you've got practitioners who are being properly developed and are safe for the public.

[290] In terms of workforce planning, I know there's been other evidence that's said that AHPs are shortage professions and so there's no point trying

to even develop that workforce, but the evidence from the workforce commissioning numbers is that, certainly, there's been an increase, steadily, over the last few years, of the commissioning of student training numbers, so there is a recognition that the AHP workforce is being commissioned bigger and bigger, because we can work in these different service models and take away pressure from both GPs in primary care and elsewhere in the system.

12:15

[291] **Ms Ford:** I think there's a lot to be said for future models with pooled budgets, joint posts across secondary and primary care. So, I think that's something that will be definitely happening in the future, because it's a workforce across the whole. It's a whole-systems workforce. It's not just a primary care workforce, separate, and a secondary care workforce, separate. So, I think that's key, particularly when you're thinking about strategic leadership, who are our therapy leads, and how they are working with the primary care clusters and the primary care divisions within the health board. There is a danger of a separation, still, between what general practice is doing and what the primary care community resource teams are doing, which are part of the health boards. So, we would like to see much closer working, and I think if there is much closer working, you've then got the opportunity for more in the way of pooled budgets and joint posts, and that gives opportunities for undergraduate development—being able to have practice-based learning, going out into general practice and going out into community resource, because you've got a whole system and a whole service. So, that's what we'd like to see.

[292] **Rhun ap Iorwerth:** That leads me on to my last question. You've described the future. The question is, and I guess what we're looking at in this inquiry is, how we get to that future. You talk—I can't remember which one of you in your—it was you. [*Laughter.*] In your written submission, you talk about the need for a strategy. Who is taking that strategic lead on making sure that through workforce planning we've got the AHP requirements for all those clusters? Is it currently being left to the individual clusters? Some of them might be doing it very well, or—

[293] **Dr Stroud:** I think it's coming from several directions. So, yes, some of the work—. GP clusters are individually indicating that they want to have this AHP workforce, and then that can be fed into the NHS. The uni-professional heads of service in each of the seven health boards inform the

commissioning of student numbers, plus the professional bodies sense-check it. But in order to do that planning, you have to have some fairly solid indication of the direction of travel for the future, because, obviously, you're not going to get the new workforce until four years' time, otherwise, by the time—. So, there is an issue, I think, about AHP—that understanding between the clusters over what AHPs can offer to get to that future. So, what needs to happen is ways of ensuring that these direct access services are understood, so that the GP doesn't keep being used by the public as the route in.

[294] **Ms Crowder**: I think, traditionally, GPs have found it very difficult to access us. They haven't been able to refer directly to health service occupational therapists, and local authorities have tended to respond to written referrals rather than being part of embedded teams. So, it's very difficult for them to understand exactly what it is that we offer. So, the pilots and projects that we're seeing developing across Wales are really, really important in demonstrating that impact. Alison's right, at the moment, it's the LHBs who lead the workforce planning, and, particularly from our perspective, the local authority need for occupational therapists is also embedded into those plans, and that's actually directly come out of a recommendation from the workforce inquiry that the health committee did back in the second Assembly. So, it's really important to make sure that we don't lose that. But the clusters have never had that experience. So, we're in a sort of chicken-and-egg situation, inasmuch as they're not going to be saying they need lots of us until they know what it is that we bring, but there is also an issue about funding us. If they're going to be employing us, then they've got to know that we bring a sustainability to their businesses, and if the LHB is employing us, they—

[295] **Rhun ap Iorwerth**: So, we need a clear definition of what a cluster is, in basic terms, and we want clusters to behave, in all cases, the 64 of them, like mini hospitals in an area where there is an expected range of services provided by the allied health professionals, as well as the GP and everybody else.

[296] **Ms Ford**: They will need to feed into the workforce planning process. So, you've got your health board workforce planning process that occurs, which feeds into the integrated medium-term planning process, from which comes the requirement that they're going to have. So, the clusters will need to feed into that process, because again it's that holistic, whole service that we want to be looking at, not something in isolation. But as Ruth said, GPs don't know what they don't know. So, if they don't actually know what we do,

there's a job of work for us as professions, and there's a job of work for Welsh Government, to really make sure that they know, so that they can plan and feed their requirements into the planning process.

[297] **Rhun ap Iorwerth:** And you are wonderful advocates for the work that AHPs do, but it's got to be more than that, hasn't it, really?

[298] **Ms Ford:** I think one of the things—sorry, Alison.

[299] **Dr Stroud:** We have another role as well, which is not just about increasing this workforce, but changing service delivery models, because we've got a big role, but some of these projects have shown we're just a small—. We've done training of other parts of the workforce, almost like the generic nursing workforce, or the care home workforce, and they can then reassure themselves that they can keep people safe without even needing to access the specialist level. But you need to invest in those people to do that training in the first place. They may be able to disappear then, once the confidence of other parts of the multidisciplinary workforce has improved. The evidence from some of these pilots has been—. I think Cwm Taf has shown something like a 60 per cent drop in demand from nursing homes, either via the GP or directly to them, once they've done some training, but it has to be kick-started somehow.

