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

5/10/2016

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Others in attendance

Dr Philip Banfield	BMA Cymru BMA Wales
Yr Athro / Professor Adam Cairns	Prif Weithredwr Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Chief Executive, Cardiff and Vale University Local Health Board
Dr Tony Calland	BMA Cymru BMA Wales

Stephen Harrhy	Cyfarwyddwr Bwrdd y Rhaglen Gofal heb ei Drefnu Director of Unscheduled Care Programme Board
Gaynor Jones	Cadeirydd Bwrdd Coleg Nyrsio Brenhinol Cymru Chair of the Royal College of Nursing Welsh Board
Dr Jo Mower	Coleg Brenhinol Meddygaeth Frys, Cymru Royal College of Emergency Medicine, Wales
Dr Robin Roop	Coleg Brenhinol Meddygaeth Frys, Cymru Royal College of Emergency Medicine, Wales
Lisa Turnbull	Cynghorydd Polisi a Materion Cyhoeddus, Coleg Nyrsio Brenhinol Cymru Policy and Public Affairs Adviser, Royal College of Nursing, Wales
Vanessa Young	Cyfarwyddwr, Cydffederasiwn GIG Cymru Director, Welsh NHS Confederation

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

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

Dechreuodd y cyfarfod am 9:15.
The meeting began at 9:15.

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

[1] **Dai Lloyd:** Croeso, a bore da i chi i gyd i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol

Dai Lloyd: Good morning, and a very warm welcome to this latest meeting of the Health, Social Care and Sport

a Chwaraeon yma yn y Cynulliad. O dan eitem 1, ymddiheuriadau, dirprwyon a datgan buddiannau, o blith fy nghyd-Aelodau, rwy'n credu bod y sefyllfa yna'n iawn. Wrth estyn croeso i chi i gyd, a gaf i egluro, yn amlwg, bod y cyfarfod yn ddwyieithog? Gellir defnyddio'r clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2.

Committee at the National Assembly. Under item 1, introductions, apologies, substitutions and declarations of interest, I believe the situation is fine in terms of declarations of interest. May I, in extending a very warm welcome to you all, explain that the meeting is bilingual, and headphones can be used for simultaneous interpretation from Welsh to English on channel 1, or you can amplify proceedings on channel 2?

[2] A allaf i atgoffa pawb, yn cynnwys y Cadeirydd, i ddiffodd eu ffonau symudol ac unrhyw offer electronig eraill a allai ymyrryd â'r offer darlledu? Nid ydym ni'n disgwyl clywed y larwm tân y bore yma, felly, os bydd yna un yn canu, bydd yna ddisgwyl i ni ddilyn cyfarwyddiadau'r tywyswyr a gadael yr ystafell yn drefnus.

May I remind everyone, including the Chair, to switch off their mobile phones and any other electronic equipment that may interfere with our broadcasting equipment? We're not expecting a fire drill this morning, so, if an alarm does sound, then please follow the instructions of the ushers and leave the room in an orderly manner.

09:16

Ymchwiliad i Barodrwydd ar gyfer y Gaeaf 2016-17: Sesiwn Dystiolaeth gyda Choleg Brenhinol Meddygaeth Frys a BMA Cymru
Inquiry into Winter Preparedness 2016-17: Evidence Session with the Royal College of Emergency Medicine and BMA Wales

[3] **Dai Lloyd**: Felly, o dan eitem 2, ein hymchwiliad ni i barodrwydd ar gyfer y gaeaf hwn sydd yn dod, dyma sesiwn dystiolaeth gyda'r Coleg Brenhinol Meddygaeth Frys a BMA Cymru. Felly, mae'n bleser i groesawu i'r bwrdd Dr Robin Roop, Coleg Brenhinol Meddygaeth Frys; Dr

Dai Lloyd: Item 2 is our inquiry into winter preparedness. This is an evidence session with the Royal College of Emergency Medicine Wales and BMA Cymru Wales. So, it's a great pleasure to welcome Dr Robin Roop from the Royal College of Emergency Medicine; Dr Jo Mower,

Jo Mower, Coleg Brenhinol Meddygaeth Frys; Dr Philip Banfield, BMA Cymru; a Dr Tony Calland, BMA Cymru.

Royal College of Emergency Medicine; Dr Philip Banfield, BMA Cymru; and Dr Tony Calland, BMA Cymru.

[4] Yn sylfaenol, diolch yn fawr am eich adroddiad. Rydym ni i gyd wedi darllen pob gair mewn manylder, ac wedyn awn ni yn syth i'r cwestiynau, os ydy hynny'n iawn gyda chi. Bydd y sesiwn yma yn dod i ben am 10 o'r gloch.

Now, first of all, I'd like to thank you for your papers. We've all read every word in great detail, and therefore we will move immediately to questions, if that's okay. This session will conclude at 10 a.m.

[5] Felly, yn unol â'r traddodiad arferol, gwnaf ofyn y cwestiwn cyntaf, a hynny ydy: yn eich barn chi, pa mor barod ydy gwasanaethau—bydded hynny yn wasanaethau ysbyty yn ogystal â gwasanaethau gofal sylfaenol, pa mor barod yw gwasanaethau i wynebu her y gaeaf 2016-17? Nid ydw i'n gwybod pwy sydd eisiau dechrau.

So, in accordance with our usual practice, I will ask the first question, and that question is: in your view, how prepared are services, be they hospital services or primary care services? How prepared are these services to deal with the winter challenges of 2016-17? I don't know who'd like to kick off.

[6] **Dr Roop**: Shall I kick off, please? From the Royal College of Emergency Medicine, we looked at all the emergency departments across Wales and we got a bit of a consensus about what happens. We like to be a bit positive about it, in terms of that there is a lot of work going on behind the scenes in a lot of the health boards to try to make provisions for the winter, but our overall assessment is we think that emergency departments this winter are going to be very stretched, and we don't think that we've fully prepared for the winter. But we just want to say by extension that we've been stretched, as today we're all stretched, and probably across the entire year we'll continue to be stretched. So, winter, while it comes with different problems, I think we're still under-resourced and overstretched for winter.

[7] **Dai Lloyd**: Ocê. Ac o'r ochr gofal sylfaenol—Tony neu Philip.

Dai Lloyd: Okay. And in terms of primary care—Tony or Philip.

[8] **Dr Banfield**: Our members report throughout Wales that the NHS is relatively unprepared. It's unprepared because the pressures have come

throughout the entire year. We're getting reports from primary care that they cannot admit emergency patients directly to the wards. They're phoning up and finding that their patients are behind a queue of 20 or 30 other patients waiting for an emergency bed, and therefore they're adding to the emergency department pressures by being told to send their patients for assessment to the emergency department rather than to get a medical view. We think that this has happened because of two reasons: firstly, because we've closed too many beds in secondary care at the same time that the number of community beds has also fallen.

[9] **Dai Lloyd**: Ocê. Yn dilyn hynny, Lynne—mae cwestiwn gyda ti.

Dai Lloyd: Okay. Following on from that, Lynne, I believe you have a question.

[10] **Lynne Neagle**: Thanks, Chair. Can I just ask whether you think it is a winter pressure problem now or whether you think the pressures are becoming all year round? For instance, we heard from the ambulance service last week that March was an incredibly difficult month. Can you just comment on how seasonal you actually think this problem is?

[11] **Dr Mower**: Well, we've got good evidence from the college that, actually, this is not a seasonal—we don't have peaks, although we have a difference in populations and attendances throughout the year. We have constant pressure throughout the year. What we do see in the winter is the case mix is slightly different, with more elderly, frail, vulnerable patients who have more complex health needs, attending emergency departments, and therefore often require lots more input—social care packages—to get them home. So, that's what puts more pressure on in the winter, but, actually, the pressure is throughout the year.

[12] **Dai Lloyd**: Ocê. Caroline, y cwestiynau nesaf.

Dai Lloyd: Okay. Caroline has the next questions.

[13] **Caroline Jones**: Yes. Diolch, Chair. Can you tell me, please, regarding hospital bed capacity during this time, during the winter time, is it an issue? And, if so, can you tell me what you are doing to address this issue? And because there's an increased emphasis on shifting services away from hospital, with conventional A&E services provided in a fewer number of sites across Wales, maybe this will alleviate problems or add to them. Could you tell me, please, what issues you are facing regarding hospital bed capacity and what measures you've taken to address it?

[14] **Dr Roop**: So, as emergency physicians, we're very simple people, in terms of that we've broken this down into probably two or three little parts. So, what happens in the emergency department? We have increased attendance, so increased demand. Our workforce hasn't changed that much over the last two or three years, so we're pretty much stagnant in terms of retention and recruitment. But, also, bed availability has gone down. So, on that balance there, we're already seeing that there's too much in the system and not enough place to put them. There's also, as Jo mentioned, the delayed transfers of care. That bed that's available is being used for a longer period of time, so our flow through the system has been a lot less. So, in terms of what we've done, the royal college has put forward a STEP campaign. STEP basically means that we want to have increased staffing, our terms and conditions for people who work in Wales need to be different and to be reviewed, and the exit block needs to be looked at actively by health boards. And the final part is that the co-location of primary care services within emergency departments needs to be robust as well.

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

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

[17] **Jayne Bryant**: Thank you very much for that. You mention the pressures on A&E. How do you think that that can be tackled? What practical measures do you think we can do to alleviate that, particularly during the winter period?

[18] **Dr Mower**: Well, as Robin said, if we go back to the STEP campaign, the biggest factor that's actually hindering our performance in A&E is actually the exit block, so the delayed transfers of care, those patients waiting for a social care package. So, we really need to address that so that we can improve the flow through the department. We also need to make working in A&E attractive, so that we can recruit and retain staff, because, if we look at the deanery, we do fill our places for training in Wales, but the trouble is we lose a lot to Australia or they just give up, because, actually, the working conditions are quite hard.

[19] **Jayne Bryant**: Thank you for that. In the papers, there's mention about different opportunities, perhaps whether to look at staff moving into perhaps A&E to help, whether that was possibly GPs, or additional trainees to triage people out of A&E. Do you think that's a practical solution, or do you think

there are any other ways around that?

[20] **Dr Roop**: So, with the co-location of services, I think we need to be able to have those services there. So, if someone attends the emergency department, and they don't need particular emergency care, we should be able to offer them the alternatives. So, if they need a GP, or if they need a physiotherapist or a pharmacist, or just probably even mental health, those are all part of the hub that we're trying to encourage health boards to look at, in terms of that as a way forward, because, let's face it, accident and emergency has become an 'anything and everything' speciality. But people trust the A&E brand, so, when they feel that they need something, they know that our doors will always be open, so they come to us. But, if we want to redirect them, we need to be able to redirect them to a service that they have. So, we can't just say we need a GP; we need to have that GP there for them as well.

[21] The other point that Jo was making about our recruitment—in Wales, we've expanded our numbers of trainees, which is good. So, positively, we—. But we could have recruited to those numbers three times over. So, people are attracted to come to Wales, and, if we have the posts available, we will be able to fill them, because it's such a vibrant speciality that people are interested in coming to it. But, also, sometimes they think, if the numbers are too small, the competition for that post will probably be difficult, so it might detract people from applying as well. So, I think we need to keep pushing forward in terms of recruiting all the available staff.

[22] **Dai Lloyd**: Okay. Angela, then Julie, then Dawn.

[23] **Angela Burns**: Just talking about winter pressures, and you mentioned triage—. Of course, in A&E—with small children, I can see it works so well—you have a special triage line for paediatrics and then there's everybody else. Is there any consideration given to, perhaps, a way of—? Of course, as we all understand, with winter pressures, the mix of people coming in to A&E changes, and there are a lot of elderly fallers and people with pneumonia. Because we're trying to think of how we can usefully look at trying to take some of that pressure off A&E, is there any way of looking at another triage system—would that work?—to be able to hive some of those people off perhaps into a different area, to take that pressure off A&E?

[24] **Dr Mower**: Some departments are actually using their acute physicians at the front door, which is very helpful and a very good model. I don't think

we have it in Wales currently, but actually using frail elderly assessment areas, co-located at the front door, is an excellent model. Getting those specialist services and those social care packages started very early on in that patient's journey, having an overall assessment with an occupational therapist and physiotherapists—all of these enablers to get the patients home. So, that's definitely a model worth looking at and investing in.

[25] **Angela Burns**: Could you give us an example where we could perhaps go and have a look or get some information on somewhere that's practising it?

[26] **Dr Mower**: I think Leicester has a very good model.

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

[28] **Dai Lloyd**: I feel a trip coming on. [*Laughter*.] Julie.

[29] **Julie Morgan**: It was a similar question, really, but in terms of the actual people who are arriving in A&E, do you have any estimate of the percentage who really would be better off going somewhere else?

[30] **Dr Roop**: Any redirection services usually have 20 to 30 per cent of people. That's our best estimate. So, 15 to 30 per cent of people could probably be served with a different type of service, not necessarily an emergency service.

[31] **Julie Morgan**: Right, so it's trying to get them there before they arrive at A&E.

[32] **Dr Roop**: Yes. As I tell my patients, we're there to deal with emergencies, basically, but what someone considers an emergency for them, at that point in time. So, for example, narratives usually help: if a dad comes from work in the afternoon and he sees his kid with a fever, that is an emergency for him, rather than looking at primary care, because that's his only available time to do it and that's the only available place for him to go to, sometimes.

