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

17/05/2017

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Others in attendance

Joanne Carter	Rheolwr y Practis, Pen y Bont Health Practice Manager, Pen y Bont Health
Dr Alison Craven	Pen y Bont Health
Yr Athro/Professor Keith Lloyd	Coleg Brenhinol y Seiciatryddion Royal College of Psychiatrists
Dr Ian O'Connor	Pen y Bont Health
Dr Gail Price	Pen y Bont Health

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	Ymchwilydd Researcher

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**: Bore da i chi gyd a chroeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. O dan eitem 1 y bore yma, a allaf estyn croeso i fy nghyd-Aelodau? Rydym wedi derbyn ymddiheuriadau oddi wrth Jayne Bryant a hefyd oddi wrth Angela Burns, ac mae Mohammad Asghar yma yn dirprwyo dros Angela Burns, ac mae Julie Morgan yn rhedeg ychydig bach yn hwyr y bore yma ond mi fydd hi yma cyn bo hir.

Dai Lloyd: Good morning, everyone, and welcome to this latest meeting of the Health, Social Care and Sport Committee here in the National Assembly for Wales. Under item 1 this morning, may I extend a welcome to my fellow Members? We have received apologies from Jayne Bryant and also from Angela Burns, and Mohammad Asghar is here substituting for Angela Burns, and also Julie Morgan is running a little late this morning, but she will be joining us soon.

[2] Yn bellach, gallaf gyhoeddi 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 i naill ai

May I further announce that this meeting is, of course, bilingual, so you can use headphones to hear simultaneous translation from Welsh to English on channel 1, or for amplification of the verbatim on channel 2? May I remind everyone either to turn off their mobile phones

ddiffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall neu eu rhoi ar dawel? Nid ydym ni'n disgwyl larwm tân y bore yma, felly os bydd tân neu larwm, neu'r ddau, bydd angen dilyn cyfarwyddiadau'r tywyswyr wrth adael.

and any other electronic equipment, or put them on silent? We are not expecting a fire alarm to sound this morning, so if there's a fire or an alarm, or both, we will then need to follow the ushers' instructions as we leave.

[3] A ydy'r clustffonau'n gweithio? Nid yw clustffonau Caroline yn gweithio. Mi wnawn ni eu newid y nawr.

Are the headphones working? Caroline's headphones do not seem to be working, but we will change those now.

09:31

Ymchwiliad i Ofal Sylfaenol: Sesiwn Dystiolaeth 8—Coleg Brenhinol y Seiciatryddion
Inquiry into Primary Care: Evidence Session 8—Royal College of Psychiatrists

[4] **Dai Lloyd:** Symudwn ymlaen i eitem 2 a pharhad efo'n hymchwiliad i ofal sylfaenol a chlystyrau meddygon teulu. Sesiwn bore yma yw sesiwn dystiolaeth rhif 8 yn y gyfres, ac o'n blaenau ni y mae Coleg Brenhinol y Seiciatryddion, ac yn benodol, felly, yr Athro Keith Lloyd o Goleg Brenhinol y Seiciatryddion. Rydym ni wedi derbyn eich papur gerbron, ac yn unol â'n harfer nawr—ac rydych wedi dod i arfer bod yma fel tyst hefyd—awn ni'n syth i gwestiynau. Mae'r cwestiwn cyntaf gan Caroline Jones.

Dai Lloyd: We move on to item 2, which is a continuation of our inquiry into primary care and general practitioner clusters. This morning is the eighth evidence session in the series, and before us we have the Royal College of Psychiatrists and representing them, Professor Keith Lloyd. We've received your paper, and as per usual—and you will know this having been a witness—we will move immediately to questions. The first question is from Caroline Jones.

[5] **Caroline Jones:** Diolch, Chair. Good morning. Could you tell me, please, regarding the increased workloads in mental health—we've been taking evidence to that fact—whether there has been parity in terms of prioritising cluster funding between mental health and physical health?

[6] **Professor Lloyd**: Okay. So, according to the Royal College of General Practitioners—their data from 2014—out of every 1,000 people who go to see their GP, about 300 have a mental health problem: 230 will be seen, 24 will be referred on to secondary mental health services and six will eventually be admitted to either psychiatric hospitals or crisis teams. So, the vast burden of that workload falls on the primary care team. That notwithstanding, increasing amounts of that work are now being referred into secondary care.

[7] So, I think your question was about how the clusters have helped with that. The honest answer is: I really don't know. I can talk to the workload and I can speak to the fact that the challenge, given that workload, in primary care is that even though things have improved greatly, only about just under half of general practitioners have done any postgraduate experience in psychiatry or mental health—I think the Chair of this committee was one of that trailblazers in that respect—but there remains both a workload and a skills issue and it's difficult to know how clustering will address that. There is a general parity of esteem point about how clusters might prioritise mental health within their workload.

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

[9] **Dai Lloyd**: Mae'r cwestiynau nesaf o dan law Oscar.

Dai Lloyd: The next questions will be from Oscar.

[10] **Mohammad Asghar**: Thank you very much, Chair, and thank you, Professor. My question is regarding reducing demand on GPs in the same area that you just answered on to Caroline. There seems to be limited hard evidence on the impact of clusters. What is your view on the quantifiable effect the various cluster initiatives are having in terms of improving access to psychological therapies and reducing demand for GPs?

[11] **Professor Lloyd**: This relates to other questions that will come up later, I suspect, about social prescribing and other forms of intervention, but have clusters made a difference to that? It's difficult to say. At the moment, I guess clusters don't have that much influence on, as far as I can tell, the types of services that they provide. If it's possible for a cluster to work collectively to deliver alternatives to medication, so psychological therapies, then that would be a good thing. If we work backwards at your question—what's missing and how clusters could play a role in providing it—then we might be able to approach it from that direction.

[12] In England, they had a scheme a few years ago called IAPT, which stands for improving access to psychological therapies, and that was rolled out in primary care there with some success. We don't have an equivalent scheme here. Similarly, although on the plus side, we do have something called primary care mental health liaison nurses—people who are generally psychiatric nurses who are based in secondary care who work, primarily, in primary care, effectively triaging mental health referrals from GPs. They're able to deal with a large number of the referrals that they get and they refer only a small proportion on to those of us who work in secondary care, such as myself, who works in a community mental health team.

[13] Now, where clustering could play a part is if the cluster decided to prioritise investing in psychological therapies and alternatives to medication, but so far, I'm not aware of any evidence that says that that's happening, which isn't to say that they're not—there just isn't any evidence that it is happening.

[14] **Mohammad Asghar:** Right, thank you. What should be done to ensure that there is robust evaluation of their work and that good practice and effective service models are being rolled out in Wales?

[15] **Professor Lloyd:** Evidence-based policy making—there should always be a robust evaluation of the roll-out of policies. There are a number of reasons why that doesn't always happen. I guess, in medicine, we're fairly used to the idea of using a particular type of evidence, and evidence means different things to different people. To lawyers, it means what the person in front of them is saying, often. To us, it's about types of research evidence and audit evidence, as well as the things that our patients say. So, at the moment, there isn't the evidence for it, so, yes, the short answer to your question: clearly, there should be an evaluation of this. The important thing would be to decide what the question was that you were asking and what a good outcome would look like.

[16] **Mohammad Asghar:** Right, thank you again. In an earlier question, you mentioned the psychological therapies—there's some sort of difference in England and in Wales. Have any lessons been learned from that side of any improved service providing to the public?

[17] **Professor Lloyd:** Generally speaking, I think, probably, primary care is in better shape here than in England, overall. IAPT is something that they

have done quite well, and what they did was to take graduate psychologists, so people who've just graduated from university with a psychology degree, and trained them in the delivery of psychological therapies. That work seems to work best—there's a very good centre in Manchester that studied this in quite some detail—when people enter the care pathway for mental health services right at the beginning and don't leap-frog around it, because there's an assumption that a lot of people need to access more complicated therapies, but if everybody starts with the simplest, except where the need is very obvious, then the results tend to be better.

