Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 23 Ebrill 2013
Tuesday, 23 April 2013

Cynnwys
Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
Jocelyn Davies	Plaid Cymru The Party of Wales
Mike Hedges	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Adam Cairns	Prif Weithredwr, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Chief Executive, Cardiff and Vale University Health Board
Dr Sue Fish	Cyfarwyddwr Meddygol, Bwrdd Iechyd Lleol Hywel Dda Medical Director, Hywel Dda Local Health Board
Malcolm Latham	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru, Swyddfa Archwilio Cymru Auditor General for Wales, Wales Audit Office
Richard Tompkins	Cyfarwyddwr, Uned Cyflogwyr GIG yng Nghymru Director, Welsh NHS Employers' Unit
Janet Wilkinson	Cyfarwyddwr Gweithlu a Datblygu Sefydliadol, Bwrdd Iechyd Lleol Hywel Dda Director of Workforce and Organisational Development, Hywel Dda Local Health Board

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

Dan Collier	Dirprwy Glerc Deputy Clerk
Tom Jackson	Clerc Clerk

Dechreuodd y cyfarfod am 9.01 a.m.
The meeting began at 9.01 a.m.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody, and welcome to today's meeting of the Public Accounts Committee. It is my pleasure to be able to welcome some people to the table today, who I will introduce in a few moments, but I will just do the housekeeping announcements first and say that, in the event of an emergency, we should all follow the instructions of the ushers who will take us to the nearest safe exit. I also remind all Members and witnesses that the National Assembly for Wales is a bilingual institution and people should feel free to contribute through either English or Welsh, as they see fit, and of course

there are headsets available for translation for those who require it, and indeed these can be used for sound amplification. I remind everybody to turn off their BlackBerrys, pagers and mobiles, as of course these can interfere with the broadcasting equipment.

[2] We have received one apology today from Gwyn Price and we are expecting the other committee members who are not yet present. Unfortunately, they have been detained in another meeting but, given the time, we do need to press on.

9.02 a.m.

Contract Meddygon Ymgynghorol yng Nghymru: Cynnydd o ran Sicrhau'r Manteision a Fwriadwyd—Tystiolaeth gan y Byrddau Iechyd
Consultant Contract in Wales: Progress with Securing the Intended Benefits—Evidence from the Health Boards

[3] **Darren Millar:** We move on to item 2, which is to continue with our inquiry into the consultant contract in Wales and progress with securing the intended benefits. We are taking evidence from the health boards today. I am very pleased to be able to welcome Adam Cairns, chief executive of Cardiff and Vale University Local Health Board; Janet Wilkinson, director of workforce in Hywel Dda Local Health Board, and Richard Tompkins. Richard, just for the record, please tell us where you are from.

[4] **Mr Tompkins:** I am from the Welsh NHS employers' unit

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

[6] **Mr Tompkins:** Do you want me to explain what we do?

[7] **Darren Millar:** Tell us a little bit, if you want, yes.

[8] **Mr Tompkins:** The employers' unit works with health boards and trusts, broadly around employee relations issues, and works with trade unions, staff-side organisations and workforce directors. It also represents NHS Wales on national terms and conditions fora and pension groups.

[9] **Darren Millar:** Thank you for that. We obviously have lots to get through this morning, so I am anxious to get on. Many committee members have specific questions that they want to ask, but I will just start things off. You have obviously read the Wales Audit Office report and seen the concerns that have been raised, and, indeed, individual reports have been published in respect of your own individual health boards. What have your individual organisations, Adam and Janet, been doing to strengthen job planning in the wake of the reports that you have received and digested? What assurances are you able to give us as a committee that this is something that is now a top priority within your organisations, in order to deliver the benefits that we should be seeing by now? Adam?

[10] **Mr Cairns:** Good morning, everybody. Thank you for inviting us. To respond directly to the question, we obviously feel that the report does not make good reading and it clearly gives us a great deal of advice about what we should be doing. My approach in Cardiff and the Vale is based on the experience that I have had while working in the English system, where the job planning tool and the whole consultant contract seem to have been much more developed than they have been until recently in Wales. We are basically using a whole series of approaches that have been demonstrated to work well in England. In summary, that approach is based on very comprehensive training, as those conducting the job planning conversations need to understand the parameters that they are working to and they need to

understand how to run those conversations successfully. It is based on a presumption that the employer needs to have a clear view in mind as those discussions start about what they would like from consultants working together, ideally in teams, so that we can then place the individual contributions from consultants into a team setting, based on what we think the patients in that particular service require from the consultants.

[11] There is a bit of policy work that we have been doing too, looking at how we should interpret advice about the number of sessions of supporting professional activities worked, the number of direct clinical care sessions worked, and how we should approach issues like teaching and research. I am very happy to go into some detail about how all that works. This year, we are progressing that service area by service area. We have completed work now in surgery and in the majority of our specialist services. They are now 100% complete and we have a programme that runs across the rest of this financial year. At the end of that, we will be able to demonstrate increased value for the taxpayer, but also, I hope, a greater level of understanding that is shared between us and our consultants about what we are trying to deliver and how the consultants with their contract can contribute to what we need for our patients.

[12] **Darren Millar:** In terms of where you are specifically as a health board, has every consultant now undertaken an annual job plan?

[13] **Mr Cairns:** The numbers that I have are that 95% of our consultants have now completed a job plan. I am not, as of today, satisfied with the quality of all those job planning conversations, so we are re-running across this year, based on the kinds of things that I was discussing or describing earlier, all of those job plans again. I expect that at the end of this financial year we will have 100% coverage, give or take—somebody might leave; we might get somebody new—and that those job plan discussions will be of a high quality.

[14] **Darren Millar:** Okay. Do you want to tell us about the situation at Hywel Dda, Janet? I welcome Sue Fish, the medical director of Hywel Dda Local Health Board as well.

[15] **Dr Fish:** Please accept my apologies; I left time for the traffic, but not enough time, obviously.

[16] **Darren Millar:** We know what it is like; do not worry. Thanks.

[17] **Ms Wilkinson:** Okay, I will start and then if Sue wants to add anything, she may do so. Clearly, Members will have read the report and we were at a far lower starting point than Cardiff and Vale two years ago, when the fieldwork was conducted. We did receive our local report at that time, so, since then, an awful lot of work has gone on. One of the things that we have done is to implement a new job planning framework on the back of the local Wales Audit Office report. We also established formal reporting to the workforce and organisational development sub-committee of the board, so there is an annual report. The last annual report was produced last year. We are currently collating for this year. At the time that the data were collected and the survey of consultants was undertaken, I think that only 35% in Hywel Dda said that they had had an annual review. The data that we collected last year show that that is now up to almost 60%, so we still clearly have a long way to go. We are in the process now of collating the last year of annual reviews.

[18] We also introduced some Hywel Dda consistency principles. You will notice in the report that we went through two significant organisational changes in Hywel Dda: we had a trust merger and then we had the NHS reforms and the formation of the health board. That meant that there has been a series of medical management reorganisations, so we introduced some consistency principles to make sure that it was all being done in the same way, as there were obviously different cultures in the former organisations.

[19] We have since issued further guidance on outcomes because clearly, as Adam said, it is one thing getting your job plan done, but then there is how meaningful it is. We are now focusing on the quality of those job plans and the outcomes for the organisation. As Members will be aware, we are in the process of a further reconfiguration of services and that, again, has put some challenge in the system in terms of agreeing new job plans.