[33] **Julie Morgan**: All right; thank you.

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

[35] **Dawn Bowden:** This is much on the same line of questioning around the co-location. I was particularly interested in what you were saying about co-locating primary care within A&E. It's something I've spoken to other colleagues about over a long period of time, and, actually, the previous health Minister. So, have you, again, got examples of where that is happening, where we've got primary care actually working alongside A&E so that, when people come through, when they are triaged, they can be directed to alternative care pathways in the hospital, rather than say, 'Actually, you need to go and make an appointment with your GP'? Because that is part of the problem as well: people tend to rock up at A&E when they can't get a GP appointment, particularly an out-of-hours GP appointment. So, am I correct in interpreting what you're saying as suggesting that we should actually have primary care functions located in A&E to work alongside, which can be directly and immediately located? And do you have examples of where that might—

[36] **Dr Roop:** There's like a hub system, basically, and the examples are in Scotland. In terms of Manchester, they also have those little hubs. The ideal way is that they come to the emergency department, because those who come to use the emergency facility don't live more than about 8 miles away from the emergency department. So, that's where they will come to. If a service is there for them, they will be attracted to it, basically. So, 85 per cent of all patients live within an 8-mile radius of your emergency department. So, if they come there, we also have to have those services available within that setting. There's no point saying—. You have to have the pharmacist or the physiotherapist, or whoever they need—so, GP services, or even practice nurses who can deal with their particular needs. We don't want to take away the GPs' stream of work, because we don't want it all under one umbrella, basically, but we know that people are going to present in their own time, basically. When they need it, they will attend their emergency department.

09:30

[37] **Dawn Bowden:** Just as one quick follow-up to that, have you got any evidence that some of the public awareness campaigns around using A&E appropriately—using all the emergency services appropriately—are actually having any effect? What would you suggest could be more effective?

[38] **Dr Roop:** We support the Choose Well campaign. That is something that we—we regularly say the population should be educated about it, but, historically, all redirection campaigns have shown very little effect in terms of

reducing the numbers that attend. However, we support a campaign that will inform the public about where they should go and when they should go, too.

[39] **Dr Banfield:** It isn't this relatively minor group of patients, though, who are causing the collapse of the system. What causes the collapse in A&E is patients waiting four hours to get admitted to hospital. So, a lot of that can be prevented by not having patients present to the hospital in the first place, by reinforcing primary care. What we're seeing is some significant investment from Welsh Government in primary care and in intermediate care, but what we're having reported to us is that that money is not hitting the front line. So, we need to smooth that. We need to make sure that primary care is functioning properly and that the GP out-of-hours is adequately resourced. Our A&E departments do direct patients across to out-of-hours if they feel the patient is there inappropriately. We've seen, for example, a 30 per cent fall in district nurses, and, therefore, patients are coming in because they're not able to be sustained in the community. As one GP said to me, sending a teenager in for 10 minutes, four times a day, does not constitute care in the community.

[40] **Dr Calland:** One of the other things is, certainly in terms of recruitment into primary care, to cope with people who are discharged out of hospital—I won't say prematurely, but I'll say at a very early stage—. So, they will require, if they've been in, had their operation or their period of care—t hey come out into the community when they are just about well enough, but there isn't, in the community, the facility to actually care for them properly. The district nurses—there are fewer. Primary care practice nurses are becoming like gold dust. If you've got one or two, you really hang on to them and do the best you can, because, like various aspects of medical healthcare, practice nursing is a particular specialty. If you were a theatre sister or an intensive care sister, you might be incredibly highly skilled at doing that particular job, but if you came out into primary care, where you're dealing with people on how to work an asthma nebuliser or all the kinds of things—it's a totally different skill set. You can't just move nurses from one sector of healthcare, pop them into another and expect them to work properly.

[41] So, there has to be proper, long-term investment in primary care—something that has been, sadly, dwindling over the past 10 years—so that primary care, be it managed practices or independent contractor practices, has the ability to actually get the right staff in the right place to be able to look after people after they come out of hospital at an early stage. As has been said, most of this problem is the blockage out of hospital, not the

blockage into hospital, and that requires a mixture of things.

[42] I retired from practice some time ago, but I practised in the Wye valley for 34 years, and we had two community hospitals. We had Chepstow Community Hospital and Lydney community hospital, and they ran sort of GP units where people who didn't necessarily require the high-tech district general or major hospital care, but they'd got urinary tract infections or chest infections, and were not able to look after themselves at home—you could put them into a GP unit where GPs would continue to look after them, but they would have nursing care. Much cheaper. And certainly, the sisters that were working at the time when I was doing this kind of work—you didn't put anyone into the hospital whom you weren't jolly sure you were going to get out very quickly, otherwise the sister would have words to say to you, to encourage you to get the patient moved on. It provided a safety valve for the district generals. Over my career, I've watched community hospitals go up and down and in circles in terms of being in favour—I'm not quite sure where they are now—but I think community hospitals can provide a safe and appropriate place for patients to come.

[43] **Dai Lloyd**: Okay. Angela, on this point.

[44] **Angela Burns**: I just wanted to pick up on your comments, Dr Banfield, about the out-of-hours and using GPs. In fact, Dr Calland, you've expanded on it. We talk about this a lot, and we talk about using the GPs as an additional resource, but the reality on the ground is totally different. I've got the latest figures from the National Assembly for Wales Research Service that show that, in six areas—six Assembly constituencies—there are no GPs offering appointments after 6 p.m. So, if we can't even do something as basic as that, then how are we going to be able to use all this GP resource to take the pressure off A&E? That's surely the reality of the situation.

[45] We've got 13 in total where under 10 per cent of the GPs offer any form of appointments after 6 p.m. So, how can we use them in an out-of-hours situation? How can we try and stop people going to A&E who could, in fact, have gone to a GP, but their crisis has been at 6 p.m. or they've come back from work and thought, 'This is looking a bit odd; could it be septic?' and all the rest of it? So, surely, we need to start with that cultural change right at the very front before we can make all these assumptions that we talk about—'Let's involve the GP more'—because they're not already involved that much.

[46] **Dr Banfield:** I think the evidence is quite poor for that. There were some GP pilots in England that extended hours quite markedly and we saw GPs handing the money back because there was no demand for appointments. The sick patients who we're talking about are identified as being sick, the majority of them during the day, and there's an inability to sort out a care package for them during the day, which leads them to a long wait in A&E. So, the kind of case that you are describing is exactly what a GP out-of-hours service should be able to deal with. I think that being able to get a GP opinion, out of hours, should be relatively straightforward to do for that kind of patient who suddenly presents at that time of day.

[47] The difficulty is, in the same argument over seven-day services in England, we're struggling to cope with staffing a nine-to-five, five-day-a-week service. The staffing of an emergency service is relatively straightforward. It exists within the current contracts for both junior and senior doctors in Wales. This is about investment in the service; it's about investment in the number of beds. You can predict, from the reduction in the number of beds, that there will be a crisis with beds. Once you go above 85 per cent bed occupancy, you can predict that you can't cope with fluctuations. You need about a 20 per cent surplus of beds to cope with the kind of fluctuations that we're talking about. When you've got bed occupancies running at 86 or 87 per cent, you start getting C. diff; that delays the discharge of patients as well.

[48] There is a science to queues; you can calculate the right number of beds. The reality is that we've closed too many beds to get people in and out of the system in a timely manner. Unfortunately, that reduction in the number of beds has coincided with the reduction in number of community beds at the same time. Otherwise, we might have got away with it. We've also seen a shift in the way that our beds our used. So, whereas two thirds of the beds used to be about elective cases and a third were about emergencies, it's now switched to the majority of our beds being used for emergency care. Those are resource intensive, and that's what's producing additional pressure on the system.

[49] **Dai Lloyd:** Okay. Tony.

[50] **Dr Calland:** If I can just add about the appointments at 6 o'clock and everything. Certainly, when I was in practice, our last appointment was 6.15 p.m. We very, very rarely had any great demand at all for appointments after 6.15 p.m, but I realise the world has changed and people look at

appointments differently now. Having said that, I think you have to look at the changing world or demographic of the GP workforce. We have more women working as GPs now than ever before. Many of those, whilst doing a valuable and full job, do not want to work like I used to work—five days or seven days a week, morning till night and around the night as well. Therefore, because people work their contracted hours, they do not necessarily want to sort of work a full day and then carry on and do some more out of hours. We've got a recruitment problem, as you know, in various areas—not all areas, but various areas of Wales—and there are a number of reasons for that, partly because the day job is now extremely intensive. Whereas when I first went into practice in the 1970s—and I will remember that, many years ago, you could perhaps see 15 to 20 people in a surgery—you are now seeing 25 to 30 people in a surgery, morning and afternoon. There is a tremendous pressure in that because they're not simple coughs and colds anymore; because of the changing demographic of the population, they are now people with chronic conditions and, by and large, complex conditions. So, the pressure is greater. Therefore, it's not surprising that doctors, having worked four or five days fairly hard, aren't particularly keen to take on sessions to work out of hours or to do extra work where there may or may not be a demand for it. I think also what has changed in terms of the population is that we all expect, because of the internet and mobile phones, instant answers. Therefore, waiting is not something that modern society is very good at. Therefore, 'Okay, I can't get an appointment past 6 o'clock, so I'll trot off to accident and emergency, out-of-hours or wherever'. So, you know, I think that adds to a pressure.

[51] **Dai Lloyd:** Rhun.

[52] **Rhun ap Iorwerth:** Os gallaf i ddod â'r ffocws yn ôl i barodrwydd ar gyfer y gaeaf, yn benodol, mae llawer o'r hyn yr ydych chi wedi bod yn siarad amdano, wrth gwrs, yn berthnasol drwy'r flwyddyn. A allaf i ofyn hyn: a oes yna le, o bosibl, ac a oes angen, i ehangu'r ddarpariaeth, er enghraifft, o ran ymestyn oriau gofal sylfaenol dros gyfnod y gaeaf, er mwyn delio efo pwysau dros y cyfnod penodol hwnnw?

Rhun ap Iorwerth: If I could bring this focus back to winter preparedness very specifically, much of what you've been talking about would apply year round, but can I ask this: is there scope, possibly, and is there a need to enhance the provision, for example, in terms of extending primary care hours over the winter period specifically, in order to deal with pressures during that particular period?

[53] **Dr Calland**: I think, as Dr Banfield said, the majority of the cases from primary care that go into the hospital system occur during the day. Those are identified during the day. I think that the number of what you might call patients who require admitting to hospital because of the seriousness of their illness that are created by a GP appointment post-6 o'clock, I think, would be very small indeed. I'm sure that if people are that ill, they will be dealt with—sometimes reasonably early—urgently through the current system. I'm not sure that extending GP hours further during the day is going to make any great pressure.

[54] **Rhun ap Iorwerth**: It needn't necessarily be extending GP hours. It could be additional investment in an out-of-hours service on another level perhaps.

[55] **Dr Calland**: As one of the people who negotiated GPs' out-of-hours, I think what has happened since 2004 has been very disappointing, from my point of view. Because, before 2004, we had a very comprehensive GP out-of-hours system—GP co-ops and the like—that was, by and large, running pretty well. Most of those were disbanded very quickly after 2004, and the investment in that sort of service has, I think, dwindled over that period of time. So, it has become much less able to cope in a comprehensive way—slower response times, people having to travel further, et cetera.

09:45

[56] **Rhun ap Iorwerth**: Could that be having a detrimental effect in particular over that winter period?

[57] **Dr Calland**: I think it has some knock-on effect in the hospital sector, but, again, I think a lot of the pressure that occurs on hospitals in the winter is because of people becoming seriously ill.

[58] **Dr Roop**: Sorry, can I just say one thing? Phil talked about the 85 per cent occupancy of beds, and Tony has mentioned that a lot of the pressures are within the hospitals. The reason why is that when you have that pressure, people inappropriately go to the wrong beds. So, while we're using that 85 per cent, we have the wrong patient in the wrong bed at the wrong time, and that increases their length of stay in hospitals, because the specific treatment that they need—when they should be in a medical bed, but they're put on an ear, nose and throat ward—is completely different. So, their lengths of stay are going to change, and they're going to be the ones who end up having

delayed transfers of care, because they can't get their pharmacy done in time, they can't get their physiotherapy done in time and they can't get all of the other things that they would need in a specialist unit. You wouldn't put a stroke patient on a cardiac ward, would you? But, we end up putting all of these medical patients in inappropriate places, so we end up having these long-delayed transfers of care.

[59] So, the simple thing that health boards need to do is make sure that they have the beds that are put for their admissions—their unscheduled admissions—and that they have to be ring-fenced, as such. We talk about ring-fencing elective beds. I think we need to ring-fence our unscheduled care beds, so that we have a dedicated place for these patients and they're worked up completely so that they can move out of the system in a timely fashion.

[60] **Dr Mower:** Can I just add there that the big elephant in the room is the delayed transfers of care—the patients waiting for social care packages? Currently, there are about 450 per month in Wales, and we're starting, going into the winter, with that. That's really the big, big problem that needs to be addressed.

[61] **Rhun ap Iorwerth:** I point to the table in paragraph 16 of your evidence paper showing the decrease in the number of available beds—down nearly 10 per cent since 2010. To you, that's at the heart of the problem that we're facing.

[62] **Dr Mower:** It is, yes.