[300] **Ms Crowder:** If I might just add one more thing, we do want to make sure that we see a good linkage between the different bodies that are now leading developments on different things. So, we've got health boards making plans, we've got local authorities making plans, then we've got regional partnerships, we've got public services boards and then we've got clusters. So, we need to be clear that we're not actually all going off in different directions, and that each of those has got the ability to set a different plan, given that each cluster would be separate: that's a lot of bodies who could all be doing things very differently. So, what are they feeding into, what is the overarching intent for the—I'll say 'the regional footprint', but whatever decision is made on that, we really don't want to see plans that take people in lots of different ways and draw services into more silos and different directions and objectives. We want a common objective, which, for us, is about make sure that we deliver services that enable people to do the things that matter to them. We don't want to see lots and lots of fragmentation.

[301] **Rhun ap Iorwerth:** How are we doing for time, Chair?

[302] **Dai Lloyd**: Popeth yn iawn. **Dai Lloyd**: You're okay.

[303] **Rhun ap Iorwerth**: As well as getting the people to do the work we need places for people to do the work. From your experience, have we got the premises within primary care to cope?

[304] **Dr Stroud**: I think there are examples in Betsi Cadwaladr of bigger buildings, places to do the work, which has facilitated that multidisciplinary understanding of each other, and who can do what first, and the right person at the right time. But you can get side-tracked into buildings. Speech and language therapists are very small. There are about 450 of us in Wales, 70 per cent of which are probably in children's services. So, we are very used to working from wherever. We've got the same speech therapist and the same occupational therapist, I think, working at the bedside with the new admission, and then following them out to home to carry on the care. So, we're very used to working in whatever environment is the best place to sort out how we can functionally help that patient to manage with their difficulties.

[305] **Ms Crowder**: Absolutely, I would agree with that. There is an issue about how the team meets, and how you are embedded within the practice, and where there's space for you to actually make that relationship with your other team members. But actually, the place where we carry out our interventions is with the person in their environment—at work, at school or at home.

[306] **Dr Stroud**: Wherever that person is.

[307] The other thing we need to be creative about is telemedicine, telehealth. There are a couple of projects knocking around now so that the staff member doesn't have to keep travelling. We can telehealth in, and the outcomes are looking good in terms of patient satisfaction and patient outcome. So, we need to think to the future as well in the modernisation of those kinds of service models.

[308] **Ms Ford**: I think there will be a need to look at buildings as well. We have musculoskeletal physiotherapy services that are currently in health boards. That's just because it's a geographical patch; it's within the area. But I do think it's part of the work that general practices do in looking at their own estate. They will have to think about their planning processes for

bringing a wider multidisciplinary team in to working in their environment. But that's part of the process of development that they would be doing anyway. That will have to be looked at with themselves as clusters, and with their health board colleagues, to think about the funding of that and getting that right, to bring all these different team members in.

[309] **Dai Lloyd**: Symud ymlaen i faterion cyllido nawr, ac mae Dawn Bowden yn mynd i ofyn cwestiynau.

Dai Lloyd: Moving on to funding issues now, and Dawn Bowden is going to ask questions.

[310] **Dawn Bowden**: Thank you, Chair. Pippa, in particular, you've been raising the issues of funding quite a lot. The evidence that we've taken, not just from you, but from others as well, has set out some concerns around the development moneys available for clusters, and whether it actually inhibits the kind of innovation that you've been talking about—which I don't think any of us would argue with—and particularly the stuff you were saying, Ruth, about the need to integrate all the various bodies. So, I just wanted to ask you whether you were finding it difficult to operate within those kind of structures—the differing funding streams that come through—and whether there are alternative methods of funding that you think would better suit the kind of model that you've been advocating today.

[311] **Ms Ford**: Firstly to say that, with regard to funding for some of the pilots that have been going on as part of the pacesetter, that's funding that's come direct to the clusters, and then there's other funding that's obviously from the primary care divisions within the health board. AHPs are not involved in the actual management of clusters, so we've not really had access to funding. What we have had is that some of the pilots have actually featured allied health professions as part of that—MSK, physios, first point of contact and different triage models—some of those are out there. So, there's been funding there that's come out, and the clusters have made the decisions. In terms of future funding, we've got silos, really. We've got the health boards with their funding and we've got the clusters with their funding. Where they've spent on innovations, that's it with their innovation money. So, they're then doing whatever that service is that they've paid for in their innovation. So, unless they get more moneys for more innovations, that's the situation they find themselves in.

[312] **Dawn Bowden**: And there was an issue that we'd had flagged up as well, which was the short-term nature of the innovation funding, if you like, which makes it difficult to do the kind of longer-term projects that you're

talking about, presumably.

[313] **Ms Ford:** It is difficult. We'd like to see scaling up of good models. So, if we've got good-practice models, models that are working, and there's proof of concept that these models work, then how will the health boards and clusters scale these models up across the whole of Wales? I think that that's going to be quite difficult. Actual sustainable development comes with more long-term funding. Short-term funding is great for pilots, but we don't want to be in pilots forever and a day.

[314] **Dawn Bowden:** And just on the point of pooling of resources, which seems eminently sensible—and particularly, Ruth, from the OT point of view—I mean, I'm assuming that you would also be supportive of pooling resources where it overlaps into social care as well.

[315] **Ms Crowder:** I think it's really important—I've said this a couple of times— that we don't end up with different services. When we work with people, we need to be able to keep working with them, and not have handoffs into lots of different people or teams and services. And one of the things—this is why the three of us have identified that we really prefer this concept of an LHB employed staff member with an SLA into the general practice or primary care setting—is that need to be able to be flexible for the person—. I'm really sorry, my brain has just completely gone.

[316] **Dr Stroud:** Shall I take it?

[317] **Ms Crowder:** Thank you. While I get back—.