[20] **Darren Millar:** In terms of Welsh Government leadership on this, from the centre, is it holding your feet to the fire regarding the implementation of these job plans, to make sure we are delivering these benefits? How often is it on the phone to you? Is it writing to you? What leadership is there from the centre?

[21] **Ms Wilkinson:** There has been leadership and, certainly, there was a formal need to report following the initial implementation of the contract. We have kept that going in the board and it is part of the performance management framework by which health boards and trusts are held to account to the Welsh Government. The number of appraisals, which would include a job plan review for medical staff, that are conducted is part of the performance reporting mechanism.

[22] **Darren Millar:** Okay, so there was a lot of activity around 2004 when they were first introduced, but between then and now how many times has it featured in correspondence or how many times has it been flagged up by the Welsh Government as needing to be addressed?

[23] **Ms Wilkinson:** It is a regular focus of conversation, certainly in our joint executive team meetings with the Welsh Government and also in the performance networks that work as well. I could not, hand on heart, say how many times we have had a letter about it.

[24] **Darren Millar:** Okay. Adam, is it the same for you? Do you feel as though your feet are being held to the fire on this or not?

[25] **Mr Cairns:** I do not particularly feel the need to have my feet held to the fire, because we think this is a really serious issue anyway.

[26] **Darren Millar:** Brilliant.

[27] **Mr Cairns:** Seriously, this is a vital part of our workforce and we really have to make sure that we are getting our consultants to offer the best. I am sure they will want to offer their best. We just need to make sure that the dialogue we are having with them is based on a fairly clear-eyed view about what it is that our patients need from us, and that is the context in which we are having all of our conversations.

[28] **Darren Millar:** Sue, did you want to come in?

[29] **Dr Fish:** It is not particularly from the Welsh Government, but, with revalidation starting—it started last December, but, starting in April, the focus is very much on job planning from a professional point of view, because it is part of the secondary care doctors' appraisal. So, in order for them to be revalidated, they have to have an up-to-date appraisal, and that would include job planning. From the medical perspective, it is coming much more through the revalidation route. The discussion around job planning is very much there but it is being ramped up now.

[30] **Darren Millar:** Okay, thank you for that. Julie is next.

[31] **Julie Morgan:** To ensure that job planning is an integral part of service delivery and

business planning, it is obviously important that general managers are actually involved in the planning. To what extent are they involved in your job planning?

[32] **Mr Cairns:** I will start, if you like. To go back a step, there is the training that I described earlier on and the policy work that we have done, but in every case there is a clinical manager. So, we are usually talking about a clinical director plus, in our terms, the director of delivery for that bit of the organisation. It might be a general manager, or it might be a directorate manager. Those three will be having the conversation based on data, which says, 'This is the volume of demand being presented. This is the capacity that we are trying to supply to meet that demand' and then we have a dialogue with the individual consultant. Ideally, and we are doing this increasingly, we are looking to annualise the contributions of each member of the team and we are trying to see that in a team setting. If you are talking about general surgery, it is really helpful to ask, 'How many outpatient appointments do we need to offer in total? How many operations do we need to be supplying and of what kind?' and then we can see how each individual consultant's job plan contributes to a team plan, which delivers the capacity that we need to deal with the demand that we are being presented with. So, yes, in all cases a manager will be involved in those conversations.

[33] **Julie Morgan: '**Involved in those conversations': does that mean actually involved in the actual discussion with the consultant?

[34] **Mr Cairns:** Yes, absolutely.

[35] **Julie Morgan:** In every case?

[36] **Mr Cairns:** Absolutely.

[37] **Julie Morgan:** Fine.

[38] **Ms Wilkinson:** It would be exactly the same for us.

[39] **Julie Morgan:** Right. You have made that step, so there are not any barriers to involving the management and so there is no additional cost involved in that. Do you see any additional costs in pursuing proper job planning?

[40] **Mr Cairns:** There are some training costs, which are modest, and we have bought in a little bit of external support, just to give us some accelerated learning. We have also looked for examples of best practice from other parts of the UK and we are incorporating that learning into the way that we go about it, but, no, other than that, this is the day job; this is what we have to do.

[41] **Julie Morgan:** On that point, is there any particular part of the UK that you can use as an exemplar?

[42] **Mr Cairns:** There are various parts of the English system where, particularly in foundation trusts, in my experience the whole basis of the contract is seen as a completely integral part of designing and delivering a business plan for the year, because, fundamentally, patients come to see consultants and you need to make sure you have the right numbers doing the kinds of work that you need them to do, and so there are numerous examples we can go to, to see how that kind of approach has been working relatively well.

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

[44] **Darren Millar:** Is the situation similar in Hywel Dda, in terms of training needs, and in terms of the numbers of consultants broadly matching capacity? When you look at waiting

times, for example, it does not appear that we have sufficient opportunity for patients to be able to have outpatient appointments, does it? Have we got the balance right here?

[45] **Ms Wilkinson:** Probably not at the moment but a lot of work is going on, as Adam described, in terms of our capacity planning. As I mentioned earlier, because of the service change that we are currently involved in, there are likely to be some changes around that which will make the system work better and job planning has to be key to achieving that.

[46] **Jocelyn Davies:** The little bit of external advice to accelerate learning—does that mean that you are using a consultant? You have brought in expertise from elsewhere in order to—

[47] **Mr Cairns:** Yes, we are using Ernst & Young. This is a small part of a larger piece of work it has been doing for us, which is enabling us really to have a very forensic look at how we compare with other places, and it brings with it lots of data, lots of information, but also lots of experience of how these things work best. What we are trying to do is compress the period of time that it takes for us to get to the point where we are delivering as we need to.

[48] **Jocelyn Davies:** Are you using a similar—

[49] **Dr Fish:** Knowing that Cardiff and Vale were further ahead in the process than we are, we have had very close contact with it and discussions around the way that it is approaching job planning. It has recently come and given a presentation to our doctors and managers and we are now working through the lessons that we have learned from them to take forward the job planning for us.

[50] **Jocelyn Davies:** So, you were able to cascade what you are getting to others. I see. Right, okay.

[51] **Aled Roberts:** Rwyf eisiau cyfeirio fy nghwestiwn at fwrdd iechyd Hywel Dda. Rydych wedi sôn am y ffaith eich bod wedi etifeddu, i ryw raddau, nifer o batrymau o wahanol ymddiriedolaethau a'ch bod yng nghanol ad-drefnu pellach. Mae tystiolaeth bod anghysondebau, i ryw raddau, yn cynnwys y cynlluniau swyddi meddygon ymgynghorol, a hefyd bod anghysondebau o ran llwythi gwaith. A allech ehangu ar yr hyn yr ydych yn ei wneud er mwyn mynd i'r afael â'r anghysondebau hynny?

Aled Roberts: My question is directed to Hywel Dda health board. You have mentioned the fact that you have inherited, to an extent, a number of patterns from various trusts and that you are in the middle of further reorganisation. There is evidence that there are inconsistencies, to an extent, in the content of consultant job plans, and also that there are inconsistencies in relation to workloads. Can you expand on what you are doing to get to grips with those inconsistencies?

[52] **Dr Fish:** We brought together four organisations, because we had Carmarthenshire, Ceredigion and Pembrokeshire trusts, and although the mental health trust was part of the Pembrokeshire and Derwen trust, it was functioning, from a job planning perspective, individually, so we started from four very different places, with good points in all the job planning, and not so good points in other bits. We are currently working through learning from each other on the good points, developing consistency, using the job planning framework that has been rolled out, to make sure that we have a consistent approach across Hywel Dda. That will lead to a consistency in the workload as well, because, at the moment, if we are talking about operations, we came from a historic position where there may have been one number on operations in one hospital and another for operations in another hospital, whereas now we are reaching a joint agreement on what the expected tariff is within that session in the job plan and then moving forwards. With the work that Janet referred to, looking at, if we go back to the example of orthopaedics, the number of operations that are

going to be required over the next year and the number of sessions that will be required to deliver it, we will then make sure that the job plans are consistent across the organisation to meet that demand.