[63] **Dr Roop:** I think that there's room to say that we need to be more efficient in how we use the beds as well. So, we're not going to say that beds shouldn't be—. It has to be an efficient way that we manage it. So, we can't just have people sitting in beds, or have x number of beds and it's expanded unnecessarily. We have to be sensible about how we admit people, as well as how we deal with these people within the hospital setting itself.

[64] **Rhun ap Iorwerth:** In winter, again bringing it back to a winter focus, the problem there is that you have more people with more serious illnesses—therefore, that's where the pressure comes from, and there is no capacity in order to deal with any peak in any way.

[65] **Dr Roop:** Our elderly population will need more work-up in winter

time. As Jo mentioned, we have seasonal variation in terms of the case mix that comes in at that time. So, they have more demanding needs over the winter period.

[66] **Rhun ap Iorwerth**: Do you have ideas that you've put forward, perhaps, on building in surge capacity specifically for a busy period such as winter—those ideas that are crystal clear in your mind, 'If this was done, it'd be fine'?

[67] **Dr Mower**: Yes. I think, to be honest, sometimes we look at placing the surge capacity in the wrong area. We talk about surge capacity at the front door. The surge capacity has to be on the wards or, if not, at the back door—i.e. in the community. That's what we're saying with these beds. A lot of these beds are community beds. The patients don't necessarily need to be in hospital—they just need something to step down to get them home.

[68] **Rhun ap Iorwerth**: The idea of GPs' beds, such as those lost in Blaenau Ffestiniog recently, and the close relationship with GP care that you talked about, is missing and is being lost more and more within the system, and that could be a big help.

[69] **Dr Calland**: It was a help in my day. I can't speak for how young doctors look at a career in general practice, but one of the things that attracted me to general practice was the thought that you could continue to have patients in a hospital bed who you would look after, so that you weren't just sitting out in a surgery somewhere seeing endless waves of people walking through the door—you were actually going to have the ability to do a bit of low-key hospital medicine and use your skills in a slightly different context. That was, I found, quite attractive. Now, it may well be that doctors these days don't think that, but it was all part of the holistic, community, generalist philosophy that I was attracted to.

[70] **Rhun ap Iorwerth**: Could that even be some sort of surge capacity, where, off the top of my head, you have a department, a ward that is mothballed half the year and then is used as GPs' beds just during those periods of peak demand?

[71] **Dr Calland**: I'm not an economist and I think, therefore, you'd have to work out whether that was the most effective answer.

[72] **Rhun ap Iorwerth**: No, I'm not offering you a chance to have a wish list here and tell us what you'd like. [*Laughter*.]

[73] **Dr Calland:** If I ran the health service—yes. I think it would need to fit in with the capacity that could be managed within primary care, because, as we know, GPs are full at the moment, therefore if you suddenly opened up a hospital ward and said, 'Well, you're going to look after all those people as well', I don't think my colleagues would thank me for arguing for that. I think you'd need to build that capacity in, but if it could be built in, then it would be another release valve off the hospital pressure.

[74] **Rhun ap Iorwerth:** I have a couple more questions, but I don't want to hog—.

[75] **Dai Lloyd:** Dawn, you had something on workforce, I think.

[76] **Dawn Bowden:** I think you've kind of covered it to a large extent. My queries around workforce, I think, were more to do with how we could utilise other staff to relieve pressures on medical staff. I'm not sure that we see other professions and other staff in the system utilised as well as they could be. We've talked about this, I guess, through the prudent healthcare stuff. I'd welcome your views on whether, in fact, that is manifesting itself in the system—that we've got appropriate people, at appropriate levels, doing the appropriate work—or whether more of that would actually start to relieve some of the pressures on the front-door staff that you're talking about.

[77] **Dr Roop:** So, some of the examples are working examples that we have—like on the mental health side. So, we have liaison nurses who do a lot of the work that the doctors would have done, and that releases some of the pressure within emergency departments as well. So, a mental health nurse, based within a unit, can look after this cohort of patients, at very high standards as well, so the patients are not being lost in any way. We need to probably think about how we're going to use our advance nurse practitioners. In Wales, we've set up a training course for emergency nurse practitioners, the advanced practitioners—and even paramedics are on this course, where they can be used to look after minor injury cases as well. The ability to treat and diagnose and manage these patients can help as well.

[78] **Dr Mower:** I'd like to add, actually—I'm talking locally—that we use emergency nurse practitioners to look after our minor injuries flow. They work autonomously, so they are seeing, investigating, discharging patients and arranging appropriate follow-up. We've also extended that to advanced nurse practitioners, so these are nurses that are functioning at the level of a

senior house officer. In addition to that, we've got good practice with extended scope physios, who, again, will see patients from the front door, interpret x-rays and discharge and arrange follow-up. And pharmacists—we're actually using pharmacists.

[79] **Dai Lloyd:** Julie next, then Angela.

[80] **Julie Morgan:** It was really going back to what you were saying about having the GP beds and the cottage-style hospitals and, really, to challenge it a bit. It does seem to me that's going back to a sort of era where patients were often left indefinitely in that style of accommodation. Surely, all our efforts should be to prevent people going into hospital, particularly elderly people, because we know the dangers of going into hospital and the disruption of their lives. Just also to say, in terms of GPs extending their work, I understood there are a lot more, sort of, minor surgical things and other things going on in GP practices now, which did extend the reach of the GP.

[81] **Dr Banfield:** I think what you have to appreciate is we need capacity from somewhere, and that that capacity should be different in our current modern medical era than it was 50 years ago is quite clear. We've got fantastic practice nurses, advanced nurse practitioners—. Actually, these kind of community beds do not need to be staffed by GPs, they can be staffed by specialist nurses, supported in an outreach manner by secondary care and primary care working together. Clearly, the integration and communication between primary and secondary care needs to be better. There are opportunities for the GP clusters to work with the third sector. Part of the reason why elderly, frail patients come into hospital in winter is not just because they're iller, but because they've lost their support network. They're less likely to be seen when it's cold and wet and in the middle of winter. Getting our communities working properly again would be an important part of trying to keep these patients at home and away from the hospital.

[82] **Dai Lloyd:** Okay. Angela.

[83] **Angela Burns:** I wanted to pick up on two things. First, with you, Dr Roop, is that you made a comment earlier on that, if we had the A&E posts, you believe that there would be no difficulty in recruiting to them. Did I hear you correctly?

[84] **Dr Roop:** Yes, absolutely, that's right, because we knew our

admission—. The ACS posts that we had, we had an expansion over the last few years, but the numbers that applied for those posts were about three times, and very high-level quality candidates as well, and we could have appointed to those posts if we had sufficient numbers.

[85] **Angela Burns**: And would that have just been to Wales, or was that just in the conurbations, such as—

[86] **Dr Roop**: To Wales.

[87] **Angela Burns**: To Wales.

[88] **Dr Roop**: Yes. So, in Wales, the training programme for emergency medicine, which is called the acute care common stem—.

[89] **Dr Mower**: Yes, the training.

[90] **Dr Roop**: Yes. We've moved from eight to 12 posts, which is good. But, if we're looking at projections of how many consultants—because all of these will be consultants in the next seven years. If we look at the projection of where we should be at level pegging, Wales has about 62 or 63 consultants at the moment. If we compared to Scotland, there's 200 plus consultants, and we have comparable ratios of population, so 5 million to 3 million—we're way behind in figures. But if we look at the seven years to recruit these numbers, I think we'll probably not even be breaking even by then.

[91] **Angela Burns**: I'm just so pleased to hear that commentary from you because we're always told that no-one ever wants to come to Wales and, coming from west Wales, to know that there are any people who would love to come and work in west Wales, or work in Wales—let me correct myself—is also very good news. So, thank you for clarifying that.

[92] **Dr Roop**: Not only do they want to work in Wales, when they get trained in Wales, they stay in Wales.

[93] **Angela Burns**: Brilliant, thank you. My second quick question was, actually, do you have any feel, Doctors Calland and Banfield, as to the numbers of orthogeriatricians that we have within Wales? Because I know that where we could use them so usefully is in stopping the revolving-door syndrome with elderly people who come in with, say, a broken fracture and then go home and have pneumonia because they can't move around et

cetera and then they're back in all the time, all the time. Whereas somebody who can take that holistic view—and orthogeriatricians appear to be one of the key players of that team, but my understanding is that there are very, very few.

[94] **Dr Banfield:** As you know, we've been critical about HR processes within the NHS in Wales. Now that the attitude has changed, I'd say, we've kind of missed the boat over appointing these orthogeriatricians. So, they aren't out there. So, it's quite clear that Wales has to go about training its own to retain them. This is why we're so keen to change the fundamental culture of what it means to work in the NHS in Wales. We've got to build a place where people want to come and work. The A&E departments—they don't like me calling them A&E; the emergency departments in Wales—there is some brilliant work going on in there. That's not just in the big units, it's in the small units as well. There are some very exciting recruitment opportunities and strategies going on. People are being very novel, they're being very proactive, not just in attracting trainees to work in Wales but in attracting staff and associate specialists to work in Wales. So, it's very much all to play for.

[95] **Dai Lloyd:** Diolch yn fawr. Ar y nodyn positif hwnnw, mae'r amser wedi dod i ben. Felly, a allaf i ddiolch i chi'ch pedwar am y datganiad ysgrifenedig ymlaen llaw a hefyd am gyfoeth y dystiolaeth ar lafar y bore yma? Diolch yn fawr iawn i chi i gyd. A allaf i hefyd gyhoeddi y byddwch chi'n cael trawsgrifiad o'r cyfarfod yma i gadarnhau ei fod yn ffeithiol gywir? Ni fedrwch newid eich meddwl am unrhyw agwedd, ond o leiaf y medrwch chi siecio bod y ffeithiau yn gywir. Bydd y clercod yn danfon hwnnw atoch chi. Ond, gyda hynny ychydig o eiriau, a allaf i ddiolch yn fawr iawn i chi i gyd am eich presenoldeb y bore yma? Diolch yn fawr iawn i chi. Fe allaf gyhoeddi i'r pwyllgor y bydd egwyl fer nawr, a byddwn yn ailgynnull am 10.15 a.m.

Dai Lloyd: Thank you. On that positive note, our time is at an end. So, may I thank you all for your written evidence and also for the wealth of oral evidence that we've received this morning? Thank you all very much. May I also announce that you will be sent a transcript of this meeting so you can check it for factual accuracy? You can't change your mind on anything you've said, but at least you can check that the facts are accurate. The clerks will forward that to you. With those few words, may I thank you all very much for your attendance this morning? Thank you. May I tell the committee that there will now be a short break and we will reconvene at 10.15 a.m.?

Gohiriwyd y cyfarfod rhwng 10:00 a 10:15.
The meeting adjourned between 10:00 and 10:15.

Ymchwiliad i Barodrwydd ar gyfer y Gaeaf 2016-17: Sesiwn Dystiolaeth gyda'r Byrddau Iechyd Lleol
Inquiry into Winter Preparedness 2016-17: Evidence Session with Local Health Boards

[96] **Dai Lloyd**: Croeso i sesiwn diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon, yma yn y Cynulliad. Hon ydy'r ail adran y bore yma, a'r rhan ddiweddaraf yn ein hymchwiliad ni i barodrwydd ar gyfer y gaeaf. Mae'r sesiwn dystiolaeth yma gyda byrddau iechyd lleol, ac mae'n bleser gen i wahodd a chroesawu i'r bwrdd yr Athro Adam Cairns, prif weithredwr Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro; Stephen Harrhy, cyfarwyddwr bwrdd y rhaglen gofal heb ei drefnu; a Vanessa Young, cyfarwyddwr Cydffederasiwn Gwasanaeth Iechyd Gwladol Cymru. Croeso i'r tri ohonoch chi.

Dai Lloyd: A very warm welcome to this latest session of the Health, Social Care and Sport committee, here at the National Assembly. This is our second evidence session this morning, and the latest part of our inquiry into winter preparedness. This evidence session will take place with the local health boards, and it's my pleasure to welcome to the table Professor Adam Cairns, chief executive of the Cardiff and Vale University Local Health Board; Stephen Harrhy, director of unscheduled care programme board; and Vanessa Young, director of the Welsh NHS Confederation. A very warm welcome to you all.

[97] Rydym ni i gyd wedi darllen y papurau gerbron mewn manylder, felly awn ni'n syth i gwestiynau, gyda'ch caniatâd. Gwnaf i ddechrau gyda'r cwestiwn cyntaf: yn gyffredinol, gan ein bod ni'n sôn am barodrwydd ar gyfer y gaeaf, a allaf i ofyn pa mor barod yw byrddau iechyd lleol i wynebu her gaeaf 2016-17? Beth yw'r prif bryderon, a sut y bydd y pryderon hyn yn cael eu rheoli? Nid ydw i'n gwybod pwy sydd

We've all read the papers submitted in great detail and, therefore, we will move immediately to questions, with your permission. I will start with the first question: in very general terms, as we are discussing winter preparedness this morning, can I ask you how ready the local health boards are to deal with the challenges of the winter of 2016-17? What are the key areas of concern, and how will these concerns be

eisiau dechrau—Vanessa.

managed? I don't know who'd like to start—Vanessa.