[318] **Dr Stroud:** [*Inaudible.*]—back in the day of children's services, where we had to do exactly the same work as we're trying to do now: changing services from just a specialist AHP model to more universal targeted training and examining at the specialist end. In Wales, where we tried—. The most success has been where that preferred model has been the model. So, schools have either bought an SLA in their local health board for speech therapy into their school, or a local authority has done an SLA for a type of service, and those have been the better ones. The ones that have worked less is where they've been directly bought by these little pockets and there's professional accountability, governance and clinical issues—

[319] **Dawn Bowden:** So, can I be very clear in terms of the model? You're saying that you don't believe that the clusters should be separate entities, or

if they should, that they shouldn't be the entities that employ therapists and other professions—that that should continue from the health board, but that they buy into the primary cluster.

12:30

[320] **Ms Crowder:** We think that offers a real opportunity for making sure that you have good professional supervision. The reality is that a practice is probably not going to need an awful lot of people. They're going to need a very experienced person if that person is single-handed. If you've got a pooled approach, you can rotate staff; you can access those LHB services; you've got supervision and governance. So, it really does enable us to keep the way that all our services have been driving so far—of integration. Having a single-handed practitioner who can't then be released to go on any training, doesn't have access to professional supervision—. You've also got a range of skills, and we are dealing with people with very, very complex needs. We need to enable them to find ways to manage for themselves. That might mean that I want to be able to access some advice from one of my mental health colleagues or from my stroke specialist colleagues in order to be able to keep working with them. And as soon as you have that separate employment, you start getting into competition, you start getting into separation. And one of the areas we're really concerned about is bits of the service not allowing access to community equipment, or not allowing access to community adaptations, not being able to talk to the housing grants department because they only take from the local authority. We don't want to create those kind of barriers. So, pooling for a common objective in order to put the person at the centre.

[321] **Ms Ford:** I think there are definite advantages with the model that we were talking about where the AHPs remain health board employed, and that is around the area of indemnity and insurance. Because, again, you've got the health board, as the employer, picking up the vicarious liability. That's a particular issue that general practitioners have raised. We do all have professional liability insurance. So, professionals are Health and Care Professions Council registered—our regulatory body, and our professional bodies—you know, our members have professional liability insurance. But it is an issue if you are an employer taking on vicarious liability, and as they have a wider remit of multidisciplinary team members, they see the issue for them of risk in terms of employment. So, we can understand that as an issue. And there are other benefits here—major benefits of having employment. But, we need, still, for our clinicians to be embedded in general practice

primary care. It's still a whole service, so they're embedded and part of general practice teams, but they're employed by the health board. That's our preferred model.

[322] **Dawn Bowden**: Okay, that's fine. Thank you.

[323] **Dai Lloyd**: Mae'r cwestiwn olaf o dan ofal Lynne Neagle.

Dai Lloyd: The last question is from Lynne Neagle.

[324] **Lynne Neagle**: Thank you. I just wanted to ask if you feel like you are full partners in this process, and whether you're actually involved in planning and decision making at the heart of this.

[325] **Ms Crowder**: I think it's variable. Obviously, we're really pleased that we've got executive directors for AHPs and health science on the health boards, and that has allowed us to have a voice in the strategic planning in the health board. There are 64 clusters. We are a small workforce. It's really difficult to engage on a strategic level, for our managers and leaders, with each one of those 64 clusters who are all working differently and engaging differently. So, I think there are some areas where our leaders have had really good relationships, really good conversations. They've developed absolutely innovative services that are making a significant difference to how we help people to live their lives. There are other areas where the clusters maybe aren't as experienced with working with us, or there are other challenges and other priorities, and so it's hugely variable. It will be important in the future to make sure that's more strategic.

[326] **Lynne Neagle**: That's the same for the three of you, yes?

[327] **Ms Ford**: Yes. And again, it's still early days, but it is vital that our professions are involved with the clusters. So, as things develop further, then it's really important that we're getting out there. That bit that we were talking about—the job of work to do to actually make sure clusters and GP practices really do know what our professions can bring—is crucial. So, perhaps we're not full partners at the moment, but that doesn't mean to say that, you know, we've stopped doing what we're doing. We've got to keep, really, raising the profile of what we can bring that actually helps general practice and takes pressure off the GPs and, again, brings patients out of the hospital environment.

[328] **Lynne Neagle**: Okay, thank you.

[329] **Dai Lloyd:** Diolch yn fawr. Wel, dyna ddiwedd y sesiwn yma. Mae'r cwestiynau wedi rhedeg allan. A allaf i ddiolch yn fawr iawn ichi am eich presenoldeb ac hefyd am y dystiolaeth ysgrifenedig y gwnaethom ni ei derbyn ymlaen llaw? Fe allaf i bellach gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r trafodaethau yma i gadarnhau ei fod yn ffeithiol gywir. Ni allwch chi ddim newid eich meddwl ynglŷn â dim byd ond o leiaf medrwch chi wirio bod y ffeithiau yn gywir.

Dai Lloyd: Thank you very much. Well, that's the end of this session. We've run out of questions. Can I thank you very much for coming today and also for the written evidence you submitted in advance? Can I let you know, also, that you will receive a transcript of this discussion to check for accuracy? Obviously, you can't change your mind in relation to anything, but perhaps you could check that the facts are correct.