[18] **Mohammad Asghar**: Okay, thank you.

[19] **Dai Lloyd**: Rhun, mae gennyt ti gwestiwn fan hyn hefyd.

Dai Lloyd: Rhun, you have a question on this, too.

[20] **Rhun ap Iorwerth**: Just picking up on what you've said and what a number of others have told us during this inquiry about it being difficult to measure whether clusters have worked. Is that a concern of yours that we aren't able to evaluate if they're working or not?

[21] **Professor Lloyd**: I'm not saying we aren't able to evaluate whether they're working. I'm saying we haven't done it yet, that I know of. If that were seen as a priority for funding, then people would be able to evaluate it. And I guess there would be a range of outcomes that could be looked at—I mean, from what the end users of it thought, what the patients using the service thought, through to what it does for recruitment, retention and things like that for primary care. I suspect that, for the last one, there are probably other things that'll have more impact, such as the recent upturn in the recruitment of GP training slots, which seems to be down to a variety of measures, of which I'm not sure clustering is necessarily one. So, it's quite difficult to tease out those different effects, but if the patients like it and the professionals like it, then it must be doing something right. So, that would be a place to start.

[22] **Rhun ap Iorwerth**: We've picked up quite clearly on there being more than a little ambiguity about what it is exactly that clusters are meant to be delivering that wasn't being delivered before. Are you clear in your mind, in terms of psychiatry and mental health, what we should be getting out of clusters as opposed to the previous situation?

[23] **Professor Lloyd**: I would think it would be helpful if clusters could

organise the delivery of psychological therapies and other things that are not currently available as a group for their patients, because sometimes there are economies of scale in doing that.

[24] **Rhun ap Iorwerth**: Okay, we'll come back to those issues, I'm sure.

[25] **Dai Lloyd**: Mae'r cwestiynau nesaf o dan ofal Lynne Neagle.

Dai Lloyd: The next questions are from Lynne Neagle.

[26] **Lynne Neagle**: Thanks, Chair. We know that some of the clusters have invested in mental health services—some of them third sector, others primary mental health care services. To what extent is it possible to ensure that these roles are well aligned?

[27] **Professor Lloyd**: Are you thinking about the third sector?

[28] **Lynne Neagle**: Well, I suppose, all the investment, really, that is going from the clusters into mental health services, but, yes, with third sector and the statutory sector.

[29] **Professor Lloyd**: Okay, so some of the stuff that's being provided from the third sector is very good. I hope it's not just being used as a cost-shifting exercise, so that care that was previously provided from the NHS or from primary care is being provided from the third sector, but some of that stuff is very good. I guess what would help clusters in making informed choices about which of those services to go with would be clear guidance on the type of provision that is helpful and beneficial to people. I think, at the moment, there are some very good initiatives in some clusters and some third sector organisations are doing fantastic work—Hafal and Mind come up frequently in this. I guess the answer to your question would be that clusters would probably be aided in this if they were given explicit guidance on what works for who and who can provide it.

[30] **Lynne Neagle**: From Welsh Government.

[31] **Professor Lloyd**: From somewhere—from people with the appropriate expertise. I think the RCGP and the RCPsych are probably both well placed to inform that debate.

[32] **Lynne Neagle**: Okay. If primary mental health services are patchy, is cluster funding being used to reduce the gaps in provision as far as you're

aware?

[33] **Professor Lloyd**: I think it is in some places. It's hard to generalise about that. Speaking as a clinician, I haven't seen much happen in that respect so far in the patch where I work, but I'm aware there are GPs who are looking to do that in other areas. It's kind of quite early days as well for clustering, I think.

[34] **Lynne Neagle**: Okay, thank you. We've heard about the need, in cluster and practice teams, for clarity in the scope of professional skills and practices and avoiding overlap in new clinical roles. What are the challenges here and what needs to be done?

[35] **Professor Lloyd**: I think that's very important and that touches on the prudent healthcare agenda as well. You want the right person doing the right job with the right set of skills, neither too much nor too little. That's why I think the IAPT scheme that I mentioned before for graduate psychologists is quite a good example of people coming in with the right level of skills and the right skill set to deliver what's needed in primary care. We haven't really done that yet. That would be a good example of something that we could roll out more extensively if there were a will to do so.

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

[37] **Dai Lloyd**: Diolch, Lynne. Yn nhermau heriau y gweithlu, mae cwestiynau gan Rhun.

Dai Lloyd: Thank you, Lynne. In terms of workforce challenges, Rhun has some questions.

[38] **Rhun ap Iorwerth**: Continuing from that, really, we know that getting the people in the right places with the right skills is one of the biggest problems that we face in the NHS. You talk about the potential economics of scale that clusters bring you. Is the assumption perhaps correct that we also have economies of workforce, if you like, whereby bringing different elements of primary care together, we can use the limited personnel resource that we have in a better way, spreading that workforce across a wider area and being able to treat more patients and so on? Is that part of the workforce planning answer?

[39] **Professor Lloyd**: I think it is part of the workforce planning answer, and that really touches on a broader set of issues around the workforce that we're training.

09:45

[40] I've been to this committee previously in another role, as dean of the medical school in Swansea, and I'm very aware of the issues around the need to train a workforce with the right skills that we can retain and keep in Wales, and who will then continue to develop as they go on. Because I think the challenge, certainly for primary mental health care, and I guess in other areas of primary care as well, is that the nature of the work that's done in primary care is changing. We're seeing a move away from hospital-based care increasingly towards intermediate and ambulatory care and more being done in the community. So, there will be a need to refresh people's skills, if they're able to keep ahead of the workload and the changing population that we face, with an increasing number of older adults. So, it's going to be more people with memory problems and dementia and that will require a rethink about how we deliver those services. So, we're going to need to train that workforce right from when they first start in medical school, or train as nurses or psychologists or physician associates, or whatever, right the way through to maintaining and refreshing their skills later.

[41] **Rhun ap Iorwerth**: There seems to be a blurring of lines that, as far as I can see, is welcome, between primary care and secondary care, and elements of secondary care need to be involved in the delivery of primary care and vice versa. Is there evidence that clustering is making that easier in the development of multidisciplinary teams across primary care clusters—that that makes the interaction somehow with secondary care better or easier?

[42] **Professor Lloyd**: At face value, it would be very reasonable to think it was. I'm not aware of any evidence that it's making it harder. I think it's too early to say whether it's helping, but it seems like a good idea.

[43] **Rhun ap Iorwerth**: Is there potential to develop that? Because one thing we've seen is that there's not a formula for the development of clusters—clusters are developed in different ways in different parts of Wales. Have you identified some areas where there's a particularly good model of clustering that facilitates that working with secondary care?

[44] **Professor Lloyd**: The variation in—to answer that with respect to mental health care—the ability of practices to support the people who are on their lists with mental health problems seems to be affected more by the skill set of the people in the practice than it does by whether or not they're in

clusters. I can think of practices where the level of care that they deliver is superb and others who seek advice from us much earlier in managing, say, depression than they would if they were managing diabetes or hypertension—it's just a skills gap really. So far, I think that has a bigger impact. I guess that if I follow that through, logically, what I would be saying is that clustering could make a big difference if it helps to skill up the people within the cluster to feel able to deliver mental health services. One of the things that can be quite difficult for mental health care, and where I think there isn't parity of esteem, is where cost shifting happens and practices are reluctant to prescribe drugs that are slightly more expensive than things that have been around since the 1950s, in a way that they aren't with other specialties. That's a slightly different point, but—

[45] **Rhun ap Iorwerth**: Yes, but I guess that's about the sharing of good practice: if you have a practice that is particularly strong on mental health within a cluster, there's more of an opportunity for that best practice to be—

[46] **Professor Lloyd**: And there are some practices that are absolutely superb at delivering mental health care that I work with, and some that are less comfortable with it.

[47] **Rhun ap Iorwerth**: Going back to our other inquiry on workforce planning, is it clear who's taking the lead on making sure that proper skills are there and available for developing clusters? Is it down to the clusters themselves or is there a clear lead at Government or health board level?