[98] **Vanessa Young:** Thank you. The health boards have prepared winter preparedness plans, and they've done that to cover the period October to May. In each case, the health board has worked with the Welsh ambulance service trust, and also with the local authorities in their area, and often also with third sector organisations. They, in preparing the plans, have looked at lessons learned from previous years, and have elements of the plan to deal with contingencies. But the major risks or challenges that they're facing in putting those together are numerous. The first is, really, around the ageing demographic—you'll all be very familiar with that, and that's not just a Welsh problem or phenomenon, it's facing most Western health economies, and that just increases the demand across the year. So, it's particularly, then, difficult when we enter the winter period, because there is this present increased demand all through the year.

[99] Finance and resources are also an ever-present issue for health boards, and we recognise the public finance constraints, which make it very difficult for us, but our members are trying to work to provide the services within the context of the resources that they have. In particular, challenges in the winter relate to workforce. Workforce is actually the most pressing challenge for health boards throughout the year but, actually, that's then exacerbated in the winter when there is an increase in demand, so trying to deal with how we meet that demand while we are already struggling with recruitment and retention issues is a challenge. The other challenge is around social care, and the provision of domiciliary, residential and nursing care and the capacity within certain areas of Wales is making that also difficult and leads to potentially delayed transfers of care. So, those are perhaps some of the most significant challenges facing us.

[100] **Dai Lloyd:** Diolch yn fawr. Awn ni i fanylder nawr yn y cwestiynau sydd yn dilyn. Mae cwestiwn Lynne wedi cael ei ateb—da iawn. Caroline, te.

Dai Lloyd: Thank you very much. We can dig into the detail in the questions that follow. Lynne's question's been answered. Caroline.

[101] **Caroline Jones:** Diolch, Chair. Good morning to you all. My question's in two parts. First of all, could you tell me if the pressures are becoming all-year-round, or are they showing seasonal variations? What are the pressures driving the increased demand?

[102] **Professor Cairns:** I'll make a start, if I may. Good morning.

[103] **Caroline Jones:** Certainly. Morning, Professor Cairns.

[104] **Professor Cairns:** We used to talk about winter being the time of peak demand but, actually, we do see peaks at different times of the year now, and actually winter isn't always necessarily the busiest period. In fact, last Easter was a very, very busy period for the NHS in Wales. I think part of the reason for that change is that we have, as Vanessa was already saying—. One of the successes of the health service is that we are able to keep people going, and people do accumulate more and more disease as they age, unfortunately, and there's a big issue for us about moving away from this reactive phase and emphasising much, much more how we can maintain people's health status, intervene proactively in managing those long-term conditions that people live with, and securing very rapid interventions when people's health status changes. Without that, I think what we're going to see is this demand bubble continuing to increase. So, for the health service, it is absolutely crucial that we build our community, primary and mental health infrastructure around the populations that we're serving and that we are doing everything that we can to keep people healthy, keep them well and only try and restrict, I suppose, access to hospital to those situations where that is the only option and get people home again as fast as we can.

[105] **Caroline Jones:** Thank you for that. To understand that increased demand, obviously, we need to have an overall picture. Communication between departments is of paramount importance and you have mentioned the link between the departments just now in your answer. So, can you tell me to what extent local health boards have involved the other key partners, such as local authorities, ambulance services and primary care and GPs, so that an overall picture can be put together and then we can combat whatever is the need—you know, supply and demand?

[106] **Professor Cairns:** The days when the NHS would look at those sorts of issues on its own are long gone. In every case, every health board is working very closely with its local authority partners and that's not an activity that's focused just around the winter—all health boards are working very closely with all of their partners, whether they're local authority partners or third sector partners. The system is also one where, within health boards—so, primary, mental health services, community services, secondary care services, and, in our case, tertiary services; all of those have got a

contribution to make. But, as you mentioned, the ambulance service plays a really critical role and Stephen is in an excellent position to advise the committee about how our engagement with the ambulance service has shifted over the last couple of years to a completely different place.

[107] **Mr Harrhy:** As well as being the director of the unscheduled care programme for Wales, I'm also the chief ambulance service commissioner for Wales. I know that you've taken evidence from the Welsh Ambulance Service NHS Trust—I think last week.

[108] **Dai Lloyd:** Last week, yes.

[109] **Mr Harrhy:** They would have talked to you about the commissioning arrangements and putting the patient at the centre of what we do and the five-step ambulance pathway model. That model is geared at making sure that, across each of the steps of that pathway, we're able to put alternatives in place other than admission to hospital.

[110] You asked about pressure on the system and it might be helpful just to give you a couple of maybe helpful facts and figures. So, in terms of admissions into A&E departments, we know, over the last five years, there's been a small—but, nevertheless, an increase in activity. If you look at the ambulance service, there's been slightly more of an increase in activity. Coming back to the emergency department, where we have seen the biggest rise is for patients over the age of 64. So, 65 and above, over the last five years, we've seen a 47 per cent increase, and then if you look at under-64s, there's been a decrease and the decrease has been in the order of 25 per cent. So, that won't be a surprise to any of us because we know we have an ageing population, but that's the pattern that's emerging.

[111] So, one of the things that's really important in that is that, earlier on in the pathway, we're able to put alternatives in place. So, one of those alternatives will be around 'hear and treat'. I know you would have taken evidence from WAST about that. We're able to measure that now; we have a comprehensive set of indicators, called 'ambulance quality indicators', which are able to measure this.

[112] What's also really important is that we've put alternative pathways in place. In terms of those alternative pathways, again, there's useful evidence in the system about that. We know, for example, that the greatest number of admissions into hospital would come through fallers. We know that the other

two largest presentations would be for individuals with breathing difficulties and individuals with chest pain. We know that now from the ambulance quality indicators, so we can start to look at how can we put alternatives in place.

[113] One other fact that, again, just may be helpful to you would be that we know that of all of the patients that come in via an ambulance and go into an emergency department, over 20 per cent of those don't need to stay in the department. They don't need to go into hospital. So, I think there's a fair amount for us to go at in terms of how we can put these alternatives in place to avoid patients unnecessarily coming into hospital. We know mental health patients, for example, don't need to come into a busy emergency department. They would be better off seen in the community by their practitioner in the community. So, there's scope for us to do things here to try and make sure that we're treating people in the right place, with the right quality of care.

[114] **Dai Lloyd:** Okay. Lynne.

[115] **Lynne Neagle:** Thank you, Chair. I was personally very reassured by the evidence we took last week from the ambulance service. However, we also took evidence from representatives of general practice who told us that they weren't being involved in planning for winter. What do you say to that?

[116] **Professor Cairns:** I can only comment on my own local health board. And my response to that would be that whilst I can't say that every single practice and every single GP would have been involved personally in every single conversation we've had, we have engaged fully with our cluster leads, our leadership around primary care, and it would be a very strange plan that we would be constructing without engaging with primary care. I don't know—I can't speak for the rest of Wales, but I do know that, within Cardiff, that is very much our approach. And as I say, if I was stepping back from the position we're in, and thinking ahead to the kinds of things that we're going to need to do more of, I'd think we' would have to build more resilience and sustainability in our general practice, primary care system. There are big pressures in primary care, and there are big challenges that we face in sustaining that part of our system. So, that's a really critical part of the work we need to do to make sure that in the future we're going to be in a good position.

[117] And then, hand in glove with that, the other key dimension—and,

again, primary care have a very important role to play in this—is in supporting, particularly older patients, and being able to surround primary care with enabling capacity that can proactively support people in their own home, or close to their own home. Those two things are a really critical part of the forward plan that we're constructing, because, without those, we simply won't have a system that works as it needs to.

[118] **Dai Lloyd:** Okay. Vanessa.

[119] **Ms Young:** Having seen the plans for each of the health boards, they do all contain an element around primary care and recognise the important role and the work that they are doing with primary care cluster leads, and with their own primary care leadership within the health boards. Just a couple of examples: in Cwm Taf there are cluster schemes around chronic conditions, in particular, focusing on how the clusters can support people with chronic conditions to keep them well. And they've also—and this is not just in Cwm Taf but more broadly—agreed joint pathways with the Welsh ambulance service for chronic conditions like falls, diabetes, where paramedics pass information to GPs and district nurses, so that they can be supported and not have the need to go into hospital. So, I hope that provides some reassurance.

[120] **Dai Lloyd:** Okay. Moving on to capacity, Angela's got a couple of questions.

[121] **Angela Burns:** Thank you. Thank you very much indeed for your paper—I found it really interesting—but I do have quite a lot of questions around the whole capacity and demand issue. I think what I'd like to perhaps start with is the previous evidence session, where we were told fairly clearly that there are lots of surges, obviously, throughout the entire system, but that one of the surges is actually trying to get people out of A&E and admitted into a hospital. So, with the focus on winter pressures, could you tell me if the whole winter pressure element is a distinct area within the integrated medium-term management plans, so that it's always on the horizon? Could you also please tell me whether or not—and Professor Cairns, I appreciate you can only answer for your own health board, but maybe, Vanessa, you might be able to pick up on the others—health boards are actually opening up some of their closed beds? I know, when I walk through the hospitals in my patch, there's always that dark corridor with lights off, empty wards and piled-up beds. If the reason for that is that they haven't—. I'll ask all my questions in one go; it'll annoy the Chair less. If you are

brilliant, I'd like to know how many, where and how that's happening. If the answer's 'no', has there been any discussion or thought about, perhaps, asking third sector providers, care homes, or whoever else, to perhaps use the NHS infrastructure of hospital building, heat, light, power and beds to operate step-down beds during the winter to alleviate those pressures?

10:30

[122] **Professor Cairns:** I'll make a quick start, and then I'll hand across to Vanessa. Just in terms of our own health board, one of the phenomena that we—. Let me start in a different place. So, first of all, capacity and demand is an all-year-round frame that we put around everything that we do. And, of course, our capacity isn't just for unscheduled care, we've also got lots of other patients who need treating, whether they are patients who need cancer treatments or other kinds of treatment. So, we take a 24/7, 12-month view of our capacity, and our integrated medium-term plans are shaped around what we expect to see right across a year, and then what we're forecasting for the next two years. So, that's the way in which we look at that.

[123] When we do that work in Cardiff, there are a couple of features of the Cardiff position that are important and that we do need to get ahead of. The first is that our population numbers are swelling. So, in Cardiff, five years from now, we'll have put 200,000 or so additional patients into the health board population. That's a big challenge for us. So, we've got to bear in mind what's happening to our population. The other phenomenon is the rise and rise of the numbers of very old and very frail people in our community. We've been doing quite a lot of thinking about what that means for us in terms of capacity. What we're now developing is a new response to that. So, we understand really quite well, in a lot of detail, the population of in-patients we have at any one time. We understand quite a lot of the detail of why they're in, what their current needs are and so on. And what we can see is that a lot of very frail and older people are staying in hospital longer than they want to and longer than we'd like them to.

[124] I think when you put that context together with something that Vanessa mentioned earlier, which is workforce, the reason why capacity isn't open, usually, is because we can't get the staff to run the capacity. So, one of the big challenges we're all facing for the winter in front of us is: can we recruit the numbers of, particularly, nurses, but not just nurses, to ensure that we have the capacity as we want it to be? So, linking those two thoughts together, for us, we're beginning to redesign our in-patient platform to

better reflect the needs of patients who are actually in those beds. One of the challenges is to shift, if you like, from the presumption—. People always imagine that patients in hospital are being actively treated for a sickness, a disease or an injury; actually, quite a lot of our population of patients are no longer in that phase of their journey. So, we've got an opportunity to re-think in what we describe as a graduated care model, better reflecting the needs of those patients with a different skill mix. So, there's quite a lot of moving parts in all of this, and the real challenge for demand and capacity management is to keep current, to keep on top of your numbers, to understand the dynamics of your system and to keep adapting the approach that you're making. And there are big challenges, as Vanessa was saying earlier on, particularly, I would say, this winter. There are big challenges around nurse staffing.

[125] **Angela Burns**: Professor Cairns, I take on board what you say, but one of the things I don't understand is that, when you look at anything, when you're looking at putting beds wherever it may be in the system, you're going to have enormous costs associated with it—and it's not just the workforce, but you actually need the building, the infrastructure, the heat, light, power, et cetera. It does strike me that when you have, predominantly I guess it would be the elderly or elderly and confused, who need to be moved through the system because they've come in for an issue that has now been resolved but they're still not well enough to go home, but local authorities don't have the capacity themselves—. These poor people have got to go somewhere. So, I just wonder if there's much thinking out of the box in terms of using your current infrastructure that could be sitting idle somewhere, and getting that third sector to come on board and look after those individuals, but it's not part of your key bit.

[126] **Professor Cairns**: Yes. So, I completely agree with you. So, as a commissioner, when I look at what we're currently commissioning, the question I'm asking is: in a sense we think we're commissioning secondary care in-patient provision, but actually, when you look at the detail of that, that's not really what we're getting. What we're getting is quite a lot of—I mean, the nearest proxy, probably, is nursing home care. So, our approach to this is to try to recommission that capacity, not necessarily from ourselves, but thinking more broadly, just as you're suggesting, actually, because I think the quality and number of older people, particularly in our in-patient bit of the system, is evolving quite quickly, and we need to change with it. That's very definitely part of our current thinking.

[127] **Angela Burns:** Because I did note again in your papers that you talk about the fragility of the private care sector, and the fact that the beds were shrinking there.