[53] **Aled Roberts:** Roedd yr ad-drefnu olaf yn 2009, ac nid ydych mewn sefyllfa gyson o fewn eich bwrdd iechyd. Pryd fyddwch yn cyrraedd sefyllfa lle bydd cysondeb yn amlwg?

Aled Roberts: The last reorganisation was in 2009, and you are not in a consistent situation within your health board. When will you reach a situation where there is obvious consistency?

[54] **Dr Fish:** We have action plans for the forthcoming year and we will have delivered the job plans by the end of this year.

[55] **Aled Roberts:** Beth am y llwyth gwaith?

Aled Roberts: What about the workload?

[56] **Dr Fish:** The gut feeling is that, if we are talking again about orthopaedics, we are likely to have the required number of consultants to deliver it. With the acute medical pressures that our hospitals are under at the moment, I would not like to guess as to whether we have the required input, but I do not believe it is due to additional consultant sessions. I believe it is due to implementing our clinical services strategy, which is developing a lot more care in primary care and the community. I would not want to see a great increase in consultant sessions, but the job planning will allow us to look at where those sessions are delivered from the consultants and whether they could be delivered in a different hospital site, if there are additional pressures there, or whether they could be delivered in the community to reduce the impact on hospitals in terms of admissions. This is something that we will be working through over the next six months, but finalised in a year.

[57] **Aled Roberts:** A oes unrhyw ofynion gan Lywodraeth Cymru ichi gwblhau'r broses hon o fewn y flwyddyn?

Aled Roberts: Has the Welsh Government required you to complete this process within the year?

[58] **Ms Wilkinson:** There will be. I understand you received evidence from the Welsh Government on this very matter last month. The task and finish group has been set up, which will look at those recommendations, and there will be a clear time frame around that. Do you want Richard to comment on that from an all-Wales perspective, as he will be leading the task and finish group?

[59] **Darren Millar:** Yes, we would be happy for Richard to do that.

[60] **Mr Tompkins:** I have been asked to lead the task and finish group. I understand that David Sissling has written to the Chair, outlining the terms of reference. That will cover reviewing the all-Wales job planning guidance. Particularly, we have had the local audits and there has been a lot of work undertaken, as you have heard from the two health boards here this morning. So, the group will be identifying the best practice across Wales from that. We are due to produce an interim report in September and a final report at the end of this financial year, at the end of March. I understand that David Sissling is also going to be writing to health boards and trusts as well around completing this exercise within this financial year.

[61] **Darren Millar:** Okay. We will discuss that in a little bit more detail later. Jenny, you are next.

[62] **Jenny Rathbone:** The consultant outcomes indicators project was abandoned in 2009. How are you developing the information to ensure that you know that the job planning is delivering what you think it is?

[63] **Mr Cairns:** At a local level, we are basing our work first of all on measuring the capacity that we think we need to supply, and we then translate that into time quantums, or time blocks, which we can attribute to programmed activity times within the consultant working week. It is important that we have two things happen with that, the first of which is that we have a proper discussion about this because it is important that we interpret that information correctly and that we are not misunderstanding what it is telling us. The consultants clearly have an awful lot of insight that they can give us about how that gets interpreted. The other bit is that we are trying to establish benchmarks that would give us a sense of what we should be expecting from a consultant surgeon, for example.

[64] There are two kinds of benchmarks that we are using. One is an internal benchmark. For example, if a surgeon has, let us say, two operating lists a week and we set a particular case mix for those in agreement with the consultant for those operating theatres, then what is the range of output we should expect from those operating lists over the course of a week or a year? You do not want to be enormously prescriptive about that, because we do not want people operating more quickly than they feel comfortable, but there is clearly a range, and if you are stepping outside of that range, it does look odd and we need to ask some questions about why it is taking so much longer or why it is being done much more quickly than by others. Then we are able to level up, usually, the amount of activity that we are securing through those discussions.

[65] We can also look externally. We have developed a set of benchmarks that compare how we do in our hospital settings with other hospitals in the UK. We can widen those comparisons and we can ask more questions. For out-patients, there is a wealth of information that we can use: how many new patients do you tend to see in a clinic; why is it that you see this number when your colleagues see another number; what is it about your particular service? Sometimes there is a good reason and sometimes we need to ask further questions. That is part of the conversation that we have.

[66] It is slightly more difficult when you get into some of the medical specialties where some of the doctors, some of the consultants, do not perform procedures, and so a ward round is harder to count: what is the output of a ward round? What we talk about there is what we would expect the product of a ward round to be, and we agree with consultants about the timing and the frequency. We are trying to build in, particularly in the case of our physician colleagues, the notion of daily, short board rounds, as we call them. These are very short visits to the wards just to make sure that things are as they should be. We are trying to incorporate that now into a review of their working week.

[67] There are other items in the dialogue that we need to take account of. As has been mentioned here, there is now the important dimension of revalidation through the GMC. We have to make sure that we are allowing sufficient time for the consultant to undertake appropriate continuing professional development activities. With that, we need to be reviewing very carefully what contributions we are getting from teaching. If people are doing teaching, we need to know when they are doing it and what the output is that we should be measuring, and similarly for research. In research terms, our guidance is very clear and very straightforward. We will recognise in job plans research that is National Institute for Social Care and Health Research-associated or on a pathway to NISCHR research projects, but not other kinds of research. We are doing that because we want to make sure that we are focusing all of the time where we are going to get the biggest benefits, whether that it is in teaching, research or service. It may be different in other health boards, but that is the sort of approach that we use when we are trying to look at outputs from the conversations we are having.

[68] **Jenny Rathbone:** Just before we move on to Hywel Dda LHB, the 2011 local audit report mentions that Cardiff and the Vale has more academic contracts than other health

boards in Wales. You did have a plan, says the 2011 report, to ensure that your strategic objectives were not being overridden by Cardiff University's strategic objectives. Is that absolutely embedded and have you resolved the issues around equitable on-call responsibilities? Do you have the information systems to identify where mortality rates are—where you have outliers in terms of the outcomes?

[69] **Mr Cairns:** With the university, we are increasingly aligned, particularly around the research and teaching fields, and so it is much easier for us now to say, 'What is the teaching requirement on this specialty?' We do that jointly with the university and we are able to say when, where and how that teaching needs to be supplied across the year. That is against the teaching plan that is developed, so that is relatively straightforward. We can do that with quite a lot of precision now.

[70] In terms of research, there are a couple of different dimensions to research. We are very keen to promote a research culture in our organisation. Whether or not people are academics, we think it adds to the fabric of the institution if people are contributing to research, but the research that we want to support and recognise in job plans has to be aligned to NISCHR priorities, because that is where the majority of the effort is being applied. We want to maximise, if you like, the impact of all research, and we do that through aligning it around NISCHR priorities, or pathways to NISCHR priorities. Again, that is relatively straightforward. You either are or you are not, and we can define quite clearly whether or not you are doing that in a lab setting, whether you are doing it in a clinical setting or whether you are doing it in some other setting. We can do all of that relatively straightforwardly.