[48] **Professor Lloyd**: With regard to the general skilling up of clusters, I don't know. In terms of mental health care, we do work with local clusters around where I am to do skills and education sessions with the GPs. So, that's happening on the ground; I'm not aware of how it's organised centrally.

[49] **Rhun ap Iorwerth**: Okay, thank you.

[50] **Dai Lloyd**: Symudwn ymlaen ac y mae'r cwestiynau olaf o dan ofal Dawn Bowden.

Dai Lloyd: We will move on now and the final questions will come from Dawn Bowden.

[51] **Dawn Bowden**: Thank you, Chair. You touched on this in your earlier answers and this is a chance to enlarge a little bit now on the issue around social prescribing, because you touched on that earlier. And, certainly, I was

having a discussion only recently in my constituency with a third sector organisation that had been set up to deliver well-being projects and services, and they're very keen to interact with the GPs in the area, but that hasn't happened yet. You were saying that there isn't actually any evidence that these alternative therapists are being used to any great degree. But can you tell us what you think the potential benefits of social prescribing would be, given that preventative mental health treatments are obviously the way forward, really?

[52] **Professor Lloyd:** So, yes, I noticed this in the question, that social prescribing and prevention are elided, kind of put together, in the question there. I think they're separate. I think they overlap, but they're separate. So, taking the social prescribing bit first, I looked around for the evidence for social prescribing, because at face value it's a great idea. So far, the evidence base to underpin social prescribing hasn't been fleshed out. It seems like a good idea, but we really need to evaluate it, particularly for mental health care. I found some stuff—. I found two studies that looked at who was likely to take up initiatives in social prescribing. They're very recent, from 2017, these two studies. And one of them found, from a small study of about 100 people, of qualitative design, that people with anxiety and depression were less likely to take up social prescribing options than people with some physical conditions—so, arthritis pain and so on. Exercise programmes seem to work better for people with physical health problems than they do for mental health problems.

[53] **Dawn Bowden:** Because we generally associate well-being with mental health, don't we?

[54] **Professor Lloyd:** Yes. It needs working through. Hafal do some very good things; the Samaritans do some very good things; Mind Cymru have some very good initiatives in this respect; and, on the face of it, they really ought to help be part of the picture. As long as they're properly evaluated, then I think they could help. The prevention agenda is broader than the social prescribing agenda. There's a full range of public health initiatives that could play a part in promoting wellness and well-being in the population, from promoting resilience and well-being in schoolchildren, for which there seems to be some evidence, through to supporting people who are recovering from a more severe mental illness. So, there does seem to be evidence for that, which I would tend to separate out from the social prescribing agenda slightly.

[55] **Dawn Bowden**: So, would you be suggesting that the preventative measures, given the evidence base, should be prioritised for clusters, but that they could work with other social prescribing therapies, if you like, as a separate kind of service delivery, really?

[56] **Professor Lloyd**: There's been a debate over the years about the role of primary care in prevention. There was a big debate about cardiovascular prevention, for example, and asthma. I personally think that there is a significant role for primary care to play in raising awareness about, promoting help-seeking for, and reducing stigma around mental health. That goes with the parity of esteem agenda and will help people to feel empowered to seek help. It's then important that we have a range of options for them, which is where the social prescribing stuff might come in, except we don't yet know how well it works.

[57] **Dawn Bowden**: Sure. Okay. Yes, I understand that. Can I just ask you one further question? This is around leadership, and whether you feel that your members have had any specific involvement in cluster work. Do you feel as though you've had an involvement in terms of how they might develop, or are you coming late to the party?

[58] **Professor Lloyd**: I think it's been very much—. You have to be on the guest list to get into the party, and it's been very much a primary care party. We have been invited. We are involved a bit. People do seek our advice about mental health services. The Royal College of General Practitioners works quite closely with the Royal College of Psychiatrists around this, so that's the level at which we've engaged really.

[59] **Dawn Bowden**: Sure. Okay. That's fine. Thank you.

[60] **Dai Lloyd**: Just a question to—. A general one, really. There's a general tension, certainly in GP circles, between what happens in the normal general practice and what happens at the cluster level and, obviously, the financing of both. Obviously, recent increases in primary care funding have all gone to the clusters, none of which have come to the ordinary GP practice on the ground. In terms of, say, people—even though you're on the guest list to the party, but possibly not intimately involved in that sort of tension—can you think of a way of trying to defuse any such tension, do you think?

[61] **Professor Lloyd**: Possibly the provision of things like psychological therapies, which could be dealt with at a cluster level, would help, because it

would be a tangible example of something where there would be trickle-down to the practices, and if the service were provided by the cluster then the practices would benefit from it, and it would be a way of getting individual businesses to work more closely together.

[62] **Dai Lloyd**: That's good. But the counter to that would be—because I've heard this debate as well—in terms of clusters being expected to use their moneys to actually do things that the health board should already be doing. How would you value that sort of—? Or the clusters being expected to plug current gaps in provision, and letting the health board off scot-free.

[63] **Professor Lloyd**: I guess that's the same argument about cost shifting as I was making about the third sector. We are going to have to see a move of money over time—which is very difficult given where many of our health boards are at the moment—from secondary and tertiary care towards primary care. So, as long as the clusters are adequately funded to deliver these services, I think that could be a positive thing.

[64] **Dai Lloyd**: Good. And just a final one from me. As Rhun pointed out earlier, there is this general shift and it's recognised generally that, actually, we should be doing more stuff in the community and secondary care practitioners need to be in intermediate or even primary care, and vice versa. How can you see that being helped or actually hindered by the development of clusters?

[65] **Professor Lloyd**: I think if the clusters take on and engage with the training and staff development role, they can play a role both in recruitment and retention and staff development going forward. So, that could be a positive force around the use of clusters. From a mental health point of view, the Royal College of Psychiatrists would be very keen to engage with them on that training.

[66] **Dai Lloyd**: Great.

[67] Dyna ni. Diolch yn fawr iawn i chi. Unrhyw gwestiynau eraill? Pawb yn hapus? Reit, dyna ni; dyna ddiwedd y sesiwn. Diolch yn fawr iawn i chi am eich tystiolaeth ac hefyd am y dystiolaeth ysgrifenedig. Fe fyddwch chi, fel rydych chi'n Thank you very much. Any further questions? Everyone happy? Okay, that's the end of the session. Thank you very much for your evidence and also the written evidence you gave us. As you'll know, you will receive a transcript of the discussion so that

gwybod nawr, yn derbyn trawsgrifiad o'r drafodaeth er mwyn i chi allu ei wirio. Ond dyna ni; diolch yn fawr i chi am eich presenoldeb. Ac wrth fy nghyd-Aelodau, fe wnawn ni dorri am egwyl nawr o chwarter awr a dod yn ôl am 10:15. Diolch yn fawr iawn i chi.

you can check that for accuracy. Thank you very much for coming today. And to my fellow Members, we will have a break now for 15 minutes and come back at 10:15. Thank you.

[68] **Professor Lloyd:** Diolch.

Gohiriwyd y cyfarfod rhwng 09:58 a 10:17.
The meeting adjourned between 09:58 and 10:17.

Ymchwiliad i Ofal Sylfaenol—Sesiwn Dystiolaeth 9—Pen-y-bont Health
Inquiry into Primary Care—Evidence Session 9—Pen-y-bont Health

[69] **Dai Lloyd:** Croeso nôl, bawb, i sesiwn ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym ni'n cario ymlaen rŵan dan eitem 3 efo'n hymchwiliad ni i ofal sylfaenol, a'n hymchwiliad ni i sut mae clystyrau meddygon teulu yn gweithio. Hwn ydy sesiwn dystiolaeth rhif 9, y nawfed yn y gyfres, ac mae meddygfa gyfunol Pen-y-bont o'n blaenau ni. Efallai, cyn i fi gyflwyno, y byddai'n well imi ddatgan rhyw fath o fuddiant. Cyn i chi i gyd gael eich geni, roeddwn i yn feddyg teulu ym Mhen-y-bont. Fe wnes i dderbyn hyfforddiant ym meddygfa Oldcastle, sydd nawr yn feddygfa Oak Tree; pobl fel Dr Steve Madelin a Huw Mason oedd fy nghyfoedion i. Byddai'n well i gael hynny ar y record, neu fe fydd pobl efallai yn dweud rhai pethau.