[330] Cyn imi gloi'r sesiwn yma, mae hefyd yn gadarnhaol imi allu cyfarch y myfyrwyr o'r proffesiynau yma, ac eraill i'r dyfodol, sydd hefyd yn yr oriel gyhoeddus. Maen nhw yma gyda ni am y dydd ac, yn naturiol, byddan nhw yn yr oriel gyhoeddus hefyd am y sesiwn dystiolaeth nesaf ar ôl cinio am 1:30 p.m. Hefyd, fe fyddwn ni'n cael sesiwn yn y fan hyn efo'r myfyrwyr wedi'r sesiwn hwnnw. Felly, croeso i bawb yn yr oriel gyhoeddus hefyd. Gyda'r ychydig yna o eiriau, diolch yn fawr, unwaith eto, i chi'ch tair am eich tystiolaeth. Felly, gallaf i gloi sesiwn fore'r pwyllgor iechyd gan gyhoeddi i fy nghyd-Aelodau y byddwn ni'n ailagor y prynhawn yma am 1:30 p.m. Diolch yn fawr iawn ichi.

Before I bring this session to an end, it's also nice to be able to welcome these students from these professions, and others, here—our future students—who are up in the gallery. They are here for the day and they will be in the public gallery for the next evidence session after lunch at 1:30 p.m. Also, we will have a session in here with the students following that evidence session. So, welcome to everyone in the public gallery also. With those few words, thank you very much to the three of you for your evidence. I shall bring the morning session to an end and let my fellow Members know that we will be beginning again this afternoon at 1:30 p.m. Thank you very much.

Gohiriwyd y cyfarfod rhwng 12:36 a 13:33.
The meeting adjourned between 12:36 and 13:33.

Ymchwiliad i Ofal Sylfaenol—Sesiwn Dystiolaeth 7—Coleg Nyrsio Brenhinol
Inquiry into Primary Care—Evidence Session 7—Royal College of Nursing

[331] **Dai Lloyd**: Croeso nôl i bawb i adran y prynhawn o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Croeso nôl i Aelodau a hefyd croeso i'n tystion. Rydym ni'n symud ymlaen i eitem 6, ymchwiliad i ofal sylfaenol a materion ynglŷn â gweithgaredd clystyrau meddygon teulu. Gerbron mae sesiwn dystiolaeth rhif 7. O'n blaenau mae aelodau o Goleg Brenhinol y Nyrsys. Rydym ni wedi derbyn eich tystiolaeth ysgrifenedig ymlaen llaw. Diolch yn fawr iawn am hynny.

Dai Lloyd: Welcome back all to this afternoon's session of this committee here at the National Assembly for Wales. Welcome back to Members and also to witnesses. We move on now to item 6—the inquiry into primary care and issues relating to GP clusters. Before us is evidence session No. 7 and with us are members of the Royal College of Nursing. We have received your written evidence beforehand. Thank you very much for that.

[332] Felly, a allaf i groesawu Louise Lidbury, arweinydd gofal cynradd Coleg Brenhinol y Nyrsys Cymru, a hefyd Alison Davies, cyfarwyddwr cyswllt ymarfer proffesiynol, Coleg Nyrsio Brenhinol Cymru? Fel rydw i wedi crybwyll eisoes, rydym ni wedi derbyn eich sylwadau ymlaen llaw. Wedyn, fel sy'n arferol, fe awn ni'n syth i mewn i gwestiynau. Mae gyda ni rhyw 40 munud am gwestiynau ac mae'r cwestiynau'n mynd i ddechrau efo Lynne Neagle.

May I welcome Louise Lidbury, primary care lead from the Royal College of Nursing Wales, and also Alison Davies, associate director of professional practice for the Royal College of Nursing in Wales? As I've already mentioned, we have received your comments beforehand. And, as is usual, we'll go straight into questions. We have about 40 minutes for questions and the first questions are from Lynne Neagle.

[333] **Lynne Neagle**: Hi. Thank you. We think that there's little hard evidence of tangible benefits of the clusters from what we've seen so far. Are you able to tell us what your evidence is of real and tangible benefits that these are bringing on the ground?

[334] **Ms A. Davies:** Well, thank you very much for the invitation to come and speak to you this afternoon. I'm very pleased to answer your questions. I think it's probably important to note that the principles underpinning the cluster development were in existence before the clusters. So, there are many good examples, over a long period of time, where teams have worked well together to look at managing the health of the population in those communities.

[335] From our own experiences, our members tell us, who are actively involved in developing the cluster agenda now, that there are really good examples of the way in which services are developing in different ways to meet the needs of the population. In terms of formal evaluation, obviously those results are awaited; it's difficult to comment on what might or might not come out of that.

[336] We're also aware that initiatives, where they've been funded, are undertaking evaluation of particular interventions also. So, the backdrop should suggest, if services are well-designed to meet population need, there should be good outcomes, but obviously, we don't know as yet, until the formal evaluation comes out.

[337] **Lynne Neagle:** So, you haven't got any examples that you know of, of things working really well?

[338] **Ms A. Davies:** Yes, we've certainly got some examples that we can share with you. I think, in terms of one or two key aspects, Louise can share.

[339] **Ms Lidbury:** There's a really good example of advanced nurse practitioner developments in Denbighshire. Their cluster there developed an advanced nurse practitioner role looking at the caring of residents in a care home. So, the developing skills of that nurse allowed that person to have such an advanced skill that they were able to take over and substitute the role of the GP in terms of that environment, providing a safe and efficient role there, really, as well, such as looking to help patients remain in their home. That's under way at the moment and, as we say, we're awaiting to see the evaluation of that at the moment, but it seems, by all accounts, to be very, very well accepted.