[71] You mentioned mortality and, in a sense, that is rather more of an appraisal conversation than it is a job planning conversation, I think, because—

9.30 a.m.

[72] **Jenny Rathbone:** Is the appraisal system not part of the job planning?

[73] **Mr Cairns:** It would certainly feature. For instance, you might worry about a consultant who appears to have a very packed job plan. There is an issue there about how confident we are that, at all times, you are functioning at the very best of your capabilities, for example. One of the reasons for doing job planning in this way, and trying to do it in a team setting, wherever possible, is that you can try to balance that out across the team, if you need to. You can move commitments around, if that is what you need to try, to even out the pressures that individuals are feeling. The reflective part of the dialogue with consultants takes place in the appraisal context. If we had a performance issue—if we were detecting, in any particular service, that there was a cause for concern—we would not wait for a job planning conversation to happen; we would step in. We would put the data on the table, we would invite people to join with us and have a conversation about it, we would get underneath it, see what it was that was driving it and then we would tackle whatever the issue was that we needed to tackle. We would not see it fundamentally being a job planning issue; we would see it much more as a performance and outcome-based conversation.

[74] **Jenny Rathbone:** Moving to Hywel Dda LHB, do you feel that you have the information that you need to ensure that you know what your consultants are delivering in their job plan, but also that you have that sort of equitable distribution of on-call responsibilities and so on?

[75] **Ms Wilkinson:** We are not there 100% yet. The information that we have is 100% better than it was two years ago. We certainly have basic data around job planning. You mentioned mortality earlier; we have very good information, which Sue can talk about, in that regard. However, I would agree with Adam that that was an appraisal conversation rather than

the nitty-gritty job planning. We are doing some work jointly—managers and clinicians—to start developing some meaningful outcome indicators for some of those areas that Adam referred to; for example, mental health. Again, Sue can talk in more detail about that. They are very difficult areas to define in terms of what outcomes you expect from a consultant.

[76] **Dr Fish:** Certainly, the information is not as good as it needs to be if we are going to do robust job planning. We need to work on that information, and the consultants are asking for that information as well. Where there is a link between mortality and job planning, even though I agree that it is part of the appraisal, it is about making sure that there is sufficient time within the job plan for the doctors to undertake clinical audit and attend clinical audit meetings and hospital-based meetings. That certainly does form part of the SPA activity.

[77] **Jenny Rathbone:** Given that the impression that you are giving is pretty tentative, and given the demands on you in terms of the reconfiguration of services, do you have external consultants coming in, along the lines of Ernst & Young, to assist you to fast-forward that?

[78] **Dr Fish:** We do not around the job planning, but we have done that around the need to understand our business a lot better and the requirements of our business. That will be some of the information that is used to inform job planning.

[79] **Jenny Rathbone:** Does everybody now have an annual review?

[80] **Dr Fish:** Everybody will have a job plan in this year. We are up to about 60% at the moment. Everybody will have an annual appraisal. We have done an awful lot of appraisals over the last year, but we have action plans that we are monitoring that will mean that both are delivered within the next year.

[81] **Darren Millar:** Richard Tompkins, this issue of identifying key performance outcomes so that we can measure success, or lack of success, as it were; is it something that the task and finish group will be looking at, within its terms of reference?

[82] **Mr Tompkins:** Yes. We have been asked to look at the work with the Office for National Statistics to try to see if we can disaggregate that work that is done on a UK basis. Also, one of the important things is to understand what happened with the consultant outcomes indicator project and some of the products from that, to see if we can build on those and use that as a platform for moving forward, picking up on some of the work that is already being undertaken and different approaches that may take us down a different road than was originally envisaged in 2003-04.

[83] **Darren Millar:** It is obviously critical that you have local performance indicators, if you like, that monitor the outcomes, but it is also really important that you are able to benchmark against other health boards within Wales and, indeed, other peers elsewhere in the UK and beyond, in terms of outcomes, is it not?

[84] **Mr Tompkins:** Yes. One thing that was clearly identified is that some of the measures, like the community healthcare statistics, are produced for a different purpose. I think that what the consultant outcomes indicator project was trying to do was to identify something that would support consultants do the job planning process in a perspective fashion. That was seen to not cover all specialties and not be sufficiently valid to have the confidence of consultants. That is quite important—it is a two-way process. The consultants need to have confidence in the data and confidence in the material that is being produced. That is something that we will have to consider and reflect on.

[85] **Darren Millar:** The ones who had particular confidence in it were the ones who

came out well from the performance monitoring, and the ones who had less confidence were the ones who appear to have come out worse.

[86] **Jocelyn Davies:** I have a question on excessive hours. The report said, in an analysis of the reported job plans—we know that that did not cover everybody—that one in six consultants are working excessively long hours. Mr Cairns, you talked earlier about 'smoothing out'. Does that mean that you are satisfied that, within your area, there are no consultants working excessively long hours?

[87] **Mr Cairns:** The average working week for a consultant in our organisation is now less than 40 hours a week. There is a distribution. It is fairly tightly packed. If you did a distribution curve, it would be quite a narrow curve.

[88] **Jocelyn Davies:** So you would not have many outliers on that?

[89] **Mr Cairns:** There are a few at the right-hand side, which is the side that you would rather they were not, and usually it is because there are particular circumstances that are affecting that situation. For instance, until recently, we were struggling to recruit paediatric cardiologists to join the teams—we had two, not three—and it meant that, because the children do not go away, you have to ask people to cover the service, and they were doing that. You then have a responsibility to stay very close to that, to make sure that things are okay. We have worked very hard to make the post that we have been advertising more attractive, and I am very pleased to say that we have somebody who has just started in the last month.

[90] There are fewer and fewer of those areas that we have and, where we have any that are left, it is simply because we still need to find an additional pair of hands to come in to support the service. There comes a point where you cannot continue offering a service that rests on that kind of contribution, but we have not reached that point in any service yet, but we are keeping that under review.

[91] **Jocelyn Davies:** How are you reducing the risks to patients within that? Somebody could, perhaps, do it for a short period of time, but over a prolonged period you would have greater concerns.

[92] **Mr Cairns:** We would, and that is why we stay too close to it. What I mean by that is that we are in regular contact with team members, to make sure that they are okay, at one level. There is something just about human beings in all of this. We are also looking at hard measures, so that, if outcomes were drifting, we would be able to see that, where those outcomes are available to us. I characterise those areas as being ones where there is just a great deal of interaction on an ongoing basis in the team setting, because everyone is very focused on making sure that the service remains safe but that it continues to be delivered. It is small numbers.

[93] **Ms Wilkinson:** It would be a very similar picture for us. Back when the data were collected, just over 11% of our consultants were working over 12 sessions a week, which is over 45 hours a week. Now, that figure is down to 6%.

[94] **Jocelyn Davies:** Did you know that for all of the consultants?

[95] **Ms Wilkinson:** That is for all of our consultants; yes. We have halved that number and they are only working 12 or 13 sessions, which is probably still within the 48-hour working time directive target. Again, we probably have a couple of areas where there are outliers, and they will be areas where they are probably covering a vacancy or where we are minimising the cost of locums. Sue, do you want to comment on that?

[96] **Dr Fish:** There are some hard-to-fill areas, but the further west you get, the hard-to-fill areas become even harder to fill, so we have a number of vacancies that may mean that our consultants are having to work longer hours than we would want. An example is radiology. I was chairing a radiology meeting yesterday where we have only got about half the number of consultants that we would ideally like to recruit because of a national shortage of radiologists, particularly those who want to come to work in west Wales. However, we are looking at alternative methods of supporting and to get the team to work to reduce the risks to the patients.