Dai Lloyd: Welcome back to everyone to this latest session of the Health, Social Care and Sport Committee here at the National Assembly for Wales. We are continuing now under item 3 with our inquiry into primary care and how GP clusters work. This is evidence session 9, the ninth in the series, and Pen-y-bont Health are before us. Before I make some introductions, can I declare an interest, please? Before you were all born, I was a GP in Bridgend. I was trained in Oldcastle surgery, which is now Oak Tree surgery. People like Dr Steve Madelin and Huw Mason were my compatriots. But I should put that on the record, I think, otherwise people will have some things to say.

[70] Ond gyda chymaint â hynny o ragarweiniad, a allaf i groesawu, felly, Joanne Carter, *practice manager* o feddygfa Pencoed, Dr Alison Craven o feddygfa Riversdale, dros y ffordd o lle roedd Oldcastle arfer bod, Dr Ian O'Connor o Oak Tree, a hefyd Dr Gail Price, hefyd o feddygfa Pencoed? Bore da i chi i gyd.

But following that introduction, can I welcome Joanne Carter, practice manager for Pencoed medical centre, Dr Alison Craven from Riversdale, over the road from where Oldcastle used to be, Dr Ian O'Connor from Oak Tree, and Dr Gail Price, also from Pencoed medical centre? Good morning to you all.

[71] Ein ffordd traddodiadol ni o ddelio efo hyn ydy: yn sylfaenol, rydym ni'n gofyn cyfres o gwestiynau, a theimlwch yn rhydd i'w hateb, un ai bob un ohonoch chi, neu—. Nid oes rhaid i bob un ohonoch chi ateb pob cwestiwn. So, nid oes yna ddim pwysau, felly. Ond rydym ni'n dechrau gyda chwestiynau cyffredinol o dan law Caroline Jones. Caroline.

Our traditional modus operandi is to ask a series of questions. Feel free to answer them individually, although you don't all have to answer every question, of course. So, there's no pressure to do that if you don't want to. So, can we begin with some general questions from Caroline Jones, please?

[72] **Caroline Jones**: Diolch, Chair. I'd like to ask you, please—good morning—regarding the profile of the federation itself. For Pen-y-bont Health, could you tell me what the population profile is, and the numbers of staff employed?

[73] **Mrs Carter**: Right. Well, we cover six practices on the east side of Bridgend and we are just over 70,000 between the six. We've got 30 GP principals, a mixture, then, of salaried GPs, and five of the six are training practices as well.

[74] **Caroline Jones**: Right, okay. Thank you. That's quite large. Does anyone else want to elaborate on that?

[75] **Dr Craven**: That's the profile of our individual practices all added together.

[76] **Caroline Jones**: All added together. Okay. So, my second question is: could you tell me, please, what motivated you to set up—the reasons for

setting up the federation? Were some of these reasons influenced by workforce, finance, capacity to improve services or sustainability? Could you—?

[77] **Dr O'Connor**: Well, I think it's a combination of all of those things. When the decision was to have networks and funding attached to the networks, we felt that there needed to be a better way of deciding, with clarity, what you're going to spend your money on. The way that networks were set up in many areas was that there'd be representatives from all walks of social and health care, but it was chiefly the GPs or the GP practices that would be seen as the main drivers of any change and implementation. Because of that, it was at the behest of the GP practices, to have a unified decision on what they were doing. We didn't think that we had that capacity; there was no governance structure in place for us to make decisions that would be fair and democratic. Therefore, we wanted to look at a way of solidifying that and cementing that in our network, and then, as a consequence of that, that led us down the road of looking into the means of doing that and taking that a bit further.

[78] **Dr Craven**: I think we all felt that networks had got bogged down, really. Everything was very slow, there was no mechanism for it to be fair. We're six practices, but two of us are very large, two medium and two very small. We're all individual businesses. So, you had to be fair—that the decisions you were making were going to apply to all, and there was no mechanism for that in the cluster. It all depended who turned up to the meeting, which we didn't feel was very fair, really.

[79] **Dr Price**: There was quite a bit of disengagement, wasn't there?

[80] **Dr Craven**: Yes.

[81] **Dr Price**: The cluster working was becoming a bit stale. There was a lack of progress, really, and that was frustrating. That led to a bit of disengagement. So, we then decided to take it forward and looked at various models, with the help of the Bridgend Association of Voluntary Organisations. We had discussions with BAVO. Then we went back from our cluster leads to all our GPs within the six practices. We had a protected learning time session to discuss, really, ways forward, to look at different models of companies, and it was decided then that we would look at a non-profit special purpose vehicle. Then we became engaged with mutual ventures that took us through the feasibility study and then the business

planning, which took, really, the best part of 18 months. It was quite arduous, with twice-monthly meetings taking us out of our practice time.

[82] **Caroline Jones:** Could I ask you to elaborate on when you said the clusters were becoming stale? Do you mean because of patient outcomes or—what do you mean by 'stale'?

[83] **Mrs Carter:** No, it was that the ideas that we came up with—. We looked at numerous ideas. We started off as networks, many years ago, and then, obviously, went on to clusters, and we came up with projects at the very outset of the networks, and they never came to fruition. We could never really—we tried to move services out of secondary care and bring them into primary care, but we could never actually drill down the budgets to try and find out where we could move with these projects. We looked at contraceptive services to take the pressure off family planning, and we looked at the wound care and the dressings with district nurses, and we always hit a brick wall. So, we just felt that by having a more cohesive working situation and a business, we could—

[84] **Caroline Jones:** So, there's more flexibility.

[85] **Mrs Carter:** Yes, very much so.

[86] **Dai Lloyd:** Julie.

[87] **Julie Morgan:** Can I just ask: do you remain as individual businesses?

[88] **Mrs Carter:** Yes.

[89] **Julie Morgan:** Right. Thank you.

[90] **Dr O'Connor:** We are six practices, and each practice is an independent business, but each practice has agreed that they will send a nominated representative to attend the network meetings on a regular basis. But it's also transpired now that those six have taken on a role on the new federation board as well. So, we have the voice, if you like. We have to report that back to the board from each practice. So, my view might be to spend the money in this way, but if my partners are saying, 'We think it ought to be spent in this way', then that's the message I have to bring to the board.

[91] **Julie Morgan:** And then the board reaches a decision.

[92] **Dr O'Connor:** Yes. We've decided, no matter what the population size of the practice, that each practice has one vote and that vote is equal amongst us. We have a decision, then, made on voting, as to what we do. So, a majority vote will carry the day.

[93] **Dr Price:** The six practices have a GP principal as one of the directors on the board, assisted by two practice managers, and we've just employed an administrative assistant as well. We have to be quorate to make a decision. Then, we feed back to our practices what's happening in our board meetings and vice versa—what we discuss as projects, we then bring the voice of our practices back to the board.

[94] **Dai Lloyd:** Rhun, ar y pwynt yma. **Dai Lloyd:** Rhun, on this point.

[95] **Rhun ap Iorwerth:** Just on another point of clarification, I assume that, although you have made this arrangement, which is a voluntary arrangement, you are viewed as a cluster in the eyes of Welsh Government and the local health board.

[96] **Dr O'Connor:** We're two things, now. That's one of the things—. We were lucky enough to receive Pathfinder moneys to develop the federation, and it's through those moneys that we've been able to have protected time to have discussions and meetings and all the rest of it and take things forward. But, where we've got to, essentially, is that we've got two entities now. We've got the network and we've got the federation. They are separate but they overlap, because the voice of the federation is what we would bring to the network.