[128] If I could just make one, sort of, quick leap, because it's still under capacity and demand, and I know I'm eating up a lot of time: elective surgery. The *cri de coeur* that comes to me year after year after year in the winter from my constituents is that they've been postponed for their knees, their hips, their cataracts, or whatever because there are no beds, because they've all been taken up by A&E. A couple of winters ago—not last winter, but the winter before—I actually had a lot of input from consultants in specialisms that are elective surgery, saying, you know, 'This is crackers. We're not going to do anything till February or March', and essentially you've got highly powered people, incredibly expensive and very capable, standing—I won't use the word 'idle', but you know, not doing their prime task. So, what have you put in place to ensure that elective surgery doesn't take a hit because of the bed issues? Again, I refer back to our first session this morning: the A&E colleges were definitely saying that there is that surge of trying to get people out of A&E and into beds, so that's obviously going to—people are ending up on inappropriate wards for the condition that they've come in with.

[129] **Professor Cairns:** Again, I'll just speak for our health board. In terms of elective care, elective care is not all of the same. So, you've got patients who have non-urgent procedures that need to be done in a planned way, and then you have very urgent, critical patients who need to be done much more quickly. We've just completed the seventh consecutive quarter of delivering, quarter to quarter, to the last individual patient, our agreed pattern of activity for elective patients of all kinds. Our plan for the winter is essentially to make sure that we can maintain the treatment of very sick and urgent patients who are elective stream, and we'll do everything that we can to maintain the profile that we've planned to deliver for less urgent patients.

[130] We've put some counter-measures in in Cardiff that are helping to support particularly the big surgical programmes around cancer, for example. So, we've created something called the post-anaesthetic care unit. It's a slight step down from intensive care, but many of the patients who go through our hospital need intensive care support post surgery, and traditionally in winter that's been one of our constraints. So, we've put some counter-measures in there.

[131] I would say that our planning assumptions take a look back five years, and we're trying to shape our response around what we've seen in the last five years. I would suggest that we are due a big flu year. We hope it's not this year, and, of course, we're doing everything we can to make sure our staff are protected. But I think there will always be an extraordinary set of circumstances where we just, on a particular day, get over-topped, and therefore we have to make sure that patients are accommodated. But, in general, I think all health boards are trying to model through their capacity across the year, and wherever possible, ensuring that larger numbers of patients for elective care are moving through the system during periods when it's less busy.

[132] **Dai Lloyd**: Okay. Jayne.

[133] **Jayne Bryant**: Just quickly, thank you, you mentioned that workforce numbers are exacerbated in the winter period. I just wondered what the process is if there are nurses who are retiring or finishing. What is the process in terms of planning for that, really? Is there a delay in the time that a nurse says that they're leaving in advertising the job? Because I see that that could be, obviously, a problem, and made worse in the winter. Also, just quickly, you mention in your evidence tools that allow you to predict the specialty requirements, month to month. You say that

[134] 'Health Boards are developing a range of options that will be dependent on the staffing resource models available.'

[135] I just wondered what they were and if there were good practices available.

[136] **Ms Young**: In the plans that they're preparing for winter, each health board is also looking at workforce plans. So, each directorate within the health board will look forward and say, 'How are we going to manage our workforce over this period?' So, they're looking at things like how will the pressure be managed, what will the mitigations be, how will their workload be prioritised, what are the opportunities, for example, for short-term contracts, and maybe employing people in that way, and how are they going to staff surge capacity, so that if there is a surge in demand, how would they meet that. That includes reviewing things like annual leave, leaving dates and that sort of thing. So, they're trying to look at all aspects of the workforce to ensure the plan is as fit as it can be in terms of the risks that they're expecting to face.

[137] **Jayne Bryant:** What is the timescale between that? Is there a delay, would you say, in advertising jobs?

[138] **Professor Cairns:** In our health board, we've got a particular suite of measures that we always review—looking at the lead time to recruit, basically. We've got a plan; we call it our 95 per cent plan. We aim to be at 95 per cent of establishment all of the time, more if we can, with a minimum floor of 95 per cent. We're not there yet. Part of the reason we're not there yet is that we've got some particular hotspots where we're finding it very, very difficult to attract nurses to work in those bits of our system. Scrub nurses, for example, in theatres—that's a huge shortage for us. In some of our medical areas, where the perception—and, I think, probably, the reality—is that the work is very heavy and unremitting, we also find that we are not always able to have the numbers of nurses that we ideally like, which then goes back to changing the requirement for nurses by thinking differently about the way in which we organise, if you like, groups of patients in the hospital, which is where we are focusing now. So, I do think that this winter is going to be quite challenging from the staffing perspective, not because we're not trying, not because there's a delay, not because we're holding money back, not because we don't want to. It's simply because we simply haven't got the workforce presenting itself to us in the numbers that we need to cover all of the gaps that we've got.

[139] **Dai Lloyd:** Mae'r cwestiwn nesaf o dan ofal Rhun.

Dai Lloyd: The next question is from Rhun.

[140] **Rhun ap Iorwerth:** Bore da i chi. Os gallaf i ganolbwyntio ar y pwysau ar adrannau brys, rydych chi wedi sôn yn barod, Mr Harrhy, nad oes angen, o bosib, i lawer o bobl hŷn sy'n dod i mewn i'r adran frys aros o fewn yr adran frys ac y gellid eu symud nhw oddi yno ar fyrder. Pa fath o fodelau newydd—pa arloesi sy'n digwydd o fewn ein hadrannau brys ni er mwyn lleihau'r pwysau yna ar y rhan cwbl allweddol yna o'r system?

Rhun ap Iorwerth: A very good morning to you. If I could concentrate now on pressures on A&E services, Mr Harrhy, you've already mentioned the fact that many of the older people who come into A&E don't need to remain there and that they could be moved as a matter of urgency. What kind of new, innovative models are being considered within our A&E departments in order to reduce that pressure on that crucial part of the system?

[141] **Mr Harrhy:** A couple of things to say to that. The first would be that we are measuring the differentiation between minor illness and injury that comes into the ED department and major injury and illness that comes into the ED department. Across Wales, on average, about 70 per cent would be minor injury and illness and about 30 per cent would be the major injury or illness. So, one obvious area to go at would be the minor area and how can we put a protective resource into the minor area within the department to make sure that we are then protecting the major side of things. Within health board unscheduled care and winter plans, that is part and parcel of that plan.

[142] In terms of working with colleagues in community and primary care, it's making sure that we are putting capacity in community and primary care, through things like cluster funding and ICF funding, to say, 'Well, if their illness is a minor illness, did they really need to come into the department and how could we avoid them coming into the department in the first place?'

10:45

[143] The second big issue in the emergency department is releasing space within the hospital so that patients can get into the bed that they need to get into. That gets us to discharge. If we're not discharging the right number of patients on a daily basis, the system will block up. We can predict, broadly, the level of demand that's coming through the system. So, we'll know, again, on average, in a hospital in Wales—it will change from hospital to hospital—your average hospital, you'd have to discharge about 40 patients a day to stop the system blocking up. When patients are being discharged, they're either going to home-based care—and they might need a bit of domiciliary care support, so how are we working with social services to provide domiciliary care support? They might need some bed-based support, so, do they need to step down to community beds or to nursing and residential care, as Adam was describing? Or they might need some reablement support to enable them to get back to what is normal for them as quickly as we can. So, it's really important that we look at things from a whole-system point of view.

[144] We get two pinch points with that. The pinch points that we get are coming out of the ED into bed—and the other pinch point is discharge out of hospital. So, those are the points that the plans are concentrating on in terms of how we can make sure that we're putting the things in place that we are able to, within the constraints that we talked about, to make sure that we

get this flow through the system. So, it's that type of approach that we're adopting.

[145] **Rhun ap Iorwerth:** I'll ask you the same question again, but with a specific reference to winter. What might be different? How would the pinch points pinch a little bit more? How would your responses change due to pressures, even though we've established that there are different peaks there throughout the year, specifically in winter 2016-17?

[146] **Mr Harrhy:** Sometimes, we talk about surge capacity and we talk about our ability to put surge capacity in place. What we've done traditionally is we've put surge capacity into hospitals. So, we try to commission extra beds and that's becoming more difficult because of the staffing pressures that there are in the system—the available staff within the system.

[147] What we're looking to do this year is to say, 'How can we put capacity in other parts of the system?' So, can we be proactive and work with residential and nursing homes and purchase additional care where there is capacity there? Through ICF funding, how are we able to support more reablement teams, to make sure that we are able to put resources in so that patients can step down? I think it's also about having an honest conversation with patients when they're coming into hospital, to say, 'We're trying to get you out of hospital within this timescale. This is what we're going to be doing; these are the steps that we're going to be taking to enable you to get out of hospital'. So, we redouble our efforts on those areas.

[148] **Professor Cairns:** One other specific pinch point that is definitely a feature of winter that we don't see at other times of the year is norovirus, which is a virus that we do see in the winter months. The challenge that that presents to us is that, in order to protect patients, we need to make sure that the risk of cross-infection is minimised. That tends to mean closing capacity down so that we can isolate those patients. Thinking that through, one of the counter-measures that we're developing in Cardiff is to try and avoid, if we can, funnelling patients with norovirus into the hospital system, which means supporting patients at home or in the nursing homes, very actively. It's not always possible, because sometimes, these patients do need very active intervention and support because of their condition. But if you're looking for an example of a specific pinch point that happens at winter and no other time, I think norovirus would be a good example of that.

[149] **Rhun ap Iorwerth:** Okay. Again, keeping people away from hospital is

the key. Maximising the use of the clinical skills that you have is key. Is there any redeployment or a difference in the use of your clinical staff during those surge periods over winter that perhaps wouldn't be sustainable on a month-by-month period, but actually, you have to move into an emergency mode, which alters the way that you would deal with winter pressures?

[150] **Professor Cairns:** Yes. I think when we're under the most pressure, we've all got plans to react to those situations, and there are various stages of contingency that you move through. An example of that might be that we might take a view that, selectively, some outpatient activity might cease and we can redirect those resources perhaps to engaging with the front end of our system, making sure that patients are safe there and are being assessed. Is that the kind of thing that you were—?

[151] **Rhun ap Iorwerth:** Yes. That's what we're trying to avoid, of course, because the cancellation of treatment is one of the issues that are raised. I'm not suggesting this, but some might think that that response from you has become the norm—there are pressures, therefore we cancel operations. Well, if you know that you're going to have to cancel operations because of winter pressures, surely you should be planning to not have to cancel.

[152] **Professor Cairns:** Yes, indeed. Absolutely. I suppose what I was responding to was when—. We have a plan, and that plan should allow us to operate within the tolerances that we've set to ensure that we can manage the elective activity and the unscheduled care activity. I suppose what I'm talking about is, if we move to a position where we're outside of those tolerances, we're beyond what we were expecting reasonably to happen. Under those circumstances we must react, and clearly we do. Thinking about how we are shifting roles within the expected plan, there are good examples. So, for instance, we've commissioned 14 beds in nursing homes on a discharge-to-assess model. That means that patients who we suspect are quite likely to be able to manage outside of hospital don't need to complete their assessment process. Some of the staff that would have been doing that in the hospital are moving out into the nursing home environments that we've created so that they can complete those assessments not in the hospital setting but in a nursing home setting.

[153] We do move people around between teams as part of our thinking. So, for example, in our community resource teams—the people who are out there to try and keep people healthy and manage the preventative part of our programme—we'll be shifting boundaries between those teams, depending

on what the shape of the demand looks like. So, rather more occupational therapy, rather less physiotherapy, rather more social care, rather less healthcare, just depending on those circumstances. So, we do take a very—. We have a plan. I can't remember who it was that said this, but no plan survives contact with the enemy. I think there is something about—. You can have a plan that's a framework, but then you've got to be on top of it all the time consistently, and you've got to be able to respond in real time to what's happening in front of you.

[154] **Dai Lloyd:** Vanessa, do you want to come in?

[155] **Ms Young:** Yes. There are a number of examples in health boards where they have put in place additional arrangements within their plan—things like increasing the hours of the acute physicians. In Cwm Taf, they're looking at implementing an integration of health and social care in the emergency department to then work right through the pathway to say how they can support one another. In the ambulance service, you've got advanced paramedic practitioners who are working with patients, and hopefully avoiding even the need to take them to hospital by being able to redirect them to another health service. There are also, in the plans, arrangements to target potentially high-volume care homes—where we see a lot of admissions from particular care homes and whatever—to work with them to try and avoid admissions in the first place. So, there's a range of work going on across health boards to do that, but as Adam says, it's within a range of tolerance. If we have a very severe winter, if we have a flu outbreak, it may be that those arrangements do need to be changed. In health boards, they have winter pressures groups that meet weekly, or two-weekly, with all of the partners so that that plan can be reviewed, updated and amended. Within the hospitals themselves, the availability and use of data to understand what's happening to patient flows is also critical during the course of the day. So, all of those things are being considered and the plans being adapted as they need to be.

[156] **Mr Harrhy:** I'm a director in Cwm Taf health board, and I can give you a couple of very practical examples of what that health board is doing. One is: in terms of working with social services, we would place a social worker in the main district general hospitals, and also in the community hospitals. That enables us to speed up the process. The other thing we do is that we hold daily patient huddles. So, every day, you will have a look at what patients we've got in the system and who needs to do what to make sure that that patient can go to where they need to go. If that means that we need to

refocus our resources and people need to be doing different things than they otherwise would've planned to do, we do that, but that's a moveable feast—we have to do that on a day-by-day basis as the pressure builds up in the system. So, we hold these daily patient huddles as well.