[97] **Jocelyn Davies:** What about managing risks to the patients in that situation?

[98] **Dr Fish:** That is what I am saying. We are looking at alternative ways. With radiology, you have got the option of buying out radiology reporting time, having reporting radiographers, having teams of consultants with different patterns of working across the health board—sharing images and supporting each other. As I say, that is very topical, given that I was chairing a meeting that was looking at that yesterday.

[99] **Jocelyn Davies:** Have you put any of those alternatives in place? Are you taking up any of those options?

[100] **Dr Fish:** We will be. Some have already started, but it is an ongoing process. This is the core business for us, is it not? This is what we do all the time.

[101] **Jocelyn Davies:** Okay, thank you.

[102] **Darren Millar:** Aled, do you want to come in?

[103] **Aled Roberts:** We have come across certain instances in certain disciplines where health boards have referred to difficulties in recruiting, certainly in the west. Yet, when the health boards have been challenged regarding attempts to recruit, they have not always been able to show that they had made those attempts. Are there any areas where you keep posts vacant, pending reorganisation?

[104] **Dr Fish:** No.

[105] **Ms Wilkinson:** No. We have made considerable efforts and I know that we have had a lot of local challenge around that. We have been able to demonstrate that we have used whatever methods we can, including working with an external organisation in terms of overseas recruitment. We have had to try that because we have had long-standing vacancies in some areas, and we have had to stop advertising for a period because it is less than helpful to constantly see an advert every week for a job. So, we may well pause an advert for a few months, and then try again. However, that is not because we are holding the vacancy; it is because we are giving the market a chance to renew itself.

[106] **Julie Morgan:** I want to ask you about supported professional activities. What have you done to increase the emphasis on SPAs and to discuss them in the job planning reviews and not just see them in terms of the number of those that you have?

[107] **Dr Fish:** We are defining what we believe should be included in an SPA. Education and teaching other doctors is very important, along with other people's education. We have the three SPAs within the Welsh contract, but we are focusing very much on two SPAs and getting people to demonstrate the activity for those two SPAs. If they can demonstrate two SPAs, then there will be a discussion about the third SPA. We are trying to get as much agreed within the SPAs as we can—reducing the need for any additional payments. Certainly,

our clinical team leaders have this within their job plan and it is all seen as an SPA activity. It might involve an additional session, but it is a way of managing that workload in a different, more manageable way.

[108] **Mr Cairns:** In Cardiff and Vale, we have been slightly meaner in terms of our approach. We are saying that for revalidation purposes the core professional activities can be consumed within 1 to 1.5 SPAs a week. That is for revalidation purposes and then, on top of that, we would enter into discussions about any other kinds of SPA activity, particularly the teaching and research to which individuals contribute. We will only agree to those where we can see that there is a defined teaching output that is going to be delivered at a defined time and in a defined place. We do not at all accept that teaching SPAs can be provided away from base, and certainly not overseas; it has to be done in the base. As far as research is concerned, we will, again, only acknowledge and recognise research activities that are completely aligned either to existing NISCHR priorities or to pathways towards NISCHR priorities.

[109] What does that mean in practice? It probably means that we are more likely to see the standard ratio moving towards a ratio of about 8:2—two SPAs to eight direct clinical sessions. That is roughly where we would like to end up, if we can.

[110] **Julie Morgan:** How do you measure the outcomes from the teaching?

[111] **Mr Cairns:** We do that in lots of different ways. We have student feedback, which is probably the most important feature. We have also got a new curriculum that we are developing with the medical school, called C21, and as part of C21 there are going to be a number of features of that teaching that we will also be able to measure, but I suppose that the fundamental measure will be the results and feedback from the students.

[112] **Julie Morgan:** How often do you do student feedback exercises?

[113] **Mr Cairns:** It is done almost continuously.

[114] **Julie Morgan:** All the time?

[115] **Mr Cairns:** Yes.

[116] **Dr Fish:** The deanery is working to agree a tariff within Wales for various activities, for example how much SPA weight they should cover, and that discussion is ongoing. It is a negotiation in terms of deciding on the health boards delivering the service and delivering education.

[117] **Darren Millar:** There are differences of approach, are there not, between what constitutes an SPA in your board, in Cardiff and Vale, as compared with what might constitute an SPA in Hywel Dda? That was one of the issues that was picked up in the audit work that the WAO—

[118] **Ms Wilkinson:** There will be broad consistency. However, there are some differences. Adam said he was meaner than we were and because it is a little further along the journey, it is probably more sophisticated. We are learning from them in terms of being able to do those things.

[119] **Dr Fish:** Also, listening to what Cardiff and Vale was saying about us not being affiliated with a university, it is far harder for us to define that additional education and research activity. We have to learn from how it does this in order to see how it is appropriate to us.

[120] **Darren Millar:** Richard Tompkins, will your work include looking at this to get some national definitions?

[121] **Mr Tompkins:** Absolutely. There are already some definitions embedded within the contract and the guidance and we will need to be working with colleagues across Wales and with BMA colleagues as well to get a core understanding of those definitions, but allowing for local determination of how that works in practice.

[122] **Mike Hedges:** How confident is your organisation that clinical leaders and managers are properly equipped and trained to undertake effective job planning? The BMA said when it came to talk to us that it had offered to work with the NHS on delivering joint training for clinical directors undertaking job planning, but that its offer had not been accepted. Do you know why it was not accepted?

[123] **Mr Cairns:** I can deal with the first point. Do you want to go first?

[124] **Ms Wilkinson:** No, because certainly locally it has been done very much in conjunction with our local negotiating committees, with which the BMA negotiates performance within the local health boards.

[125] **Dr Fish:** We currently have Derek Jones leading the development on an all-Wales level and who is working with us and our associate medical director for workforce, going out doing regular training sessions with the medical managers and the clinical leads. They have probably covered pretty much most of the health board now and are now doing round 2, going back where they have been asked for further detail.

[126] **Ms Wilkinson:** We would be very confident that both clinical and general managers have the tools to do it.

[127] **Dr Fish:** Yes.

[128] **Mr Cairns:** I concur with that. I think that we are running what are called, rather grandiosely, master classes, which we are offering so that we can give people the very best quality advice we can find about how to construct and run really good job planning conversations.

[129] **Darren Millar:** Let me just get this clear: you are saying that you have fully engaged with the BMA in terms of the training needs of those staff who require some support in undertaking job planning meetings?

[130] **Dr Fish:** Yes. I am not aware of an issue with other health boards around not taking up BMA help.

[131] **Mr Tompkins:** It may be that the view is that there is a lot of work going on locally within health boards and that, therefore, that is where the emphasis would be—that is, around training, consultant contracts and the work on delivering the job plans. So, it may have been more around whether there was a need for all-Wales training. That is something that I will take forward in terms of the task and finish group—how we support the broader training around job planning, which does not necessarily interfere with how the individual organisation's own clinical management models needs to work on the ground.

[132] **Ms Wilkinson:** Part of the training locally is about the conversations, is it not? It is about the developing of trust and sharing information. To do that on a national basis would mean losing some of the benefits of doing that.

[133] **Darren Millar:** Okay. We will share your evidence with the BMA and see what it says to us; I am sure that it will be an interesting response. Oscar?

[134] **Mohammad Asghar:** Thank you very much, Chair, and thank you, ladies and gentlemen. My question is on consultants who engage in two jobs, rather than one: a private job and an NHS job. Local audit work has found that there are some negative consequences to job planning and that in the job role process there are some challenges for the consultants involved in it. Do you have clear and agreed arrangements in place to ensure that job planning properly recognises the entirety of consultants' commitments when they are working for more than one employer?