[97] So, if there's a discussion around—. The wound care LES is a good example. If there's a discussion over how that should be funded, we carry the voice of our six practices to the network discussion, and then other members of the network, whether that be the district nurses, the local health board, or whatever, will have the discussion with us. But, unfortunately, within each network, we haven't got a constitution or a voting system in place to say, 'Okay, well, we'll take a vote on this now', it's just whoever happens to be there, and some of those people who will be there might have no interest in wound care services, yet they—. I recognise that, in other networks, they would still be able to have a vote.

[98] **Rhun ap Iorwerth**: By 'network' you mean cluster.

[99] **Dr O'Connor**: Cluster network, sorry, yes.

[100] **Rhun ap Iorwerth**: We're very simple people around here.

[101] **Dr O'Connor**: Part of the problem, all along, has been the terminology of these things.

[102] **Dai Lloyd**: Iawn, Rhun? **Dai Lloyd**: Okay, Rhun?

[103] Oscar, you have the next two questions.

[104] **Mohammad Asghar**: Thank you very much, Chair, and good morning, panel. My question to you is straightforward: what are the advantages and disadvantages of the federation model and the major challenges you face?

[105] **Mrs Carter**: I think the advantages are—. When we started out, each practice was individual, we all had our own business. When you went to these meetings, you always came away with what was best for your individual practice. I think, working very closely for nearly two and a half years now, we all work very cohesively and we've all got the same thought process when we take that back to our practices. So, it's made collaborative working a lot easier and we all communicate a lot better as well, as individual practices working together.

[106] **Dr Craven**: I think we've started to think of the bigger picture, in that there are things we can share even though we are individual practices. We're much more amenable to that—sharing staff and expertise, and the website. So, we're all involved in that.

[107] **Dr Price**: Sharing premises as well.

[108] **Dr Craven**: Sharing premises for various services—you don't go to the practice that you're registered with, necessarily; you go to the one where the person is delivering the service. That would never have happened before. It's much more sensible and much more efficient.

[109] **Dr Price**: And I think, also, safety in numbers. Projects that we've been looking at, we've been able to undertake because we are a six-practice organisation, rather than a smaller, individual attempt on some of the

services we've already put in place.

[110] **Mohammad Asghar:** I've heard a couple of times that you run individual businesses. So, basically, there are two elements involved in this: one is profitability and the second one, in your case, should be the customer or patient satisfaction. So, which is your priority in this area?

10:30

[111] **Mrs Carter:** There's no profitability in either because we're not—

[112] **Mohammad Asghar:** You said it's a business.

[113] **Mrs Carter:** It is a business.

[114] **Dr O'Connor:** It's not for profit.

[115] **Mrs Carter:** It's not for profit. It's a special purpose vehicle that was set up not for profit. So, obviously, we've got two tranches. Looking at services, we've got ones that we have to do to generate profit that goes back into the business to be able to provide services that—. For instance, Dr Price is looking at a healthy children initiative at the moment, tackling obesity in our area. That doesn't generate any profit or anything to our business, so we have to then look at another stream of income, because eventually we have to be a stand-alone, because the Pacesetter moneys were only guaranteed for three years. At the end of that three years, we have to be able to move forward, support the business, but then put the money back into other services that will benefit the patient population.

[116] **Mohammad Asghar:** Okay. And you share best practice also, I hope.

[117] **Mrs Carter:** Yes.

[118] **Mohammad Asghar:** Okay, fair enough. The second question: what are the governance, planning, and decision-making structures, including the publication of federation plans, and are there any difficulties in establishing priorities and leadership?

[119] **Mrs Carter:** Well, we have a chair. We elected a chair when we formed the federation. So, obviously, you've got six GP directors, but Dr O'Connor is our chair. As we say, we are quorate, so we always have to have four board

members present at each meeting to be able to make a decision to move forward. If the board isn't quorate, then we can't make any decisions.

[120] **Dr Craven:** And we're listed with Companies House and the accounts are listed and public, as they would be for anybody else.

[121] **Mohammad Asghar:** Okay, thank you.

[122] **Dai Lloyd:** Could I just flesh out some potential challenges in terms of patients at one practice obviously being seen by somebody from another practice? Could you just flesh out the data protection and patient confidentiality challenges inherent in that, and also if there are any indemnity issues in terms of people, not necessarily other GPs, but from other organisations that you might have contracted with? How does the indemnity situation—how is that covered?

[123] **Mrs Carter:** Patients don't see other GPs in other practices; your registered patient is with your registered practice. But, to date, we have developed a tier 1 mental health counselling service, where we've got a contractor to do that for us and she is covered by her own indemnity registration. We use three of the practices because some patients don't want to be seen in their own practice for mental health issues, they'd prefer anonymity, to be seen in another practice, so we have a room there, and we use three of them to rotate. But, if you're registered, say, with Pencoed Medical Centre, you would only be seen by the GPs for your primary care. And there's a vasectomy service that's hosted by one of the practices, so patients from all six practices go there, but, again, that's a separate contract and all the indemnities are in place.

[124] **Dai Lloyd:** So, that operates, effectively, as if it was mini secondary care, is what you're saying.

[125] **Mrs Carter:** Yes, very much.

[126] **Dai Lloyd:** And that any GPs with a special interest operate on that same—rather than being other practitioners in the same—

[127] **Mrs Carter:** No, we don't—they stay with their own practice.

[128] **Dr O'Connor:** One of the issues we've had when we've gone through it is the funding stream for those sorts of things. So, if we wanted to engage in

any new project, we would have to have agreement from our health board that they would pay us through an SLA arrangement rather than directly into practices. So, that took quite a lot of discussion and clarity around the section 50/51 moneys, because it wasn't clear as to whether the type of company that we'd set up would be allowed to receive those sort of moneys. We couldn't get answers very quickly to that and it took quite a long time to eventually nail down that if we wanted to deliver a service on behalf of the health board then we would have to enter a SLA arrangement.

[129] **Dai Lloyd:** Just one other question from me in terms of potential challenges, because we've heard evidence from other witnesses in terms of tensions between what clusters—just normal clusters—are expected to do vis-à-vis what health boards should have been doing anyway. There's a sort of feeling in some parts of Wales that actually some cluster moneys have been used to plug the gap where it should have been health board provision anyway.

[130] Now, with that as a backdrop, if you are now instituting new services for your federation, are there potential difficulties for neighbouring clusters, who would think that, say, the vasectomy service should actually have been provided anyway? Obviously, they will not have access to your federated vasectomy service. So, what happens to—that was just an example—any service that your neighbouring clusters would feel they ought to have, or feel that the health board should be providing, but now you're providing in your particular part of Bridgend? How does that help the wider Bridgend general population?

[131] **Dr O'Connor:** I think there are two issues, really. Each cluster network across Wales has taken on different projects that they feel are going to be worthwhile to their population, and they've had recurring funding to support those issues. Now, we're two or three years into that. Certainly, from a GP perspective, the way we read this at the beginning—. The majority of GPs, I think, read this as being, 'Okay, well, if you can prove your concept and you can prove your value, then it should be the health board's decision to mainstream that'.

[132] At the moment, there's no evaluation process. We've not had a protocol or an evaluation form that we've had to fill in to demonstrate things. Each federation—sorry, each cluster network—across Wales will have done things, but not necessarily recorded it in a way that the health board's going to say, 'Yes, we can see that that's been beneficial, therefore, we're going to

fund it'.

[133] In our particular case, we've had a couple of projects that we feel have been very well received by patients, GPs, and our community at large. We believe that we've collected evidence and demonstrated their value, but we're still awaiting our health board to decide whether they're going to say, 'Right, you've proven your point. We will fund this now.' Because what will happen is that the money is going to stagnate, isn't it? You've got this money for your project, you're doing your three projects, there's no new money coming in, so how can you progress things further?

[134] So, if the project isn't successful or it's too costly or whatever, scrap that, do something different. But if you've proven something is, then there ought to be a decision by the health board to say, 'Right, that's it, you have the same amount of money coming in, now you can invest it in a different programme.' That process hasn't happened at all yet.