[157] I think that there's a very valid point you're making, though, around, as we move to more of a skills-based workforce, how we can make sure that we're transferring those skills across the system. We need to understand the system properly to enable us to do that, to make sure that the law of unintended consequences doesn't apply. But you're right: that's something that we need to make sure that we're doing and we're being agile on.

[158] **Dai Lloyd:** Okay. Moving on—Dawn.

[159] **Dawn Bowden:** Thank you, Chair. Following on from some of the questions that Rhun put to you, I notice that, Vanessa in particular, and Steven, actually, you've referred to a number of examples that seem to relate to Cwm Taf Local Health Board, which I'm delighted about because it's in my constituency. I speak regularly to the chair and the chief executive of Cwm Taf, and there seems to be some really good innovative stuff going on there that's making a real difference in terms of things like ambulance handover, for instance, the time that that's taking and the impact, the different approach they're taking to accident and emergency admissions and moving acute medicine to front of house and so on.

[160] My question, really, is a simple one, I guess, that maybe none of you can answer, but it does seem to me, as a non-health professional who sits and listens to all of this, that where there are instances of good practice that actually deliver results, why do we still continue to do seven or eight different things in different health boards? Actually, we could say, 'We know that there's a health board, or two health boards'—because I know, Adam, in your patch there's some really good stuff going on as well—and those good examples could be rolled out, piloted or tried elsewhere, rather than reinventing failure, if you like. I just wonder what discussions you have either as a confederation or as chief executives of health boards. How much do you actually talk to each other about the successful work that you're doing and why isn't there more collaborative working or sharing of experiences to make sure that those good practices are followed through everywhere?

[161] **Dai Lloyd:** Okay. Vanessa.

[162] **Ms Young**: Certainly, one of the roles of the confederation is to bring to the attention of the leadership the examples of good practice, not just in Wales but more broadly. So, we look at what's happening across the rest of the UK and in other healthcare systems. We do support chief executives and chairs, who come together regularly, and the medical directors—all of the executive directors of health boards do come together, and part of the work that they do when they're together is look at those examples and say how they could be either scaled up or replicated elsewhere.

[163] A couple of things—there are some good examples where we've done that quite well, but there are also differences between health boards in terms of some of the challenges they face. So, sometimes, it may be that the principles of a model are accepted, but with the actual implementation or delivery of those it may be more appropriate to do it in a slightly different way, depending on whether it's a rural health board, whether it's an urban health board and what the particular challenges of the population might be.

[164] You will be aware that, yesterday, the 111 service was launched as a pilot down in Abertawe Bro Morgannwg University Local Health Board, starting with Neath Port Talbot and Bridgend. That's an example where, as I say, it is a pilot. Depending on the success of that, which we are optimistic about, it's a clinical model that, basically, gives the public one number to be able to access out-of-hours and NHS Direct services, and it is based on a clinical model. If that is successful, which we hope it will be, it will be rolled out across the whole of Wales. So, there are examples where we do things at scale.

11:00

[165] In terms of digital technology, we have the Welsh community care information system, which is a system that covers both health boards and local authority social care. That's something that's being rolled out across the whole of Wales too. So, there are good examples, but there is more to go at, certainly, and that's part of our role in the confederation—to help health boards understand and identify that good practice.

[166] **Dai Lloyd**: Okay, very good. Julie, you were next.

[167] **Julie Morgan**: Thank you. Good morning. I just wanted to get a clearer picture about the delayed transfers of care. I wondered if, Vanessa, you could give an indication about how this is playing out over all the LHBs, and

perhaps, Adam, you could say what the exact position is in this LHB at the moment.

[168] **Ms Young:** Yes. In terms of delayed transfers of care, it is something that is considered a high priority within health boards not just over winter, but throughout the course of the year. I think it's fair to say, over recent years, a huge amount has been done to work with local authorities to put in place arrangements that help to support smooth discharge.

[169] Some examples of that are things like discharge lounges that have been put in place in some hospitals and the planning that goes on between social services departments and the health boards themselves to understand the individual patient cases. Another initiative is to have multidisciplinary board rounds, where you have all the people involved in the individual's care so that you can actually make changes to the arrangements as somebody is going through the hospital, to ensure that they're ready to leave hospital and that the services are available in the community or at home to enable them to go out.

[170] In some health boards, they have put in place arrangements around things like rapid response in the community, so, if somebody rings and needs something, they can respond within four hours. In some, they're also working with third sector organisations, for example, to help transport patients and settle them in when they get home. That sounds quite a simple thing, but that can be really effective in helping people to come out of hospital and make sure that they have what they need.

[171] Reablement is another area where we've seen an increase—reablement services—supported in particular by the ICF funding, and there's more that could be done on that. That comes back to what I said at the beginning, about the overall pressure on finances. If there was more money available, we could do more.

[172] Up in north Wales, if you look at the Prestatyn health centre, there's a model of care there where they're looking at minor injuries, they're looking at elective capacity for chronic conditions and they're also looking at domiciliary care services too, all within one community model. All of that is designed to help people, not only to prevent them from going into hospital but also to provide services to them so that hopefully they can come out of hospital as soon as they're fit to do so.

[173] **Julie Morgan**: Can you give any estimates? How many people are waiting in hospital, over Wales—a rough sort of idea—who aren't able to go home at the moment, who are in hospital but they don't need to be?

[174] **Ms Young**: I haven't got those figures—perhaps Stephen can help.

[175] **Mr Harrhy**: I can help on that. If we look at, say, the end of June—at the end of June, it was about 480.

[176] **Julie Morgan**: Who could be at home but who were still in hospital.

[177] **Mr Harrhy**: They were the number of delayed transfers of care that we had in the system. Of those, about 50 per cent were waiting to go into community or rehab. About 25 per cent were needing some mental health support. The remaining 25 per cent had acute problems that needed specialist packages of care at home. The other thing that is in the system, and which has just come into the system this last week and which is going to be helpful, is that a discharge audit has taken place across the major hospital sites across Wales. So, that's going to be helpful to us now in terms of getting into that information, coming up with practical and quick solutions based on things that we've been doing before. We've made reference to 'Passing the Baton' in the evidence that we've provided for you. I think making sure that we're keeping that at the forefront of our minds and that we're keeping that good practice that is identified in 'Passing the Baton' is going to be important to us. What we do need to understand is that we have got some capacity issues in the system. So, we're always doing that balancing act. There is more that we can go at. We can't eliminate those figures totally, but there is work that we can go at and we try to do that on a targeted basis now, using 'Passing the Baton', looking at the information in the system and looking at some practical suggestions that come through audits and work that all health boards will be undertaking.

[178] **Julie Morgan**: So, you can't eliminate it, but you can bring it down considerably.

[179] **Mr Harrhy**: I think it can come down. I wouldn't be in a position to tell you, 'I think it could come down to this level', because we still need to understand how much of that benefit we can realise, but there is potential for it to come down, yes.

[180] **Julie Morgan**: What about Cardiff and the Vale? Any insights?

[181] **Professor Cairns:** I haven't got today's numbers, but it'll be in the high 70s. It's been declining slowly over the last year. We have the odd month where it doesn't decline but goes up a little bit. It's still far too many. In the context of our health board, we are reducing the number of over-65s who get admitted to hospital and we're reducing the number of people being admitted with long-term conditions. Part of our challenge relates to capacity in domiciliary care and nursing homes. In Cardiff, there are some big commissioning challenges for us in that arena. We're fully engaged with our local authority partners. They are very supportive and are working very hard to help us to secure a better position.

[182] I'd also say that, although we've focused on the formal delayed transfers of care, I think there's a much larger group of patients who we need, frankly, to be doing a better job for. There is an opportunity, as Stephen was saying, to influence the speed and precision with which we're managing our discharges. There is a feedback loop here, because, if we get into a position where staffing is a challenge for us in some of our medical wards, particularly, understandably nurses tend to prioritise the hands-on care activities that they need to deliver to the patients there and then, and it can be the case that some of the detail that needs to be done to move patients' discharge processes along isn't actually attended to with the same degree of focus that we would like. So, we've got to make sure that all of these bits of the system are orientated to secure the right outcomes for our patients. Certainly for Cardiff, in the next three months, I'm directing our chief operating officer exclusively—without any other responsibility—to look at this discharge challenge that we're facing and to reform our discharge approach. So, that's a key part of securing the capacity that we need for this winter.

[183] **Dai Lloyd:** Okay—

[184] **Julie Morgan:** I just want to ask about the flu vaccination.

[185] **Dai Lloyd:** All right, that'll take care of Dawn's last question then.

[186] **Julie Morgan:** Sorry, I misunderstood. I thought I was—

[187] **Dai Lloyd:** No, Julie, carry on.

[188] **Julie Morgan:** I just wondered if you could say how many of your staff

have had the flu vaccination or have had it in past years and whether the number is going up.

[189] **Professor Cairns:** We aim to get at least half of our staff vaccinated. We fell short of that last year. It was very disappointing. So, we've been looking at how we can improve that. We've run an experiment in our midwifery service and we recruited a midwife to lead that work last year. She's just been reporting back all of her experience. In that group, we saw a 25 per cent increase in the number of people vaccinated and, as importantly, a similar percentage increase in the number of mothers who were vaccinated against flu. There's a lot of learning for us in what that individual was able to achieve. So, that process, in fact, is something that we're talking about next week across the clinical boards that we work with, because I think it is about influencing people at a peer level. I'd quite like to be able to just issue a memo and for it all to get done, but, unfortunately, it's all about individuals, and people are free to choose. So, it is about how we make sure that people are appropriately influenced by their peers. I think that's the key.

[190] **Julie Morgan:** Fifty per cent amongst health professionals does seem low.

[191] **Professor Cairns:** I agree.

[192] **Julie Morgan:** When you think of the consequences of them passing on the flu. It just seems unambitious really.

[193] **Professor Cairns:** I'm disappointed that we're aren't able to drive that much, much higher. I think it falls just short of something that people regard as being unprofessional conduct. But I do think, given the vulnerability of the patients we're looking after, I think every member of staff has responsibility to protect themselves and their family but, most importantly, the patients they're serving, and that's the message that we're driving home as hard as we can.

[194] **Julie Morgan:** But why don't they? That's what I don't understand.

[195] **Professor Cairns:** Lots of reasons. Some of it is because people aren't acquainted with the evidence. There is a perception that the flu vaccination isn't as effective as it actually is. There is a misperception about the evidence base. There's also a misperception about the complications that you allegedly acquire having had the flu vaccination. There is quite a lot

misperception out there unfortunately. Some of it is about whether or not they're able to access the opportunity easily enough. So, one obvious counter-measure to that is to take the injectors to wards and departments and places where people work, which is what we're doing. And we're role-modelling it, as you would expect us to, very clearly. I'm hoping that, this winter, we will see a marked improvement in the number of people who we are able to say have been vaccinated.

[196] **Dai Lloyd**: Okay. Lynne, did you want the final question?

[197] **Lynne Neagle**: Yes, it was on this actually. You've said that there's a responsibility on staff, and the previous health Minister also made that clear that this was a responsibility. It does sound to me like you are taking steps, but you're also saying that this is a personal choice. Do you think you could be doing more to actually say to your staff that, as a health board, you believe this is a responsibility that they should all be doing?

[198] **Professor Cairns**: We have had lots of discussions about how to shape this response. There are hospitals in the United States that say it's an absolutely free choice for staff but, if you don't vaccine yourself, you must wear a face mask at all times. There's no evidence that makes any difference, by the way, but it's creating something that's a bit of a pain point for staff. We've thought about that. There are all sorts of practical difficulties with doing something like that. How do we know who's had the vaccination and so on and so forth? So, our whole focus at the moment is on taking what we understand has been successful in midwifery—and it really has been successful. We got 80 per cent of staff vaccinated in midwifery, and for our mums, I think we got it up to about 65 or 70 per cent—really good numbers. The learning from that is something that we're going to be pushing right across our system. It is about local peers influencing their colleagues and making it easy to get access to vaccination. This peer pressure is what appears to have done the job in midwifery, so we're going to follow that this year and see where it takes us.

[199] **Dai Lloyd**: Diolch yn fawr. Mae'r sesiwn ar ben. A allaf i ddiolch yn fawr iawn i'r tri thyst? Er mwyn y record, fe wnaf gofnodi eich enwau unwaith eto: yr Athro Adam Cairns, Stephen Harrhy a Vanessa Young, cyfarwyddwr Cydffederasiwn GIG **Dai Lloyd**: Thank you very much. That draws our session to a close. May I thank our three witnesses? For the record, I will just name you again: Professor Adam Cairns, Stephen Harrhy and Vanessa Young, director of the Welsh NHS Confederation.

Cymru. Diolch i chi'ch tri am y dystiolaeth ysgrifenedig ymlaen llaw a hefyd am y dystiolaeth ar lafar nawr. Diolch yn fawr iawn i chi. A allaf i jest gyhoeddi hefyd y byddwch chi'n derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau bod beth rydych chi wedi'i ddweud yn ffeithiol gywir? Ni fedrwch newid eich meddwl am ddim byd, ond fe fedrwch o leiaf gadarnhau bod y ffeithiau'n gywir. Diolch yn fawr iawn i chi.

Thank you all very much for your written evidence and also for the oral evidence that you've just provided. Thank you very much. May I also just tell you that you will receive a transcript of this meeting so that you can check it for factual accuracy? You can't change your mind on any of the issues that you've covered, but you can just check for factual accuracy. Thank you very much.