[340] **Lynne Neagle:** You've both referred to evaluation, and evaluation came up in our previous session as well. Are you satisfied that there is sufficient evolution going on of these clusters and are you also confident that then

anything arising from those is going to be rolled out effectively?

[341] **Ms A. Davies**: I think it's difficult to be confident about the evaluation until it's actually there to be seen and analysed, but, hopefully, with the need to spread good practice and share things that work very well in meeting need, as well as some of the other secondary outcome measures, then, yes, that would need to be—. Obviously, there would be implications in terms of resource staffing and the need, whilst to meet individual local need, to make sure that those both examples were utilised across Wales where they would be appropriate.

[342] **Dai Lloyd**: Mae'r cwestiynau nesaf o dan ofal Julie.

Dai Lloyd: The next questions are from Julie Morgan.

[343] **Julie Morgan**: Thank you very much, Chair. I wanted to ask you about the multidisciplinary nature of the working and whether there are barriers to that working successfully and, if there are, what are they and how can you tackle them?

[344] **Ms A. Davies**: Okay, thank you for that. I think, again, in terms of multidisciplinary team working, there's a very long history, between health and social care services, essentially, about working well together to meet individual needs—many good examples of the effectiveness and efficiency that good team working creates. I think where it works very well is where there are excellent lines of communication, clear lines of reporting on accountability, opportunities to share information about people receiving care and the way in which they're receiving care so that there's avoidance of duplication, and an understanding—that's key—of individual professionals and what they actually bring that's added value and brings to the table, so that that person receiving care gets a rounded service, be that by one or other members of the multidisciplinary team.

[345] I think there may be some value in exploring that a little bit more at a cluster level in terms of that there are many new professionals potentially coming together to work with different ideas and an opportunity for different models. So, if that's built on a core understanding of what groups bring, then the added value to that will become more apparent.

[346] **Ms Lidbury**: I suppose an example of that is myself. As an advanced nurse practitioner with an independent prescribing background, I was able to work hand in hand with a local consultant, taking care of diabetic patients.

The model that was rolled out allowed me to work directly with that consultant. I was enabled to prescribe within the formulary and contact that consultant directly and that helped me to keep the patients out of the out-patient environment and, actually, without the data in front of me, I would suggest that it helped to keep patients admitted as well. We were able to safely work together, because of my advanced nursing skills, and because I was enabled to do that through the education and training that I had been provided with at that time. And what's more important with that is the fact that the patient experience was valued with that, and the patients valued that experience themselves as well.

[347] **Ms A. Davies**: One of the key enablers, I think, of the multidisciplinary team is understanding the need appropriately, so that the right service can be attained at the right time, in the right place, for the right person—obviously, prudent principles—and to enable that, we need real, clear thoughts about workforce planning to make sure that we've actually got the right professionals in place to meet those needs.

[348] **Julie Morgan**: Yes. Earlier witnesses said that there was some overlapping between what different professions were doing, but, in fact, that wasn't a bad thing. Have you got any views on that?

[349] **Ms A. Davies**: I think 'overlapping' is an interesting word. I think there is probably a core skill set or knowledge base that all professionals would use. It's the added value that that distinct opportunity brings from individuals. So, a doctor and a nurse and a therapist may see the same person, and they may generally see similar needs, but approach those needs in a different way and in a different setting, essentially. So, I think there is an opportunity to make sure that roles are clear, but to bring added value to that person.

[350] **Ms Lidbury**: From the patient's perspective, my experience with that is that patients will often choose the clinician that fits them. In that partnership, they will also begin to understand who best fits their needs. So, that kind of adds to that and brings value to each individual, then, in terms of what they've got to offer.

[351] **Ms A. Davies**: There is an opportunity—and I'm sure this has been said to you previously—about individual professionals bringing the maximum that they can to that person or to that community. So, whereas there might be a relatively low level of overlapping, I think the added value that that individual

group can bring, for whatever reason, is well worth exploring.

[352] **Julie Morgan**: And what about the possible indemnity issues? Has—

[353] **Ms A. Davies**: I think that's certainly an important factor—a really important factor, indemnity, and something to consider, and perhaps to consider in a bit more detail going forward as we look at new models of care and new ways of working. Today, we're here from a professional nursing perspective. If it would be appropriate to the committee, we could bring back, I think, a more in-depth written response to that question.

[354] **Dai Lloyd**: Iawn. Symudwn ni ymlaen nesaf i faterion ynglŷn â'r gweithlu, a Rhun.

Dai Lloyd: Okay. We'll move on, then, please, to workforce issues, and Rhun.

[355] **Rhun ap Iorwerth**: Ie, prynhawn da iawn i chi. Rydych chi wedi cyfeirio yn barod, wrth gwrs, at gynllunio gweithlu, ac rydym ni wedi hen adnabod cynllunio gweithlu fel un o'r prif broblemau sy'n wynebu'r gwasanaeth iechyd ar hyn o bryd. Beth ydych chi'n meddwl ydy'r prif rwystrau i lwyddiant gweithio amlddisgyblaethol, o ran cynllunio gweithlu? O bosibl, a fuasech chi'n leicio cyfeirio yn benodol at yr angen am ragor o *advanced nurse practitioners* a'r gostyngiad sylweddol sydd wedi bod yn nifer y nyrsys ardal yn y blynyddoedd diwethaf?