[135] The second issue then was around the effect on the surrounding networks and things. I think that goes back a little bit to what services you choose to deliver and the funding of that. At the moment, and I suppose for any new way of delivering a service, it would be up to the health board to set criteria as to who that's to cover and the standards that they would expect that organisation to meet. So, I think that comes down to negotiating your contract at the time, really.

[136] But, from our perspective, if, for example, there was an enhanced service, as a federation, we wouldn't be able to engage with an enhanced service. That would have to go back to individual practices to deliver that enhanced service. As a federation, we would have to ask our health board, 'Could you come up with an SLA provision for us to deliver that enhanced service?' So, it does mean more work for the health board. That's one of the things they've got to get their heads around, and work with us to find solutions, I think.

[137] **Dr Price**: An example of that is the Karuna counselling that we've had, which is tier 1 counselling where, basically, patients that don't need to be referred to the primary mental health team, they come back—come back for a dose of the doctor—but we're not counsellors at the end of the day, and it's taking up valuable appointment time. So, having this counselling service has (a) lifted the pressure on appointments for returning patients, the patients are happy that they've got contact with a counsellor, but also we've

looked at this with our cluster pharmacists and it's significantly reduced our antidepressant prescribing as well. But, obviously, a lot of these patients are not then being referred on into primary mental health services within secondary care. But we're waiting on whether that can be facilitated.

[138] **Dai Lloyd**: Dr Craven.

[139] **Dr Craven**: And we also didn't see a problem in the federation. We were talking about fairness to other people who didn't have it. As a federation, we hope we'll grow, and there's no reason why we couldn't provide that service for a neighbouring cluster if they so desired. That would be our vision, ultimately.

[140] **Dai Lloyd**: Good.

[141] Mae cwestiynau eraill o dan law Dawn Bowden.

Other questions will now be coming from Dawn Bowden.

[142] **Dawn Bowden**: To a degree, you've dealt with some of the questions I was going to ask around evaluation, but that's from a health board perspective. But can you tell us a bit more about how you have evaluated internally, if you like, in terms of what you're doing, and whether you've been able to identify what the quantifiable impact has been on the services that you're delivering?

[143] **Mrs Carter**: When we started, the first year, by the time it was registered at Companies House, we were obviously going through the feasibility process, so there wasn't a great deal of activity in the company. The best part of the second year we went through a five-year business planning process with Mutual Ventures, and we have now got our five-year plan. Year 4 was always scheduled to be our stand-alone year where we could go forward and be able to be financially stable to support the business without any Pacesetter moneys.

[144] We're just coming into year 3, and we've evaluated it by the projects that we have got off the ground in a very short amount of time—obviously, the counselling, but there's no profit coming back into the company to reinvest. But we have been very successful in tendering for GP provision in Parc prison, and we have won that contract, which is to deliver GP services for three years. The element of profit in that will be reinvested back into the company to be able to pay our administrative assistant and look at other

projects that will benefit patients. So, we evaluate every time we have a board meeting. We've got very strict criteria and we go through every project on the agenda—where we are, what challenges we're facing, what we need to move those forward—and we've also then got our five-year business plan, which has identified services that we'd eventually like to be able to provide, which will again take the pressure off primary care and, essentially, secondary care. Because we can deliver a lot of services in secondary care in primary care.

[145] **Dawn Bowden:** So, how have you been able to evaluate the impact on patients? You talked about the counselling services, and there seemed to be some clear evidence that you're prescribing fewer antidepressants and so on and so forth, and that's obviously taken the pressure off you. Have you been able to evaluate that in terms of the other services that you're delivering, and in terms of the impact on your time generally, from patient feedback?

[146] **Dr O'Connor:** One of the other projects that we engaged with was that by being a federation we were able to apply for grants and awards, if you like, that you wouldn't be able to do necessarily as an independent contractor in GP land, and you wouldn't be able to do as a cluster network. So, we've had a 10-week turnaround to try and secure some funds from the stroke implementation group. They had already demonstrated in Cardiff and Vale that, basically, if you paid practices to look at their patients who had atrial fibrillation, who were at risk of having a stroke but weren't on an anticoagulant agent, then you got a better uptake of patients who would go on those sort of agents, and the cost benefits, then, on their working module were that you would end up saving a patient from having a stroke, which would have enormous cost savings to the NHS, but also to the patient as an individual and their families.

10:45

[147] So, there were funds available for that, and as a federation we felt that we would be able to mobilise our support services to deliver that in a very short time frame of 10 weeks. We were successful in engaging with our cluster network pharmacist and with outside third sector agencies as well to come in and help support and deliver this programme to our patients. As a consequence, we've monitored those patients who were at risk who weren't on an agent at the start of the programme and compared it to the end of the programme, and we've had to deliver that as part of our award that we had—we had to provide the outcomes and evaluation, at the end of it anyway.

[148] **Dawn Bowden**: And do you think you've been able to quantify how many patients this different type of service delivery may have kept out of secondary care, or is that too difficult to quantify, or is it impossible to quantify, I don't know?

[149] **Dr O'Connor**: Well, I think, with that particular example, over our 70,000 population, we worked out that we prevented two strokes in that 12-month period. So, whilst that's a small number—it's on a population-wide basis—that can make a difference, and certainly, to the individuals, that's a huge blessing.

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

[151] **Dai Lloyd**: Grêt, diolch. Mae'r cwestiynau nesaf o dan ofal Julie Morgan.

Dai Lloyd: Great, thank you. The next questions will come from Julie Morgan.

[152] **Julie Morgan**: Diolch. I wanted to go on on the theme of multidisciplinary working, which you've already referred to, and really to ask you how the multidisciplinary team works in the federation and whether you could highlight to us any issues.

[153] **Dr Price**: I think, looking at the projects that we've individually looked at so far, for example the prison contract, obviously, the work-up for the tender process for that was a lot of work, which we did as directors of the company, to put a business plan forward and then win the contract. And we had to go to a presentation, a bit like *Dragon's Den*, which was alien to us as clinicians. So, it's been a big learning curve in that way. But also, to look at the workforce that we would like to pull on to work in that setting—we've now looked within our own teams within our practices for people who've got any special interests or special expertise who could work within that environment. Likewise, with a physio pilot that we're about to embark on, we've got partners who've got particular interests and have also got expertise and have worked in the muscular skeletal services and diabetic injectable services, and we've picked on our practice nurse specialists who are our diabetic leads, as well as the GPs, to go for training with regard to that. So, that's from the point of view of the clinicians and the nurse support team that's there as well.

[154] With regard to the project that we're embarking on now with obesity and inactivity in children, obviously, linking in and augmenting with public

health, who sit within our clusters, but also within our local Bridgend County Borough Council, with the recreational team—the teams that are going into schools—we've had meetings there. So, each project—sometimes it is just very clinically led, or very administratively led, but there are other pockets that we would pick on then, as and when needed, to come into certain specified projects.

[155] **Julie Morgan**: So, in your own individual teams, you would have a multidisciplinary team within your own individual practice.

[156] **Dr Price**: Yes.

[157] **Julie Morgan**: And you would use some of those people to go to the wider projects.

[158] **Dr Price**: Yes.

[159] **Dr Craven**: It does demonstrate one of the challenges that we've had in that as a federation, we cannot employ anybody within the—. Obviously, the people we want are going to be largely employed by the NHS. We cannot give them an NHS pension and we cannot employ them within the NHS. So, that is a great disadvantage that has not been solved, and we are waiting—

[160] **Julie Morgan**: So, did you say at the beginning that you have employed—?

[161] **Dr Price**: An administrative assistant, but that's hosted via one of our practices. We have to host them.

[162] **Julie Morgan**: So, it comes under the NHS in that way, does it?

[163] **Dr Craven**: Yes.

[164] **Mrs Carter**: Yes. We have to hold the contract. We have to rely on individual practices to say, yes, they'll hold the contract for this employee and that's how we get around it at the moment. I know that there have been some inroads in other health boards with regard to pension arrangements, but it is a massive stumbling block for us at the moment.