[200] Er mwyn yr Aelodau—byddwn yn mynd i mewn yn syth i'r sesiwn nesaf gyda'r Coleg Nyrsio Brenhinol pan fyddan nhw'n dod i mewn i'r ystafell.

Members—we will move immediately to our next session with the Royal College of Nursing when they arrive.

11:14

Ymchwiliad i Barodrwydd ar gyfer y Gaeaf 2016-17: Sesiwn Dystiolaeth gyda'r Coleg Nyrsio Brenhinol
Inquiry into Winter Preparedness 2016-17—: Evidence Session with the Royal College of Nursing

[201] **Dai Lloyd**: Reit, bwyllgor, fe wnawn ni ailymgynnull a symud ymlaen i eitem 4 ar yr agenda, gan gario ymlaen â'n hymchwiliad i barodrwydd ar gyfer y gaeaf. Mae'r sesiwn dystiolaeth yma yn cael ei chynnal â'r Coleg Nyrsio Brenhinol. Mae'n bleser gennyf groesawu Gaynor Jones, cadeirydd bwrdd Cymru y Coleg Nyrsio Brenhinol, a hefyd Lisa Turnbull, sydd efallai wedi bod yma o'r blaen, cynghorydd polisi a materion cyhoeddus Coleg Nyrsio Brenhinol Cymru. Rydym wedi derbyn

Dai Lloyd: Okay, committee, we will reconvene and move on to item 4 on our agenda, continuing with our inquiry into winter preparedness. This next evidence session is with the Royal College of Nursing. It's a great pleasure to welcome Gaynor Jones, chair of the RCN Welsh board and also Lisa Turnbull, who may have been here before, the RCN Wales policy and public affairs adviser. We have received your written evidence. Therefore, following what's become a tradition now, we'll move

eich adroddiad ysgrifenedig gerbron. Felly, yn dilyn ein traddodiad, rydym nawr yn mynd yn syth i mewn i'r cwestiynau. Fe wnaf i ddechrau gyda'r cwestiwn cyffredinol cyntaf, ond mae yna ddigon o amser wedyn i Aelodau fynd i mewn i fanylder. Felly, gan fod yr ymchwiliad yma ar barodrwydd cyffredinol ar gyfer y gaeaf, a gaf i ofyn i chi pa mor barod ydy'r byrddau iechyd lleol a'r gwasanaethau nyrsio i wynebu her gaeaf 2016-17 yn eich tyb chi?

immediately to questions. I will begin with a very general question, but there'll be plenty of time for Members then to dig down into the detail a little later on. As this is an inquiry on preparedness generally for the winter, perhaps I could start by asking you how prepared the local health boards and nursing services are to deal with the challenges of the winter of 2016-17 in your view?

11:15

[202] **Ms Turnbull**: We think there are likely to be difficulties. I think we said in our written evidence that we feel that these are a reflection of the fact that there are real pressures in the system all year round. While, as we've heard in the last session there, there are very reasonable issues with patterns of illness that may increase demand at that period, the actual impact of what's happening is actually an all-year-round pressure. So, it's a result of the fact that there's a lack of capacity in terms of workforce, and in terms of the system and skills in the right place, which happens all through the year. I don't know if you'd like to add anything.

[203] **Ms Jones**: No, I would just reiterate what Lisa has said. Although the pressures do increase throughout the winter, we do have year-round pressures, which are very difficult to plan for, because it's very difficult to know how many patients are going to come through the doors.

[204] **Dai Lloyd**: Fe wnawn ni drio llusgo allan rhai manylion. Nawr, Lynne sydd â'r cwestiwn nesaf.

Dai Lloyd: We'll try to dig into the detail now. Lynne has the next question.

[205] **Lynne Neagle**: Thanks, Chair. Thank you for your paper as well. Can you tell us what specifically you're concerned about? For example, in your paper, you refer to 'Emergency Care—A Call for Action 2009', and you say that you don't feel that a lot of those recommendations have been implemented. Can you give us some specific detail on where you feel that hasn't been done?

[206] **Ms Turnbull:** One of our main concerns is actually about capacity in the community nursing service. That has not been expanded in the way that we would have liked to have seen, and in fact, actually, it's declined. And there are some very specific issues there. One is about the more senior level of nurses in the community—the amount of those, particularly district nurses, with very particular skills. Another area would be—. And there is also then—. That follows into a pressure into the independent sector, particularly in care homes, where we know now that the really sharp recruitment and retention crisis in nursing in that care home sector then causes problems with what capacity they have to offer nursing care beds. And there is also an issue in terms of the primary care skill set, where people can actually see, treat and advise on minor illnesses when people need that, so that they don't impact on the acute sector. So, those are, kind of, the three sort of major areas outside the hospital, where we feel there hasn't been the investment in the numbers and the skills that would actually help the situation.

[207] **Lynne Neagle:** And are those pressures across Wales, or do you think there are, sort of, any hotspots anywhere that we should be aware of?

[208] **Ms Turnbull:** I'd say they were across Wales.

[209] **Ms Jones:** Across Wales.

[210] **Ms Turnbull:** Everywhere, yes.

[211] **Dai Lloyd:** Okay. Jane.

[212] **Jane Bryant:** Thank you, Chair. We heard last week from a representative of GPs about, perhaps, the lack of involvement they felt they've had with winter preparedness measures. I just wondered how actively involved nurses have been in any preparations. How do you feel that's gone this year?

[213] **Ms Turnbull:** At a national level, the Royal College of Nursing has involvement in several groups with the Welsh Government that would look towards planning. So, for example, particularly around, say, flu preparations. I don't know if you want to say something about how locally the unions and professional bodies are involved.

[214] **Ms Jones:** I suppose I can only speak from my own health board

perspective, which is Cwm Taf, and, obviously, we are really pushing for staff to have the flu vaccine, whether they're clinical or non-clinical. Nurses are, at a higher level, involved in planning and looking at where we can create capacity, how we can move patients who maybe don't need acute care out into our community hospitals for discharge planning, and how we can speed along so that we can free up capacity in the district general hospitals ready for the winter.

[215] **Dai Lloyd:** Ocê. Rhun nesaf.

Dai Lloyd: Okay. Rhun next.

[216] **Rhun ap Iorwerth:** Bore da i chi. Os caf i edrych yn benodol ar y gweithlu o fewn gofal sylfaenol, mi fyddwch chi'n dweud nad oes digon o gapasiti, ond a wnewch chi wneud sylw ehangach ynglŷn â'r lefelau o gapasiti sydd yna o ran nyrsio mewn gofal sylfaenol, ar y gwahanol haenau a'r gwahanol sgiliau sydd yna o fewn y maes hwnnw?

Rhun ap Iorwerth: Good morning to you. If I may look specifically at the workforce within primary care, you will say that there isn't sufficient capacity, but can you give us a broader comment on the levels of capacity that exist in terms of primary care nursing, at the different levels and the different skill sets that there are in that area?

[217] **Ms Turnbull:** There are several specific issues around primary care, really. One is around access to primary care. We still tend to talk, for example, about out of hours, and when you stop and actually think about that for a moment, that's really quite an old-fashioned concept, because the whole idea that nine to five is when care is delivered and out of that is 'out of hours' is a very old-fashioned approach in general.

[218] There is a limit to how far, I think, you can educate, push and try and encourage people to seek assistance from a specific model without realising that, perhaps, the issue is you need to change that model. So, there are some issues with access to that kind of primary care. There are issues, we know, with literally how many GPs are available. We have been saying for a long time that there are a lot of innovative ways that we could supplement that system of primary care, using advanced nursing skills and extended nursing skills and using salaried practitioners, including salaried medical practitioners. So, there are real problems with how the general public accesses that system of primary care, how it's perceived as accessible, and, when you are in that system, what can be seen and done. So, if you're not seeing a GP and you are seeing a nurse, an important question, for example, might be: how prevalent is, say, independent prescribing in that particular

area? What can the community nursing team, perhaps, for example, who are visiting you, do? If there is a limit to what they are able to do, then, obviously, the only alternative, really, that people have got is to try and go for the hospital admission, if there is nothing else available in that system. So, it is about all of those different types of healthcare professionals being skilled up and having sufficient numbers of them in order to prevent that kind of pressure on that A&E admission route, which then can cause so many difficulties in terms of the system.

[219] **Rhun ap Iorwerth**: Os ydych chi'n edrych ar y data, mae'r data gan StatsWales yn dangos bod niferoedd y nyrsys sy'n gweithio yn y gymuned wedi cynyddu, o ryw 3,500 i bron i 4,000 dros y pedair blynedd diwethaf. Ond, wrth gwrs, yn y cyfnod hwnnw, mae nifer y nyrsys ardal wedi gostwng yn sylweddol, tra bo pwysau gwaith wedi cynyddu. A oes angen rhagor o eglurder ynglŷn â'r data fel ein bod ni'n gwybod yn well beth ydy'r pwysau ar nyrsio o fewn y gymuned?

Rhun ap Iorwerth: If you look at the data, the data by StatsWales show that the numbers of nurses working in the community has increased from some 3,500 to some 4,000 over the past four years. But, of course, during that period, the number of district nurses has decreased substantially, while workload has increased. Do we need further clarity about the data so that we know better where the pressures on nursing within the community lie?

[220] **Ms Turnbull**: Absolutely, a key concern for us is the lack of information that we have on activity and also outcomes in the community sector. Increasingly, over the last 10 years, we've seen—and rightly so, it's a move we would support—more public money on healthcare in the community as opposed to the traditional acute sector. So, more people are being cared for, we know that, and we also know that there are more people being cared for with more complex needs, and more staff are then being moved into the community to care for them. But we don't know how many or at what level. So, it's very difficult, then, when you're just looking and, as you say, we can see this number's gone up and this number's gone down, but we don't know the level of complexity of the patients they're looking after. So, it makes it very difficult to workforce plan. It certainly makes it very difficult when you're talking about what we were just suggesting there, which is around the skill level and the experience of those people in the community so we can actually say, to answer the earlier question about whether it's a national issue or a local issue, maybe we can actually look at where best practice is and say, 'Well, here is an area where they have this number of people with this

number of skills, and look at what the outcomes for the patients have been. Let's look across here and make that comparison.' So there is a real problem.

[221] **Rhun ap Iorwerth:** You wanted to come in there as well.

[222] **Ms Jones:** Yes, can I just clarify that there is a difference between a district nurse and a community nurse?

[223] **Rhun ap Iorwerth:** Exactly.

[224] **Ms Jones:** A district nurse holds a recognised, recordable qualification, a community nurse is a community staff nurse who doesn't need to hold that qualification. So, most health boards, while increasing the number of band 5 community nurses, haven't really got the registered district nurses that they need also to keep that service running, because the community nurse would work under the direction of a registered district nurse.

[225] **Rhun ap Iorwerth:** And are they hiding behind the total number of community nurses?

[226] **Ms Jones:** I don't think so. The community nurses, along with the community healthcare support workers, are a very important part of the team. You don't need somebody with a district nursing qualification to deliver all the care to patients out in the community. They would go out and they would set the plan for that patient, and then they would evaluate it at the end. But the community staff nurse and the healthcare support worker could deliver the actual care.

[227] **Rhun ap Iorwerth:** If I can just move on, we're focusing on winter in particular, so, if we have a shortage of district nurses, if there's something not quite right in the balance there, perhaps, or the numbers being trained for those roles, what difference is that making during those peak, surge periods of winter?

[228] **Ms Turnbull:** If you have a population that is, for example, quite frail, whether they're unwell, they're—by no means all, but possibly we're talking here about the older population. If you're talking about their heating isn't on, and people are cold, people are perhaps not eating very well, they're unwell anyway, then that's likely to escalate. So, their condition may deteriorate, but also, if you then have people who are responsible for that care who do not have the right clinical supervision, the right level of experience or the ability

to provide what that patient needs, whether that's a prescription, whether that's some kind of decision on assessment of their condition, then the right and proper thing to do is to escalate. So, the escalation then may lead a hospital admission. It may be that what's actually needed is a slightly greater package of care at that time. It may be that somebody needs to make an assessment or make a decision, or some kind of treatment needs to be provided there. But, if that can't happen, then there is a hospital admission. So, that will possibly increase then the rate of hospital admissions, which then increases the pressure on the system in terms of what they're dealing with. So, that is the impact of not having the appropriate community nursing service.

[229] **Rhun ap Iorwerth:** And is there evidence that that is happening?

[230] **Ms Turnbull:** Yes, and I think the evidence is things like delayed discharges, because, you know, again—

[231] **Rhun ap Iorwerth:** But is there evidence to trace that back down to, for example, a lack of district nurses in certain areas?

[232] **Ms Turnbull:** Oh, I see what you're saying. I think part of what we're calling for, actually, is greater numbers of data and information in the community so we can more clearly see that pattern. Certainly, obviously, in our membership we have community nurses, and that is what they're reporting to us. I think it's fair to say that everybody in the system would agree that that is an issue, but it would be absolutely very useful to see more clearly the relationship in terms of the number of patients that are being looked after by a particular team.

[233] **Rhun ap Iorwerth:** That's very, very useful. One last associated question: should guidance on safe staffing levels also apply in that context?

[234] **Ms Turnbull:** Yes. In order to do that, we do need a lot more work and information about the things that you've just described.

[235] **Rhun ap Iorwerth:** Thank you.