[135] **Ms Wilkinson:** It is probably more of an issue for you, Adam.

[136] **Mr Cairns:** Private practice in Wales is a relatively small business. It certainly is not a feature that is anything like as prominent as it would be in an English hospital. Our approach to this is two-fold. The first approach would be from a job planning perspective. We effectively are constructing a timetable with that consultant for their working week. That means that we need to understand where they are on each of those days of the working week. We would then expect that consultant to say if they were not available on a Monday morning and tell us why they were not available on that Monday morning, and if they were working in a private hospital, that would be declared. As part of the appraisal process for revalidation purposes, there is now quite a lot of guidance about how revalidation should be carried out and each healthcare organisation has somebody called a responsible officer who is designated as being the returning officer for the General Medical Council. That individual has to underwrite that the medical practitioner for whom they have responsibility is fit to practice and they need to make a declaration to the GMC about that. The reason that I mention that is that the convention is that that responsible officer needs to take into account the entirety of that consultant's practice when making that declaration.

[137] In Cardiff and the Vale, we have two small private hospitals that some of our consultants work in. We would expect complete transparency between those two hospitals and ourselves, so that when our responsible officer is making that declaration to the GMC that the consultants are fit to practice, the whole scope of their practice is in view, so that we are, if you like, effectively revalidating them for all purposes.

[138] What I would say about that is that the consultant contract allows consultants to use their free time to do whatever they like. That is up to them. Our responsibility is to make sure that we have, within the working week that we are designing, a complete and transparent understanding about what consultants are doing and where they are. That is achieved. For revalidation purposes, we have a very clear and very transparent view about all the work that consultants do because we have a responsibility to the GMC to ensure that those consultants are fit to practice.

[139] **Mohammad Asghar:** Have arrangements with the Cardiff University partnership board led to improvements in the way job planning is undertaken for clinical academics?

[140] **Mr Cairns: '**Yes', is the short answer to that. We now have a much more closely aligned approach with ourselves and the medical school. We have a number of joint appointments, which help us in this area, and we have a designated member of our medical director's team who interfaces with the medical school, so that we are sharing information on both sides about what all our clinical academics are doing, whether it is from a teaching research perspective or delivering a clinical service prospective.

[141] **Darren Millar:** We have a couple of Members who want to come in on some of these issues relating to the last couple of questions, so I call Mike and then Jocelyn.

[142] **Mike Hedges:** I have a question for Hywel Dda health board. You have a situation with consultants working across health boards, do you not? Take renal services as an example. The renal service runs a hub-and-spoke model. Who actually undertakes the planning for those consultants? Is it done by Abertawe Bro Morgannwg University Local Health Board, because they do spend an awful lot of their time in the three hospitals in the Hywel Dda health board area?

[143] **Dr Fish:** The person who will be in charge of the original job plan when they are appointed will be from the employing organisation. For example, we have recently appointed ear nose and throat cancer surgeons who are going to work across the two boards. We are the employer, so we have done the initial job plan, but it includes the sessions that we have agreed with ABMU. When it comes to their job plan review, we will undertake it, just as we undertake appraisals and the responsible officer role, but they are done in negotiation with ABMU to ensure that they are still delivering what is needed for that organisation.

[144] **Darren Millar:** Julie, you wanted to come in.

[145] **Julie Morgan:** This is on private practice. Adam mentioned that there were two small private hospitals in the Cardiff and Vale area. One of my constituents raised an issue with me—you may have heard of this already. When he was at Bristol Airport, he saw an advert put in by Cardiff and the Vale advertising the services of Cardiff and the Vale for people who had had skiing injuries, which obviously must be private practice. Who are the consultants who would be doing that and where would they be doing it?

[146] **Mr Cairns:** Bristol Airport? I really do not know. I will happily look into that. I really do not know.

[147] **Julie Morgan:** Thank you very much. In terms of the break, are there any private wards at Heath hospital?

[148] **Mr Cairns:** No.

[149] **Julie Morgan:** Are there any private beds at Heath hospital?

[150] **Mr Cairns:** No.

[151] **Julie Morgan:** So, those two hospitals that you referred to are the only places where people in the area could access private in-patient treatment.

[152] **Mr Cairns:** Yes, there is the Vale Hospital and Spire Cardiff Hospital. It is possible, and I am speculating now, that that advert, if it was from us, which is—

[153] **Julie Morgan:** That is what I was told.

[154] **Mr Cairns:** Okay. I am quite surprised to hear that but, if it was us, it is just possible that we were looking to attract tariff work in from the English system, but I do not know. That would be NHS work, but I need to look at that and I will.

[155] **Julie Morgan:** The concern was obviously about the people who are on the waiting list already.

[156] **Mr Cairns:** Absolutely.

[157] **Julie Morgan:** Will you look into it?

[158] **Mr Cairns:** Yes, I will do.

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

[160] **Darren Millar:** That was very interesting. Oscar?

[161] **Mohammad Asghar:** My question is regarding private practice. We know that we do not have Harley Street in Wales, but there are still a lot of patients who go and get treatment done in private properties and private areas, rather than in hospital. Please answer one by one: how do your organisations go about recouping costs from the consultants where they may be using NHS facilities to undertake private practice?

[162] **Mr Cairns:** If that does happen in our organisation, it is a very rare thing altogether. The reason that I know that is that we are under huge pressure to deliver the NHS work that we need to do. There are some circumstances where there is a patient who has private insurance perhaps, or wishes to pay, and the local hospitals simply do not have the infrastructure to provide that service to that individual. It is very rare; I do not have the numbers in my head, but they are very small numbers. If that were to happen, that would happen in a working period of the week when all those facilities would otherwise not be in use. It would be in entirely non-NHS time, if you like, but it is happening very infrequently because we are using as much of that capacity as we can possibly find, on the whole, to deliver NHS services. Where it happens, we have a very clear billing mechanism, as you would expect, to make sure that we are recouping all those costs.

[163] **Mohammad Asghar:** Okay. How do your organisations ensure that private practice is not being used unfairly to fast-track patients on to NHS waiting lists?

[164] **Mr Cairns:** There are two answers to that. The first is that such action would mean that a consultant was failing to follow the guide to good medical practice. There is a code in there that relates to how all consultants should treat patients who are being looked after privately. It is very clear that no consultant should ever treat a private patient if, by doing so, they would disadvantage an NHS patient. If they were to do that, they would be in serious trouble with the GMC. The first check, therefore, is an individual professional responsibility not to allow that to happen. The second check is that we, from a health board perspective, also have very clear waiting time and access policies that are, I am sure, very similar to other policies across Wales. If a patient were to be moved through the system inappropriately and we were to detect that, and if we were to identify that, then there would be consequences for that individual consultant.

[165] **Mohammad Asghar:** Also, in your organisation many consultants are working long working hours. What assurance is there that private practice commitments are not making this worse?

[166] **Mr Cairns:** Again, the best answer to that is that, fortunately, the GMC revalidation now gives us a very clear remit to look at the entire scope of a consultant's practice, and the convention that we agreed locally with the private providers is that there should be full disclosure of consultants' work. Otherwise, we will not be able to fully revalidate that consultant to the GMC. So, we get an opportunity to review all of that work and, if necessary, if we have concerns about that in an appraisal context, we can advise, suggest or, if need be, instruct changes in their working week to accommodate what we would regard as a safe and not-overly-stretching working-week commitment.

10.00 a.m.