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

[166] **Mrs Carter**: We have got an advert out at the moment for salaried GPs to come and work with us to help us deliver the services that we're currently providing, and the services we want to provide. But, again, we haven't got that ability to offer them a pension, which is something that is attractive to anybody working within the NHS.

[167] **Dr Price**: And also we're now hosting—. Our practice will host one of the schemes, and sometimes, then, the financial drawdown from the local health board isn't there either. So, that's sort of incumbent on the practice, then, to subsidise that until those moneys come in. So, that's been a big problem for us as well.

[168] **Julie Morgan**: Right. And these sorts of issues that are emerging—where are you able to take those? Is there anywhere? To the health board or do you—?

[169] **Dr O'Connor**: Throughout the whole process, there's been a degree of dysfunctional communication from the health board. So, you've got the people at the very top who are generally very supportive and are keen to try and work with us to work through problems and make things happen. Middle management and below we've had all sorts of difficulties with. They've not been singing from the same hymn sheet, and it's made it very, very difficult to progress things. So, we end up having to go back to the very important people at the top, who are equally busy and stressed with their own issues, and say, 'By the way, we still haven't got a resolution on the pension situation, or procurement issues, or indemnity issues. Can we have a meeting to push this forward?' Even getting the sort of financial aspect, so that we can plan when we can have access to moneys to draw down to deliver and pay for the services we want to deliver—we've not had a free flow of money in that way.

[170] But those at the top have generally tried to find ways, so they have brought in their chief procurement officer and their chief legal person to have meetings with us, and that has been helpful and enabled us to move things forward. So, that's been good. But it's been a real battle from our perspective. When you've got your day job, and you're meeting periodically, it's very difficult then to keep chasing other things that you feel should just happen and they don't. That's been a big issue for us, I think.

[171] **Julie Morgan**: So, it's been a struggle.

[172] **Dr O'Connor**: I think we all feel that it's been good generally. We've come much closer together as practices. We've got a similar vision now that we all want to find ways of working smarter together to make our lives easier and make better services for patients, and to encourage younger GPs into our environment. It's very difficult in lots of areas, as you're well aware, to get new GPs coming in, and we've got to find a way of working slightly differently to ensure that GPs are going to come in and they're going to fill our shoes and want to carry on looking after our patients, really.

[173] **Dr Price**: I think it's been a frustration rather than a struggle. You're just frustrated sometimes at the lack of momentum, because, obviously, we take time out twice a month for our board meetings, out of clinical practice, and you're wanting to get the projects moving, and then we're coming up against stumbling blocks, waiting on information from the health board, really. I think, basically, the ethos for us becoming very interested in having the enthusiasm for this project is, obviously, we want to improve primary care, and the provision for primary care for our patients, but also the workload of GPs, because we're very aware of retainment and recruitment of GPs in our area. So, I suppose, our prime objective there is providing for our patients, and the improving of GP workload, but also looking at secondary care services that we can bring out into the community. But then that has to be worked through so that—potentially, what we would really like is that the funding follows the patient.

[174] The other prong to our working ethos is looking at business opportunities so that we can then plough money back in to look at other opportunities there, and then also augment public health agendas as well. So, there are four areas for each of our projects—that would fit into that area, and that there—so it's not just sort of one service provision; we're looking at those four areas on the projects that we're embarking upon.

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

[176] **Dai Lloyd**: Mae'r cwestiynau olaf o dan ofal Rhun ap Iorwerth.

Dai Lloyd: The final questions are from Rhun ap Iorwerth.

[177] **Rhun ap Iorwerth**: Cwestiynau ynglŷn â'r gweithlu sydd gen i. Rydych chi wedi sôn yn barod am rai elfennau o'r hyn rydych yn gorfod delio efo fo efo'r gweithlu, ond a oes

Rhun ap Iorwerth: My questions are in relation to the workforce. You have already talked about some of the elements that you have to deal with on the workforce, but are there any

enghreifftiau lle mae cydweithio a rhannu adnoddau staffio yn helpu i ddatrys y broblem fawr yna sydd gennym ni yn yr NHS o ran sicrhau bod gennym ni'r bobl iawn i wneud y swyddi iawn efo'r sgiliau cywir?

examples where collaboration and sharing staffing resources help to solve this great problem that we have in terms of the NHS, which is to ensure that we've got the right people to do the right jobs with the right skills?

[178] **Dr O'Connor:** This is following prudent healthcare initiatives and that sort of things, isn't it, really? I think that's how we've tried to set up things, as Gail just mentioned, really. We're trying to use our staff at whatever level to do stuff that they can do safely, but in a more streamlined way, so that there's fewer knocks on our door as GP to sort out things where we think, 'Well, surely, someone else could have done this bit?', or, 'If they'd only seen a physio before seeing me.' To tell them to go and see the physio would have taken a step out and I could have seen Mrs Jones with her bad leg or something. It's those sorts of things that we've looked at with all our projects.

[179] **Dr Price:** That's a pilot with us at the moment. We're just about to embark upon that with physio where, basically, at the point of contact with the patient at the surgery, they would be triaged following a set of protocols and an algorithm. The receptionist they would speak to would see if they could be directly sent to a physiotherapist without actually having a GP appointment. Similarly now with our cluster pharmacists, we're utilising them to do some of the medication reviews that don't need to come through to a GP. So, in those areas, we've started utilising that.

[180] **Rhun ap Iorwerth:** You could assume that the same issues would be true of successful and effective clusters too, that they could share responsibilities across clusters. Is this something that you looked at and then decided that a federation was a more effective way of maximising the bang you get out of your buck with your staff, as opposed to going down simply a cluster route?

[181] **Mrs Carter:** I think we've got a lot of GP principals who are very experienced and have a lot of special interests. The projects that we are looking at at the moment—. Take Parc prison, for instance: you have to have substance misuse qualifications, and we have quite a number of GPs who have those and want to work within the Parc setting. But, obviously, you have to be careful that you're not diluting what you've got in practice as well to

see your everyday patients. So, a lot of practices are now looking at employing a salaried GP and employing them for more sessions than they actually need in practice, which will then allow the partners to be released. They can back-fill them and they can go on to do other projects, using their expertise and their specialist skills. So, I think that's the way that we're looking at it. The fact that we're working as six practices, instead of one practice looking at delivering a contract, means that we can utilise the expertise across the 30 GP partners and salaried GPs as well.

[182] **Rhun ap Iorwerth**: Yes, which combats the shortage of GPs coming through the system.

[183] **Mrs Carter**: Yes.

[184] **Dr Craven**: One of the reasons we chose the federation model was the fact we could have a proper constitution. There is no constitution in clusters. That was why—one of the primary reasons. We had a bit of a disagreement, shall we say, and it highlighted the fact that there was no constitution to resolve anything like that. I don't sit on the local medical committee anymore, but when I did, what I learnt was that not all practices get on like the six of us do. Without that constitution, I don't know how they ever reach any agreement, to be quite honest—they spend more time fighting than anything else. Well, you're not going to achieve anything with that. One of the things it's done is we've had to work together. We've all appreciated each other's differences and we've moved on hugely in that respect. We are not now six individual practices—'What's he earning over there?', and, 'Why are they earning that?', and, 'Why can't we do that?' We do it together now.

[185] **Rhun ap Iorwerth**: There is still that because of the overlap that you mention with the cluster, and they're presumably looking over their shoulders at what you're doing. What is that relationship like with the rest of the cluster, seeing as you're a big, powerful group among them?

11:00

[186] **Mrs Carter**: We don't have a lot of interaction, really, with the other clusters in our area. We've got west, north and east, and we are east. We're aware of what projects they're doing, and they could very well look at projects that we're doing and think, 'Well, that would work in our area.' It works both ways. The cluster leads come together very regularly.