[236] **Dai Lloyd:** Hmm. Right. Jayne.

[237] **Jayne Bryant:** I think my question was answered, actually—

[238] **Dai Lloyd**: Yes, we've had very full and comprehensive answers, as well as some creeping and crawling on the questioners. Julie.

[239] **Julie Morgan**: Just to say that, as you well know, the safe staffing legislation was passed, so what effect do you think that will have on the nurse workforce generally?

[240] **Ms Turnbull**: Well, obviously what we are looking for is we're looking for improved outcomes for the patients as a result of the staffing. But clearly there will be an impact on the workforce. For example, in a previous session, one of the pieces of evidence given was around the difficulty of recruiting nurses because people will know that that is 12-hour shifts with very difficult circumstances where people are being put into situations where they are not delivering the care they want to give. And that's what nurses want to do. So, no-one is going to be enamoured of applying for those kind of positions if those conditions are very poor. So, obviously one of the impacts that we're hoping for is that, by allowing nurses to give the care that they are educated to provide, that best care, that will improve workforce recruitment and retention. So, that's certainly an outcome that we would be looking to see.

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

[242] **Dawn Bowden**: Yes. Thank you. It's kind of following up on the whole question of workforce planning and skill mix, the NHS workforce review, and all of those kind of things, and, in particular, whether you feel that there is enough clarity around the role that registered nurses and unregistered nurses would have to undertake—particularly in relation to preparing us for winter pressures now—whether there is enough clarity around who does what, whether—. Because, let's face it, winter pressures come every year, so it's not as though this is something that nobody should be prepared for.

11:30

[243] So, what involvement has there been from yourselves with the health boards around the workforce planning for it and has that workforce planning taken into account the different types of nurse roles that would be needed to get us through these pressures? A final point around that is in terms of recruitment, and I take your point about the difficulties of recruitment. My understanding was that health boards are, where they can't recruit in this country, looking abroad. Is that a way of, again, dealing with the kind of hump to overcome the winter pressures—if we can't recruit locally, that we

just have to go elsewhere to recruit? Sorry, lots of things in there. So, sorry.

[244] **Ms Jones:** Can I start with the first part of your question, Dawn, and just say there is a distinct line between the role of a registered nurse and a healthcare support worker, and everyone is very aware of the line that they cannot go above? But, I have to be honest, the healthcare support workers are a very, very important part of a team. What most health boards are doing now is giving them increased skills through training, which is excellent, because then they can take on, not the role of the registered nurse, but they are there to support the registered nurse while she delivers the more complex care. So, it's absolutely fantastic and I think it'll go a long way towards helping to retain health healthcare support workers, because they will feel more valued, but it'll also help the registered nurse, because they will feel that some of the pressure is taken off them.

[245] Overseas recruitment—working with nurses who came over from the Philippines around about 2000, 2001, they're an excellent resource. They really are. They settle very well into the community, they work very well with our patients. The patients absolutely love them, because they have a different way with the patients. The patients think they're absolutely fantastic. They are a very, very important part of our team. It's sad that we have to go overseas to recruit. It would be much nicer if we grew our own, but we have to make sure that our patients are cared for and that we have the right number of staff with the right skills. So, if that means going abroad, then that's what we have to do, I'm afraid.

[246] **Dawn Bowden:** And—. Sorry, yes.

[247] **Ms Turnbull:** It was just to say in answer to the question around workforce planning, I think that's absolutely critical, and that's really at the heart of this issue and it's at the heart of so many other issues. It's why we're so pleased that the committee is considering looking at that in some depth. It's fair to say that the workforce planning process has, over the years, improved immensely, and it's important to put that on record, really. But we've still made a number of criticisms of where the process is at the moment. We do think it needs to be more transparent so that people can have expertise and input into the process and improve it. So, where you have an integrated medium-term plan, for example, let's actually produce that in a very public way, and have a look at what those workforce plans are. We feel that there isn't enough account being taken at the moment of the needs of nursing in the independent sector, particularly in care homes. We think that's

one of the reasons for the current crisis at the moment. So, that needs to be taken into account when planning and commissioning, say, nursing numbers. We think that there is clearly still a mismatch between the commissioning process and the needs of the actual service itself. It's improved, but there's still a mismatch.

[248] So, there are a number of issues that we have raised with the current workforce planning process where we think real improvements could be made, going forward, that would then impact on this problem and, indeed, on lots of other problems as well. But it would impact specifically on this problem.

[249] **Dawn Bowden**: Okay. Thank you.

[250] **Dai Lloyd**: Symudwn ymlaen at gwestiynau Caroline. Nawr, rwy'n sylweddoli bod rhai ohonyn nhw wedi cael eu hateb eisoes gan atebion cynhwysfawr gerbron, ond, Caroline, mae'r llawr i ti.

Dai Lloyd: We'll move on to Caroline's questions. I do realise that some of them will have been answered already by the very comprehensive answers we've had, but, Caroline, the floor is open to you.

[251] **Caroline Jones**: Diolch, Chair. Good morning. In supporting the management of unscheduled care, do you think more clearly identified roles and better skills development can change the way in which nursing services can support unscheduled care, both inside and outside of hospitals? That's the first part of my question.

[252] **Ms Turnbull**: Absolutely, yes, and I think this goes back to what I was saying about perhaps using extended nursing skills and advanced nursing skills in primary care more effectively and adding those skills to the team where they're not already present. I think that can extend the access to the whole system, and it can extend what can be done when somebody goes in with a minor illness. So, I think that could be very—. It would also be extremely helpful in that community nursing team. A useful example is the example of independent prescribing skills, for example, so that that can be dealt with in the community nursing team without recourse to hospital admission. So, that would be an example of that.

[253] **Caroline Jones**: Okay. So, to what extent do nurses play an enhanced role with emergency patients—you know, in assessing and treating?

[254] **Ms Jones:** If I can just say that every nurse in the health board that triages a patient who comes in to an emergency department would be a very experienced A&E nurse. So, they would be able to streamline the patients into different areas. We also have, in every A&E department, emergency nurse practitioners who would see and treat patients who come in with minor injuries, or sometimes not quite so minor. In some health boards now, they have advanced emergency practitioners who look at patients who come in with minor illnesses as well as minor injuries. So, all health boards are looking to expand the knowledge and skills of nurses so that we can have a faster throughput through our emergency departments.

[255] **Caroline Jones:** Okay. Thank you. Do you think we could make better use of experienced district and specialist nurses in providing a training and advisory role to community nurses, for example, and other services—for example, care homes?

[256] **Ms Turnbull:** Absolutely. I think the key issue here is the clinical supervision that that type of nurse would be able to provide, not just in the nurse's own team but also to the healthcare support workers, as was talked about earlier. Because, increasingly, that is a huge part of the workforce that needs access to that kind of education and advice, supporting the nurse in the care home who can be, obviously, a single nurse. The connection to the community nursing workforce, connection to that kind of advice, and that connection of professional collaboration is actually really important in terms of them being able to care appropriately for those patients and maintain their independence inside their care home.

[257] **Caroline Jones:** Yes. So, is that in progress at the moment, or is it just being developed?

[258] **Ms Jones:** Can I just say, with the new concept of revalidation for registered nurses, where they have to identify all the work they've done before they can re-register with the Nursing and Midwifery Council, one of the ways that some health boards are looking at it is that people in care homes within their area are being encouraged to come in and undertake the training along with the registered nurses in that health board. So, we should all be then having the same kind of training; so, we should all then have the same knowledge and skills, hopefully.

[259] **Caroline Jones:** Okay. Thank you very much.

[260] **Dai Lloyd**: Dyna ni. Mae'r adran olaf o gwestiynau o dan law Angela.
Dai Lloyd: Okay. The final section will be taken by Angela.

[261] **Angela Burns**: Thanks, Chair. It's just a very simple one. We obviously need a well NHS in order to be able to cope with the winter pressures. So, I wondered what your views are as to why so few medical professionals take up having flu vaccinations. Because that not only protects them and their families, obviously, but protects the patients with whom they work, especially the older and the more frail. Could you also perhaps give us a view as to how you think you might be able to increase the take-up of flu vaccinations amongst medical professionals, but particularly nurses and healthcare support workers?

[262] **Ms Jones**: Can I just say what happens? I'm sorry to go back to my health board, but I know what happens there. Every time you now switch on your computer, it comes up, 'Have you had your flu jab?' It tells us where we can have them. We have registered nurses going into all clinical areas so that staff can have them while they're on duty. They've already been into the health board headquarters, so they've all had their vaccine, and they're all sporting their big badges, saying 'I've had my flu vaccine'. We are—and I think every health board is the same—encouraging people to have the vaccine. Unfortunately, we can't force people to have them, but we are really encouraging and pushing forward. In my health board we had over 50 per cent last year, and we are hoping to increase that this year. But we have to remember that we may have a statistic in the health board, but some of our staff choose to have it in the GP surgery, and they would then not show on the statistics in the health board, but that doesn't mean to say that they haven't had the vaccine.

[263] **Ms Turnbull**: I actually think it would be quite useful to look at some—and I don't know if this is something that the Welsh Government is already looking at, but I think it would be useful to look at some research into actually asking people who haven't had the vaccine why they haven't had it in order to address that more sensibly. Certainly, it's something we strongly encourage our members to have. But, I think—you know, we can speculate, is it access? Is it misapprehensions, as alluded to in the earlier evidence session? But, actually, it would be extremely helpful just to ask people and find out, perhaps, what the real answers are.

[264] **Angela Burns**: Given the effect that having a healthy workforce would have upon winter pressures, do you think that there is any room for looking at stronger actions to take to encourage people to have the flu vaccination?

[265] **Ms Turnbull**: I think we're happy to talk about that and consider some of those options. Certainly, as the Royal College, it's something we strongly encourage. There are magazine articles on our website, we have all sorts of ways that we're reminding our members, and, as Gaynor's alluded to, there are all sorts of activities going on in the different health boards. I suppose the more important question, really, is I would like to know a little bit more about why people are not taking that up, as part of a package of considering other options, because, otherwise, we're speculating and trying to solve an issue that might not be the correct issue.

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

[267] **Dawn Bowden**: I think it's been answered, but, just to be clear, you're saying, if people have the flu vaccine elsewhere, it doesn't count for the health board numbers. But do they not report into their line management that they've had the vaccine elsewhere, so that that could be included? Because the health board, presumably, would want to have an overall figure; it doesn't matter where they have the jab as long as they've had it. So, that was the first thing.

[268] Secondly, I think, Lisa, you've probably answered it, but I was just going to ask, as a staff trade union as well as a professional organisation, what obligations do you think are on you, as an organisation representing nursing staff, to encourage your members to take up the jab as well?

[269] **Ms Turnbull**: As I said, we do encourage our members and we'd agree that that's a role we can play and do play.

[270] **Ms Jones**: Can I answer the first part of your question, Dawn? Just to say that we don't have the facility in the health boards at the moment whereby we can count into our numbers the staff who've gone to their GP surgery and had it, but I think you're quite right; it's something that we really need to be looking at, because it would pull our figures right up.

[271] **Dawn Bowden**: Yes. Okay. Thank you.

[272] **Dai Lloyd**: A oes gennym **Dai Lloyd**: Any further questions? No.

unrhyw gwestiynau eraill? Na. A oes gennych chi unrhyw ddatganiad i'w wneud cyn i ni orffen, os ydych chi'n credu nad ydym wedi cyfro popeth ynglŷn â hyn o'ch ochr chi, ynteu a ydych chi'n hapus efo beth sydd wedi cael ei ddweud eisoes?

Do you have anything else that you'd like to add before we conclude? Is there anything that you don't think we've covered, from your side of things, or are you content with what's already been stated?

[273] **Ms Turnbull:** Very content, thank you—the only thing I'd just reiterate again is that the connection to workforce planning, I think, is really important. So, we are extremely pleased that the committee's considering looking at that issue.

[274] **Ms Jones:** Thank you very much.

[275] **Dai Lloyd:** Diolch yn fawr. Fe wnawn ni dynnu'r sesiwn yma i ben, felly. Diolch yn fawr i Gaynor Jones a Lisa Turnbull am eu cyfraniadau yn ysgrifenedig ac ar lafar. Cânt drawsgrifiad, fel maen nhw'n gwybod, o'r trafodaethau i'w gwirio.

Dai Lloyd: Thank you very much. We'll draw this session to a close therefore. I'd like to thank Gaynor Jones and Lisa Turnbull for their contributions both in writing and orally. You will receive a transcript, as you know, so you can check it for factual accuracy.

11:43

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod ac o'r Cyfarfod ar 13 Hydref 2016
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting and the Meeting on 13 October 2016

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod, ac o'r cyfarfod ar 13 Hydref 2016, yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting, and the meeting on 13 October 2016, in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[276] **Dai Lloyd**: Gyda hynny o drafod, fe wnawn ni symud ymlaen i eitem 5 nawr, a'r cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod a hefyd o'r cyfarfod ar 13 Hydref, sef wythnos nesaf. Pawb yn hapus gyda'r sylw yna? Dyna ni. Diolch yn fawr; awn i mewn i'r sesiwn breifat nawr.

Dai Lloyd: With those few words, we'll move on to item 5, which is the motion under Standing Order 17.42, to resolve to exclude the public from the remainder of the meeting and from the meeting on 13 October, which is next week. Everyone content? Thank you very much; we'll move into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:44.
The public part of the meeting ended at 11:44.