[167] **Darren Millar:** I have three Members who want to come in. Aled first, then Jocelyn and then Julie.

[168] **Aled Roberts:** Do you compile any information on individual consultants where there may be a pattern where, for example, people see him or her originally and are then told, 'Well, you will have to wait 32 weeks for treatment on the NHS but if you want to go private, I can see you next Monday'?

[169] **Mr Cairns:** We know in detail what the waiting times are for every single consultant in the organisation, so we absolutely have that information. I cannot think of a mechanism that would allow us to be, as it were, inside the consulting room on each occasion.

[170] **Aled Roberts:** Do you not have information that would indicate how many patients, for example, individual consultants refer over for private treatment?

[171] **Mr Cairns:** No, because that is not information that we have a way of capturing. Usually what happens is that the GP and the patient would have a conversation in the surgery about how long they have to wait to see the consultant, and it is usually—more often than not—at that point that a patient will say to the GP, 'Can I go private?' Usually, that is the way it works.

[172] **Aled Roberts:** There are also instances of people going to see a consultant for their initial appointment and he or she says that they require this, that and the other, and they then ask, 'How long will I have to wait?' It may be six or eight months—

[173] **Mr Cairns:** Yes, I am sure that that happens.

[174] **Jocelyn Davies:** So, you would not be able to tell, from the information that you gather, about this scenario that you paint: I go to my GP, he has suggested that I see an orthopaedic specialist, I pay privately at that point to see a consultant, and I then get put on the NHS waiting list. You would not be able to tell if a consultant put a patient from a private consultation onto the NHS waiting list for treatment. If there is no advantage in time for somebody paying to see a private consultant, why would anybody ever bother to find the sum of money to see the consultant to start with? What a waste of money.

[175] **Dr Fish:** As a GP, I would just like to verify what you say. In our area it is slightly different, because there is not as large a private practice as there is the further east you go. However, the conversation very much takes place in the GP's surgery. Patients, when they come, are aware of the waiting times and they have usually made the decision as to whether they are going to have private treatment at that point. If not, they go away, think about it, and phone the surgery again and ask for it to be transferred to a private appointment.

[176] **Jocelyn Davies:** For example, I have seen the consultant for the first consultation, and he or she says, 'I think that you probably need a knee replacement' or something like that; can I then get on an NHS waiting list, for the treatment, from the private consultation?

[177] **Dr Fish:** No, you can not.

[178] **Mr Cairns:** No, you can not. I think that it would need to be referred back to the GP, saying, 'I have seen this patient in my private clinic. I believe this patient needs to be seen and I understand this patient no longer wants to have that procedure privately. Please will you refer him so that I can put this patient on the list?'

[179] **Darren Millar:** Just let us get this right. What you are telling us is that, when somebody is told, 'It is six months to see a consultant to decide whether you need an

operation' and they say, 'Well, I am sorry, that is not good enough. I want to see someone next week, so I am going to pay privately for a consultation', that individual consultant will refer that person back to their GP so that they can be referred to another consultant for another consultation.

[180] **Mr Cairns:** No.

[181] **Darren Millar:** So what happens? Just explain that to me.

[182] **Mr Cairns:** The ordinary course of events would be that the patient sees the consultant privately. The consultant says, 'I think that you need a hip replacement' and the patient says, 'How much is that going to cost?' There is a conversation and the patient says, 'I cannot afford that'. The consultant will then write to the GP to say, 'I have seen this patient in my private clinic. This patient now needs to have a referral for a hip replacement and then the GP would make a referral.

[183] **Darren Millar:** So they have cut out the delay in waiting for their first consultation.

[184] **Mr Cairns:** That would be right.

[185] **Darren Millar:** People can pay £80, £100 or whatever it might be, for their half-hour consultation and skip six months of the waiting times for their procedure.

[186] **Dr Fish:** Six months waiting time for the initial consultant's appointment, but not to have the procedure done on the NHS.

[187] **Darren Millar:** Okay, but effectively they are short-cutting the time to treatment from seeing the GP.

[188] **Dr Fish:** No.

[189] **Darren Millar:** Their time to treatment is cut short by the time that they would have to wait for their initial consultation, is it not?

[190] **Jocelyn Davies:** Of course they do—the consultant has seen them. I am glad that they have clarified that, because the Welsh Government said that this was not happening and could not happen, but obviously that information was wrong.

[191] **Mr Cairns:** At the point at which the patient is referred, no-one knows whether that patient needs to have the procedure or not. A referral to treatment time would be affected but it would be affected for a proportion of those patients. That would be true. I am just trying to think if there is another element to this that we need to take into account; I do not think that there is.

[192] **Jocelyn Davies:** Some patients, of course, would not need treatment and then they would have just paid and they would have been told—

[193] **Julie Morgan:** I just want to be clear on this: in that example, the person who had paid for that initial private consultation would gain six months over a person who remained in the NHS?

[194] **Ms Wilkinson:** If they required ongoing treatment.

[195] **Dr Fish:** That is not entirely true, because what would happen is that they would get referred into the NHS system and they would start the process again. What they have received

is a medical opinion from a consultant, which has put their mind at rest and let them know that they do or do not need that particular procedure. However, if they choose to have it on the NHS, they still have to wait the same length of time that any other new referral into the NHS would wait.

[196] **Darren Millar:** I do not think that that is right, Sue, because some of these people will be the same consultants providing the NHS service, so why would they be referred back then for another out-patient's appointment with a consultant to decide whether they need an operation?

[197] **Dr Fish:** It is because that is how the system in the NHS works. They would need to have an NHS—

[198] **Darren Millar:** I thought that we just clarified this and that is not what happens.

[199] **Dr Fish:** Certainly within our health board, there would be no way of being listed for an operation on the NHS without having gone through the whole referral system that we have in place.

[200] **Julie Morgan:** So after having had a consultation with a private consultant, you would then go on the waiting list for another six months, because you would not have waited the original six months. You would then wait on the waiting list for another appointment with a consultant, who could be the same consultant, so you would not gain anything.

[201] **Dr Fish:** The only advantage that it might give the patient is the priority of that operation, in that it is not coming cold for the priority, so it may be prioritised. Say that it is a cancer patient, who did not know whether it was a cancer: he or she went to the out-patients, got diagnosed as having a cancer, the consultant then admitting them on the NHS would know that he or she was a cancer patient and would be able to put them on the appropriate pathway to get the treatment done in the right time.

[202] **Darren Millar:** It seems as though you are saying two things there.

[203] **Julie Morgan:** Is this the same in Cardiff and Vale?

[204] **Mr Cairns:** Yes. I am going to need to check to make sure. I can do a note on it. I am pretty confident that the process would be GP to consultant in the private clinic, consultant back to the GP, GP refers into the NHS, but I will just check.

[205] **Julie Morgan:** Is that the NHS consultant for the same sort of assessment?

[206] **Mr Cairns:** Yes. I will just check to make sure that is right.

[207] **Julie Morgan:** I am not sure that the examples that people have brought me match with that, and I have many people who have come in to complain about the fact that they have had an appointment with a consultant—they have not mentioned a GP so much—where they have been told how long they would have to wait for an operation and, as they leave the room, the consultant says, 'Oh, of course I could do it privately' and it would cost such and such. Many of these people have found it to be quite offensive, because they could not afford to pay for it. As part of the ethics of the consultant, is that acceptable?

[208] **Dr Fish:** It is something that we come across less in our health board. Obviously, private practice is not as widespread and, if anybody had any information that any of our consultants were doing that, it would be very valuable information to us because, as you say, it is against the ethical code of practice and good medical practice.