[187] **Dr O'Connor**: There are regular cluster lead meetings across our health board. I attend those, and we have feedback from each area on the projects and what the difficulties are. But I suspect that the long and short of it is that they've all done their individual projects, and they will want those projects to be funded centrally from the health board. At the moment, there's no light at the end of the tunnel there; there doesn't seem to be anyone about to make a decision today or tomorrow to say, 'Yes, we can see that that's useful; we'll take over that now; you go and do something different.' I think all networks would be in the same boat there.

[188] Whilst the main implementers are the GPs within each cluster network, the people who seem to have most authority in driving what is actually delivered will often be LHB managers. And so there is a feeling within our own network that we've stood up to them and said, 'Actually, we don't want to do this; we don't feel that that's value for money; that's not going to work for our area; we want to do things differently.' And because the six practices are unified in doing that, it's ruffled a few feathers within our own cluster network.

[189] **Rhun ap Iorwerth**: So, your influence as a group is greater than the sum of the parts when it comes to your relationship.

[190] **Dr O'Connor**: I think so. Definitely.

[191] **Rhun ap Iorwerth**: This isn't a criticism of the way you've gone about doing things, but do you think that if things pan out as you hope they will—and you seem confident that they will—that the success of your federation will undermine the principle of clusters?

[192] **Dr O'Connor**: Yes, I think that is the—

[193] **Rhun ap Iorwerth**: Not that I'm saying you're wishing that, but, you know— [*Laughter.*]

[194] **Dr O'Connor**: I think that is the dichotomy, because you've got networks that haven't got a constitution and governance structure in place, and don't seem to have the capacity to continue to roll out and to develop projects. Whereas we believe, even if networks fell apart tomorrow, I think we would keep our federation company going because there are other areas that we can tap into that are feasible for us to tap into as a separate not-for-profit organisation. We don't need to rely on the local health board's

moneys, if you like, in order to deliver those services, and that's the advantage that we've got as a federation.

[195] **Rhun ap Iorwerth:** The sense I get, Wales wide, is that the bringing together of surgeries and other parts of primary health delivery in groups is a good thing. There's ambiguity about how clusters can work. You've gone for a particular model. Do you think that as the notion and the principle of clusters develops that what you've put together could actually become a model that replaces the looser cluster arrangements in other parts of Wales?

[196] **Dr Price:** It could do. I think we're very fortunate that we all get on as practices, and within our local area you know that there are practices, I should probably say, that can be a little bit more awkward than others, and you think, 'Well, I couldn't work with them.' So, it's not one thing suits all. I think we've been very fortunate that we've been able to take this forward because of the way we've jelled together in the way we think, but that wouldn't necessarily run out across all practices in each cluster area.

[197] **Rhun ap Iorwerth:** Are there looser arrangements? It's clear that you've got a good working relationship. The Welsh Government could decide to force GP surgeries to come together in federation, or there could be a halfway house that is firmer than the cluster and looser than your arrangement. Is that something that you would advocate?

[198] **Dr Price:** And I think that's where we said originally that the staleness of the cluster scenario was there. Obviously, we sit around a table where we've got district nursing and public health and we all have our own agendas. We had our own individual agendas as GP practices. Now we've got a GP voice, if you like, on the cluster. The district nurses will come, public health will come with their projects, the dietetics will come, but I think what's overwhelming is that because we've formed this together, we're now driving momentum forward and things are happening where it wasn't happening at a cluster level. Perhaps that does cause a little bit of, maybe disharmony, not that we've heard it directly, but the fact that we're moving ahead with projects—'Oh, it's the GPs doing this.' Well, somebody's got to do it and this is the way we've moved forward.

[199] **Mrs Carter:** There's a lot of interest in moving to a federated model from other health boards. We've had a lot of requests to go and speak about our journey. And when we first looked into it, part of the process and the funding was to develop a toolkit to help other clusters move to a federated

model. Because I think we, in essence, were the guinea pigs, and we've ironed out a lot of the issues that became apparent as we worked through it. So, other clusters moving towards that model would, perhaps, find it a little bit easier than we did initially.

[200] **Rhun ap Iorwerth:** Have we got time for one more, which is a little bit more nebulous, perhaps? But there is a potential—. Say we went down a federated model, there's a danger that what you would be seeing is the development of large private healthcare providers—you could all merge in future; it's a possibility. Are there alarm bells there for the delivery of the NHS along the principles that are important to us here?

[201] **Dr Price:** Well, as part of our development, we actually went on a trip to Northern Ireland because, over in Northern Ireland, they'd already set up 17 federated companies. So, we went along with local health board representatives, GPs and practice managers to visit them on a day trip, and, basically, very little is happening with those federated companies. They've federated 17, and when we came back from that visit, what we were doing as a cluster was more advanced than what they were doing as their federated companies. So, obviously, it hasn't worked out there by federating a large number. I think that's perhaps a difficult call to say that, carte blanche, it would have to be all federated.

[202] **Rhun ap Iorwerth:** In terms of the growth of the private sector in the delivery of NHS services, any other thoughts on that?

[203] **Mrs Carter:** No. I think, day to day, it's still our practices that are our priorities. It's dealing with the patient demand, which is increasing on a daily basis. Part of the process was we set up our website, Pen Y Bont Health, to try and help patients to self-treat, self-medicate, to stop them coming to the doctors for simple things like hay fever, things like that. I think we're just looking to take the pressure off what is coming to the door, and looking at making things better for practices and patients. I think that's the most important point that we were trying to achieve. We share best practice as well now. Whereas every practice had their own appointment system, nursing system, we now share best practice around the table to look at it, and if something works in my practice that's not working in another practice, then we'll share that to try and streamline our services across the board a bit better.

[204] **Dr Craven:** And the whole premise when we originally asked for

support from our partners, their agreement was on the condition that it was for the patients and for their working lives, and that's our mission for the business. It's not to make large amounts of money on private medicine—we haven't got time for that—but to reinvest it in projects for our patients.

[205] **Mrs Carter:** I think it's important to note that none of the money comes into the practice. It stays within Pen Y Bont Health to be reinvested into other projects.

[206] **Dr Craven:** Yes.

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

[208] **Dai Lloyd:** Diolch yn fawr. Excellent evidence session, thank you very much indeed. It's been a very valuable contribution to this hopefully comprehensive review on clusters.

[209] Felly, diolch yn fawr iawn ichi. Diolch i'r tystion i gyd. Joanne Carter, Dr Alison Craven, Dr Ian O'Connor a Dr Gail Price, diolch yn fawr ichi am eich presenoldeb. Fe fyddwch chi'n derbyn trawsgrifiad o'r cyfarfod yma er mwyn i chi ei wirio fo a chadarnhau ei fod o'n ffeithiol gywir. Felly, diolch yn fawr iawn i chi am eich presenoldeb.

Thank you very much. Thanks to all the witnesses. Joanne Carter, Dr Alison Craven, Dr Ian O'Connor and Dr Gail Price, thank you very much for being here today. You will receive a transcript of this meeting to check for accuracy. Thank you very much for being here today.

11:09

Papurau i'w Nodi
Papers to Note

[210] **Dai Lloyd:** Symud ymlaen i eitem 4, papurau i'w nodi, a'r unig bapur i'w nodi yn fanna ydy'r papur bendigedig gan Sian Gwenllian, Aelod Cynulliad Arfon, 'Delio â'r Argyfwng: ysgol feddygol newydd i Gymru'. Dyna eitem 4.

Dai Lloyd: We move on to item 4, papers to note, and the only paper to note is an excellent paper from Sian Gwenllian, the Assembly Member for Arfon, on 'Tackling the Crisis: a new medical school for Wales'. That's item 4.

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

Cynnig:

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

Motion:

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.

[211] **Dai Lloyd:** Eitem 5: cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. Pawb yn cytuno? Ydych, diolch yn fawr. Felly, awn ni i sesiwn breifat. Diolch yn fawr.

Dai Lloyd: Item 5: motion under Standing Order 17.42 to resolve to exclude the public for the remainder of the meeting. Everyone in agreement? Thank you very much. So, we will move now into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:10.
The public part of the meeting ended at 11:10.