Rhun ap Iorwerth: Yes, good afternoon to you. You have already referred to workforce planning, of course, and we have long recognised workforce planning as one of the main problems facing the health service at this time. What do you think are the main restrictions to the success of multidisciplinary working, with regard to workforce planning? You might like to refer specifically to the need for more advanced nurse practitioners and also the significant decrease in the number of district nurses in recent years.

[356] **Ms A. Davies**: Thank you very much for that. I think that that's an absolutely key point. In terms of workforce planning, we know that, from an NHS perspective, there's been quite a cycle of boom and bust, essentially, where we've had perhaps a good number of nurses—I will speak for, as the Royal College of Nursing, but I would imagine that would apply to other professions as well—where we know that we've had appropriate numbers of student nurses commissioned and educated and able then to come into the wider workforce. We also know that, as those numbers have dropped off over

the years, then that has a detrimental effect going forward on the overall numbers of the workforce. Given the current climate we're in, where we know that people who use our services have far more complex needs, are living longer with more chronic co-morbidities, and that need is changing, then we really need to have the appropriate numbers and quality within the nursing workforce to be able to manage that appropriately, in community and primary care settings, as well as in secondary care settings and the independent sector. And I think that, in previous years, perhaps, the independent and primary care settings have not been as fully represented in the workforce planning processes as maybe, hopefully, they are now through integrated medium-term plans.

[357] I think where the IMTP planning process identifies the nursing and other need for the workforce going forward then those need to be very carefully considered and managed, because, as organisations identify the workforce required to meet need, those numbers need to be forthcoming to enable that to happen.

13:45

[358] In particular relation to district nursing numbers—thank you for identifying that—it's true that we know, over recent years, there's been a steady decline in the number of district nurses, in nurses specifically qualified in district nursing. We know that that qualification and experience in district nursing brings levels of assessment, leadership and supervision to teams of community nurses, and is absolutely essential to be managing the greater need that we all see in our population in Wales. If we lose that aspect, we will lose relatively more in being able to take that strategic direction forward, and also in meeting people's wishes to be cared for in their own home or as near to their home as possible.

[359] We also know that community services—obviously, community and primary care services—when those services are functioning well and meet community need, it obviously helps our secondary care colleagues and manages the way that those services are available and provided. So, from our point of view, it's essential.

[360] **Ms Lidbury:** In terms of the workforce planning challenges for advanced nurse practitioners, it is about allowing us to embrace the education and training that's required for that. In my own experience, that was a challenge in terms of the time away from practice and my personal

endeavour to achieve that. There is a need for more support with regard to that, definitely. If we are to support the multidisciplinary team effectively, then establishing a framework for us and a trajectory in terms of our career is really, really important.

[361] **Rhun ap Iorwerth:** We know there are shortages. We might not be able to put a figure on how many district nurses we need, or how many advanced nurse practitioners, but, surely, as the definition of what a cluster is becomes clearer, we will have a—. Well, if that's the proposal—it might be a suggestion that we make in this committee that we need a clearer definition. Are we able then to be more strategic in seeing exactly how many we need, assuming that, if we have clusters working well, you perhaps need fewer numbers because you're able to share them across different parts of the primary care sector and sort of get more out of them—not adding to workload, but just getting them to work in a more effective way?

[362] **Ms A. Davies:** I think that's of key importance. Wherever we are looking to design or redesign services and professions going into the future, it needs to be based on evidence, data and need. And I think, hopefully, we would all own the importance of meeting need appropriately in that way. In terms of the definition of a cluster, that would be very useful, to understand what that means and how that fits in with other perspectives, initiatives and organisational arrangements in terms of responsibility and meeting that need.

[363] **Rhun ap Iorwerth:** I think it struck us as a committee that there are very differing views and definitions of what clusters are currently. Some of them are behaving in an almost federal way, bringing different parts of the primary care sector locally together. Others are perhaps seeing it just as a vehicle to apply for funds for a particular project. Are you clear in your minds about what you think clusters should be? Are you seeing examples of that out there? Is there best practice that you would like to see replicated?

[364] **Ms A. Davies:** I think there are really good examples of best practice. You're quite right—there's variation in the way that clusters are developing at the moment. Variation isn't always a bad thing; we learn from all models and can then take forward the aspects that work well in terms of sharing good practice.

[365] **Ms Lidbury:** What I've witnessed is clusters that are actually matured in embracing the multidisciplinary team. They, to me, are the ones, that I've

witnessed, that are clearly making bigger steps. I can't put it more succinctly than that really—they're actually embracing the wider workforce.

[366] **Rhun ap Iorwerth**: Is the fact that, amongst those 64 clusters currently, there are all sorts of different models making it difficult for the RCN to plan what you might need to deliver, what your ask is to Government, in order to furnish those clusters with what you perceive to be the need?

[367] **Ms A. Davies**: I think our strategic asks would be around clinical leadership, would be about education and learning, and—

[368] **Ms Lidbury**: Sufficient data as well.

[369] **Ms A. Davies**:—to verbalise that in a meaningful way for a cluster or any other Wales-wide perspective. We'd be very happy to provide more information on that to you, but I think clarity is always good.

[370] **Rhun ap Iorwerth**: Are you seeing that there is strategic planning when it comes to training and skills needs now, or is that something that has to be developed?

[371] **Ms A. Davies**: From a Royal College of Nursing perspective, we are very eager to take forward an iteration of what's needed, in terms of nurse and nursing family education and learning into the future, so that we meet need.