[209] **Julie Morgan:** This has happened in the past. It was probably before your time, but I have written in about it.

[210] **Mr Cairns:** There is a code and that code is part of consultants' GMC responsibilities, so they should be working to the code.

[211] **Darren Millar:** Jenny, do you want to come in?

[212] **Jenny Rathbone:** Just moving back to the consultant contract overall, increasingly NICE and the royal colleges are raising the bar in terms of what the expectations are, in terms of safe quality services and, if you cannot meet it, then do not provide it. How robust is the relationship between health service managers and your consultants in terms of being fully signed up to that agenda?

[213] **Ms Wilkinson:** It is a challenge, as you would expect me to say.

[214] **Dr Fish:** It is, however, what has driven our clinical services strategy that our consultants have all been engaged in, and continue to be engaged in, as to how we can deliver a service that meets the royal colleges' recommendations. It is challenging, but it is something that we are in constant discussion with our consultants about.

[215] **Ms Wilkinson:** It is one of the big drivers to our clinical services.

[216] **Jenny Rathbone:** Okay. One of those specific challenges is the concept that, if somebody is suddenly taken ill at the weekend, they will get the same quality of service as during the week, or in the evening. How on board are people with the concept of a seven-day-a-week, 24-hour service, for, obviously, certain emergency services?

[217] **Dr Fish:** The newer consultants come in with an expectation that they are going to be moving to a seven-day-a-week service. It is the older consultants, nearer retirement, who are less keen. At the moment we do not have seven-day-a-week working, but we know that that is the direction of travel we have to go in, and that is the discussion that we are engaging our consultants in.

[218] **Mr Cairns:** The only difference would be that some specialties already work seven-day weeks. In intensive care in Cardiff and the Vale, consultants are in seven days a week, 24/7, and surgeons and obstetricians and a number of other surgical specialties are already operating in much more of a seven-day model than others. We have just started to implement seven-day working for physicians, doing two ward rounds over the course of a weekend, but there is more that we need to do there. The business case for doing that needs to be made and we are working on that.

[219] **Darren Millar:** Okay. We are going to have to move on. I am going to allow three more minutes, just to ask the last two questions. Oscar, please be very brief.

[220] **Mohammad Asghar:** It is very short and crisp, I think. The Welsh Government, in its evidence, suggested that the annual appraisal arrangements could provide a vehicle to look at an individual consultant's whole practice, including private work. Do you think this will happen in reality?

[221] **Dr Fish:** I will answer that as the responsible officer for Hywel Dda, because the medical directors are the responsible officers in Wales. As was mentioned, for revalidation purposes the appraisal has to be a whole-job appraisal, so it is not just the NHS work; it encompasses all the work that a doctor undertakes. You can do it in two ways. You can either

do it by submitting all the evidence to the one appraisal, and the NHS takes priority, so it will all be looked at under the NHS appraisal, or by having two appraisals but recognising that you have had an appraisal in your other workplace. Then the responsible officer has to consider that before they can make the recommendation. If you do not have that, then you will not get your recommendation to the GMC.

[222] **Darren Millar:** Okay. Thank you for clarifying that. Mike is next.

[223] **Mike Hedges:** I have two points, on consultants and managers. I can introduce you to at least a couple of consultants who do not believe that there is a role for managers whatsoever and that they could quite happily do the job without them. How do you ensure that you get a good relationship between consultants and managers and that consultants can actually see the benefits of managers and the role they play?

[224] **Mr Cairns:** We are all here to serve the patient and part of the answer to that question is that everyone has to be completely committed to that proposition. All too often, the relationship between consultants and managers is stereotyped into 'the managers want one thing and the consultants want another'. The more enlightened consultants and the better managers are completely on the same page. They understand the world that we are operating in. They both want the same things. They have different roles to play in delivering to that and, increasingly, we have to make sure that, across the service, in every single location, we are all focusing on the same issues. How can we deliver the best, highest-quality, safest service within the resources that we have available? Actually, that cannot be done by managers or doctors alone; they have to do it together.

[225] **Darren Millar:** The final question is from Jenny.

[226] **Jenny Rathbone:** In terms of the challenges ahead, how are the organisations facing problems? We have already discussed the problems you have in Hywel Dda with recruiting consultants, but how are the challenges ahead affecting your ability to retain existing consultants, as well as make the job offer look more interesting and so to recruit the people you need?

[227] **Dr Fish:** One of the biggest challenges we have had is the uncertainty around our clinical services strategy. I know that there is still some uncertainty there, but the board has agreed its strategy. That then gives more confidence to the staff we have working within the department and we can project that confidence out when we are recruiting for additional doctors.

[228] **Ms Wilkinson:** We have not had a problem with retention. The problem is that we have an ageing workforce now. Obviously, a significant number are due to retire in the next five to 10 years, so we have time to put plans in place, but it is a big challenge.

[229] **Darren Millar:** So, it is the uncertainty over new recruits that makes it more difficult to attract new people in. Is the experience the same in Cardiff and Vale, given the embarkation upon the south Wales programme?

[230] **Mr Cairns:** No, I think it is the reverse. What people are seeing is the possibility of services consolidating in more sustainable footprints. That looks better from a recruitment point of view; it looks better from a safety point of view; it looks better from virtually every point of view. So, no.

[231] **Darren Millar:** Aled, very briefly.

[232] **Aled Roberts:** Do you carry out any analysis of comparisons with England? I am

thinking in particular of where rota demands in England are less than they are here, particularly in the west. I have had comments that, if you work in Chester or Liverpool, the demands on you are much less than if you are working in north Wales.

[233] **Dr Fish:** Yes. It is a big problem, especially with the new doctors coming out of the training schemes. They expect to be able to go on to a 1 in 12 or 1 in 13 rota, whereas we are offering 1 in 6 or 1 in 8 rotas, and it does impact considerably.

[234] **Ms Wilkinson:** That is part of the reason why we are now involved in discussions with our clinicians around future clinical pathways, because there clearly needs to be some difference there if we are to impact significantly on our recruitment difficulties.

[235] **Darren Millar:** Okay, that brings us to the end of this. Sorry, go on, Mike.

[236] **Mike Hedges:** I have a very brief question for Hywel Dda. Do you see an expansion of the hub-and-spoke model that works very well in renal services, dealing with Abertawe Bro Morgannwg University Local Health Board?

[237] **Dr Fish:** The whole of our clinical services strategy is based on a hub-and-spoke model, some of it with ABMU, but some of it within ourselves where we will be centralising certain services but having the spoke out to the peripherals.

[238] **Darren Millar:** Okay. On that final note, thank you all for attendance today. Thank you, Richard, Adam, Janet and Sue. Your evidence has been very interesting. We will obviously explore some of the issues with some of the other witnesses who have given us evidence to see how it matches up, and to see what their responses are, but we have been very grateful for your attendance today. Thank you.

Papurau i'w Nodi
Papers to Note

[239] **Darren Millar:** We have two papers to note: one letter on grants management from the Wales Council for Voluntary Action, and the Welsh Government response to the action points from our meeting on this particular issue, the consultant contract in Wales, on 19 March. I will take it that those are noted.

Cynnig o dan Reol Sefydlog Rhif 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order No. 17.42 to Resolve to Exclude the Public from the Meeting

[240] **Darren Millar:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42(vi).

[241] I see that there are no objections.

Daeth rhan gyhoeddus y cyfarfod i ben am 10.18 a.m.
The public part of the meeting ended at 10.18 a.m.