[372] **Ms Lidbury**: But there is pace required with it, definitely.

[373] **Ms A. Davies**: And that's something we're progressing well. It doesn't necessarily rely upon organisational structure or otherwise, but, where there is clarity and where there are good data that inform need, then obviously we would use that to inform our way forward also.

[374] **Rhun ap Iorwerth**: Okay.

[375] **Dai Lloyd**: Wyt ti'n hapus? Trown yn awr at faterion cyllidol ynglŷn â'r clystyrau, ac mae'r cwestiynau o dan law Dawn Bowden.

Dai Lloyd: Are you happy? We'll turn now to funding issues in relation to the clusters, and the next questions are from Dawn Bowden.

[376] **Dawn Bowden**: Hello. Thanks, Chair. From the evidence that you've submitted, you did set out your concerns about the spending of clusters'

development moneys. In particular, you flagged up the concern around general practice nurses and nursing teams not being able to attend cluster meetings because that wasn't factored into the funding arrangements. Do you want to say a bit more about that in terms of how you think that could be better targeted towards the nursing aspect of cluster arrangements?

[377] **Ms A. Davies**: I think, as a non-provider, we don't have specific experience in terms of the way that funding is drawn down, implemented and monitored. However, there are principles in terms of the funding around services designed and funded being needs led and sustainable, and the services that work well and meet need being sustainable. The aspects of pay, terms and conditions and valuing the workforce within that funding is important also. There is a specific issue around GPNs.

[378] **Ms Lidbury**: Yes. In terms of engaging in clusters, being released to attend clusters, we're aware, is difficult for some general practice nurses. That's partly to do with the way that the narrative within the contract is constructed. So, that needs to be looked at in terms of improving the engagement.

[379] **Dawn Bowden**: So, does that mean you're not having an input into the strategy and the development of the cluster? What's the main disadvantage from your point of view?

[380] **Ms Lidbury**: The main disadvantage is actually not knowing what's going on. You're relying on feedback. With everything at the coalface being so busy, sometimes that can just be due to a lack of time for that feedback. It's not always to be construed as something else, it's just that everyone is so busy. It's about allowing that time to be able to have that time to explore the needs together.

[381] **Ms A. Davies**: There's also something about leadership there, the clinical leadership that's brought to a cluster environment. From a nursing perspective, we have a long track record of strong clinical leadership in many areas, and primary and community care are no different. There's a missed opportunity, really, if we are not actively engaged in helping to shape that model going forward and bringing some constructive challenge and, potentially, some solutions to that arena.

[382] **Dawn Bowden**: Okay. One of the concerns that we've had flagged up with us is that the cluster development moneys is generally short term, it's

year on year, so that potentially inhibits innovation, which is what the development money was intended for. Do you have any views on that?

[383] **Ms Lidbury:** Yes. If you're not engaged in the cluster workshops, then you're not aware of what's available in terms of developing that from a clinical leadership point of view for nursing. If you're not aware what funding is available and you're not part of that discussion, then our clinical leadership in terms of giving innovative options isn't there.

[384] **Dawn Bowden**: You're not having that input.

[385] **Ms Lidbury**: Yes.

[386] **Ms A. Davies**: I think that lesson is well learnt in many other arenas, prior to clusters, where short-term funding is available. It can very much help pump prime and change, but it's the sustaining of that change and the embedding of any change into mainstream service delivery that then remains the challenge. From an individual professional or staffing perspective, the longevity of something that you take on as your employment and the potential outcomes for that are obviously going to colour decisions. So, it is very important to resource any new way of working not only with money, but with time, commitment, thought and planning. That will enable the best outcomes to occur.

[387] **Dawn Bowden**: Okay, thank you. Thank you, Chair.

[388] **Dai Lloyd:** Diolch, Dawn. Mae'r cwestiwn olaf o dan law Rhun.

Dai Lloyd: Thank you, Dawn. The final question is from Rhun.

[389] **Rhun ap Iorwerth**: Mae'n ymwneud â'r rhan y mae nyrsys yn cael ei chwarae yn natblygiad clystyrau. Rydych chi wedi ateb y cwestiwn yn rhannol, ond mae yna ddwy ran i'r cwestiwn. Yn gyntaf, mae nifer wedi dweud wrthym ni fod yna ormod o bwyslais ar y meddyg teulu a dim digon ar y rhannau eraill o'r clwstwr. A ydy'r nyrs yn cael clywed ei llais o fewn datblygiad clystyrau yn lleol yn gyffredinol? Ac

Rhun ap Iorwerth: It relates to the part that nurses are able to play in the development of clusters. You've answered the question partly, but there are two parts to the question. First of all, a number of people have told us that there's too much emphasis on the GP and not enough on the other parts of the cluster. Is the nurse's voice heard within the development of local clusters in general? Secondly, on a national

yn ail, ar lefel genedlaethol, a ydy nyrsio yn cael clywed ei lais yn natblygiad y syniad neu'r egwyddor o'r clystyrau?

level, is nursing's voice heard in the development of this idea or the principle of clusters?

[390] **Ms A. Davies**: Well, certainly nationally, the Royal College of Nursing Wales has a key role to play and has a seat in a number of arenas where developments or otherwise in primary, community and other health and social care sectors are considered. So, certainly we have that and we would advocate for maintaining and developing that further. Good leadership is about good service delivery and good outcomes at the end of the day. Yes, we would want to be, and are, a very strong part of that. In terms of good examples and otherwise—

[391] **Ms Lidbury**: There are some good examples around, but there is variability. It's the variability that makes it difficult to give you a constructive answer. It's that variability that we need to capture, really, to explore why that's happening and explore where there is good practice and why that good practice is there and what makes that up, in terms of that good practice. That needs to be dug into.

[392] **Rhun ap Iorwerth**: You mentioned earlier the difficulty in getting nurses released to go to cluster meetings. What's the problem there? Is it funding to release them or lack of cover? How do you try to get over that?

[393] **Ms Lidbury**: Again, there is variability across the board here, but it's about the fact that everybody is so busy in that environment. Releasing members of staff is quite difficult for the employers themselves, but also in terms of the workload for the nurses as well. It's more than that, really; it's about actually seeing us as part of that voice, which is required as well, for us to feel that we are part of that and to have the confidence in stepping forward by that offer on the table not just being about a GP cluster, as many people have discussed before, but about it being a primary care cluster, and that's everybody's voice involved in that.

[394] **Ms A. Davies**: Because there is a strength in numbers, essentially, isn't there? Where you've got a number of small groups of people coming together, then that makes it inherently more difficult for those people to be fully involved at every level. It is about valuing every key stakeholder that's got a stake in taking this forward, understanding their key contribution and enabling that from the beginning, because if there is shared ownership of

goals and good leadership, then that outcome will occur far more readily.

[395] **Ms Lidbury:** And if choices are being made not to involve nurses, we need to explore why those choices are being made, really.

[396] **Rhun ap Iorwerth:** I'm not sure if there's an answer to this—the physicians told us this morning that they wanted to see more crossover between secondary and primary, with hospital doctors spending time in surgeries and GPs spending time, as they put it, at the hospital door as well. Is there an equivalent in nursing as well, where there can be a crossover?

[397] **Ms A. Davies:** Certainly.

[398] **Ms Lidbury:** Yes. That's the example I gave earlier, where I work directly with a consultant diabetologist locally. I thought that was a very powerful environment for me as an allied medical practitioner, for the consultant working directly with me, but more so for the patient, because it really helped the patient to have quick answers to their problems, quick answers to the delivery of their care, and help them to stay out of hospital. We worked almost with a compact agreement between us—it was a triad agreement and it was very beneficial. I think that model needs to be explored further.

[399] **Rhun ap Iorwerth:** But that's the doctor working in both primary and secondary, alongside primary nurses and secondary. Is there room for primary and secondary nursing to be—?

[400] **Ms A. Davies:** There are many examples where, for example, clinical nurse specialists, working across the chronic disease management agenda with children, young people and adults, work between primary and secondary care. I think that's increased since 'Setting the Direction', essentially. It has increased over time, but there's always room for more of that to happen. I think, for our medical colleagues, when you look at out-of-hours service provision and development, there's been that crossover in some areas for quite some time as well.

[401] If we look at it from the perspective of the person who's actually receiving that service, where that professional lies, whether it's in primary or secondary care, isn't of concern. It's about having continuity and clear, succinct management that's timely and manages their condition with themselves well.

14:00

[402] **Ms Lidbury:** Wherever that person sits.

[403] **Rhun ap Iorwerth:** Diolch.

[404] **Dai Lloyd:** Hapus? A dyna ni. Dyna ddiwedd y cwestiynau. Diolch yn fawr iawn ichi am eich tystiolaeth ar lafar y prynhawn yma, a hefyd y dystiolaeth ysgrifenedig y gwnaethom ni ei derbyn ymlaen llaw. Diolch yn fawr i chi am eich presenoldeb hefyd. Ac a allaf i hefyd gyhoeddi y byddwch chi yn derbyn trawsgrifiad o'r trafodaethau y prynhawn yma er mwyn ichi gadarnhau eu bod nhw'n ffeithiol cyn iddyn nhw fynd allan? Felly, gyda hynny o eiriau, diolch yn fawr ichi am fod yma. Diolch yn fawr.

Dai Lloyd: Happy? And that's it. That's the end of the questions. Thank you very much for your oral evidence this afternoon, and the written evidence we received from you in advance. Thank you very much for being here. And can I also let you know that you will receive a transcript of the discussions this afternoon so that you can check them for accuracy? Thank you very much once more for being here. Thank you.

Papur i'w Nodi
Paper to Note

[405] **Dai Lloyd:** Symudwn ymlaen nawr, aelodau'r pwyllgor, i eitem 7 a phapurau i'w nodi. Mae yna lythyr gan Goleg Nyrsio Brenhinol Cymru am yr ymgynghoriad ar ganllawiau statudol Deddf Lefelau Staff Nyrsio (Cymru) 2016. Mae hynny jest ichi i'w nodi.

Dai Lloyd: We'll move on now, committee members, to item 7 and papers to note. There is a letter from the Royal College of Nursing Wales regarding the statutory guidance for the Nurse Staffing Levels (Wales) Act 2016. That is just for you to note.

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: *Motion:*

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

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

Cynigiwyd y cynnig.
Motion moved.

[406] **Dai Lloyd**: Ac o dan eitem 8, rydw i'n cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. A oes yna unrhyw wrthwynebiad i'r bwriad yna? Nac oes, yn amlwg. Felly, mi aiff y pwyllgor i mewn i sesiwn breifat nawr. Diolch yn fawr.

Dai Lloyd: And under item 8, I move a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. Is there any objection to that intention? No, clearly. The committee will now enter a private session. Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 14:01.
The public part of the meeting ended at 14:01.